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# Minnesota All Payer Claims Database Workgroup

Minnesota Department of Health  
*Report to the Minnesota  
Legislature - 2014*

**January 2015**

# **Minnesota all payer claims database Workgroup**

**January 2015**

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*Protecting, maintaining and improving the health of all Minnesotans*

February 1, 2015

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Chair, Health, Human Services and Housing  
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The Honorable Tony Lourey  
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To the Honorable Chairs:

The 2014 Minnesota Legislature directed the Minnesota Department of Health to convene a work group to develop a set of recommendations for the expanded use of the Minnesota all payer claims database (MN APCD) established under Minnesota Statutes §62U.04.

The department established the work group and held monthly meetings during the summer and fall of 2014. Staff from Minnesota Management and Budget and a national APCD expert from Freedman HealthCare were commissioned to facilitate the process. The work group was composed of:

- (1) two members recommended by the Minnesota Medical Association;
- (2) two members recommended by the Minnesota Hospital Association;
- (3) two members recommended by the Minnesota Council of Health Plans;
- (4) one member who is a data practices expert from the Department of Administration;
- (5) three members who are academic researchers with expertise in claims database analysis;
- (6) two members representing two state agencies determined by the commissioner;
- (7) one member representing the Minnesota Health Care Safety Net Coalition; and
- (8) three members representing consumers.

This report contains a summary of the conversation and recommendations of the work group. Opinions amongst the group were varied and the report reflects the exchange of ideas that was part of the process. In those cases where clear guidance and recommendations are possible, the report reflects the group's legislative recommendations. In those areas where consensus was less achievable we reflect on the diversity of opinion of the work group for the legislature.

The work group made several recommendations. These include:

1. The Legislature should authorize MDH to develop a Public Use File(s) and summary tables that would not include provider or payer identifiers. Such files and tables should be made available to the public, if possible without cost, and with minimally necessary restrictions or barriers.
2. The Legislature should direct MDH to convene a public/private advisory group. Their role would be to advise on:
  - a. the structure and contents of use files, summary tables, and support data;
  - b. the general parameters for allowable data uses, and privacy/security provisions;
  - c. the development of an iterative process to expanded access to data; and
  - d. the process and funding for specific requests to access detailed data.
3. MDH should establish a technical group to make recommendations on issues such as:
  - a. potential changes to data elements collected;
  - b. opportunities to link MN APCD data to other datasets to expand analytic capacity;
  - c. strategies to monitor and improve quality, accuracy or timeliness of data;
  - d. formats or general content of regular data quality updates;
  - e. methodological feasibility of specific measures or analyses relative to the data;
  - f. public use file contents and summary tables; and
  - g. suitability of de-identified data for expanded research and data validation initiatives.
4. MDH should continue its work to develop APCD quality reports.
5. MDH should report to the Legislature on ongoing work, data developments and APCD enhancements after year 1 of authorized expanded uses.

For questions or concerns regarding this report, please contact Stefan Gildemeister, the State Health Economist, at 651-201-3554 or [stefan.gildemeister@state.mn.us](mailto:stefan.gildemeister@state.mn.us).

Sincerely,



Edward P. Ehlinger, M.D., M.S.P.H  
Commissioner of Health  
P.O. Box 64975  
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Enclosure

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# All Payer Claims Database Workgroup

## Recommendations to the MINNESOTA LEGISLATURE

Prepared for  
Minnesota Department of Health  
By Freedman Healthcare

December 24, 2014



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# Executive Summary

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In April of 2014, the Minnesota Legislature directed the Commissioner of Health to convene a Workgroup to develop a framework for the expanded use of the Minnesota all payer claims database (MN APCD). As required by the Legislature, the Workgroup represents a variety of health care professionals with a breadth of expertise and insight into the Minnesota health care delivery system, consumer needs, provider communities, and academic researchers. The Legislature directed the Workgroup to consider six specific questions and provide a report by February 1, 2015. The Workgroup met six times between July and December 2014.

The Workgroup brought a diversity of opinions to bear on the Legislature's questions, and did not always achieve consensus. Recognizing the six-month timeline for developing answers to the six questions, the following themes emerged from the Workgroup's meetings:

- The MN APCD is an important, publicly funded resource that can help Minnesota move towards achieving the Triple Aim for health care: better patient experience, improved population health and lower per capita costs. The MN APCD should be leveraged for a broader range of uses and users, and ultimately provide demonstrable value to Minnesota residents.
- While the Workgroup's Members differed to some degree in their ultimate vision for types of allowable uses and extent to which uses would be subject to review or approval, Members agreed that Minnesota should move forward with developing a system of broader, expanded uses based on an iterative process, starting with access to Public Use files and summary tables and transitioning to more 'high stakes' uses over time.
- A public/private advisory or governance body should help shape the transition towards broader uses of the data. Members expressed a range of opinions about such a group. Some Members supported immediate broader uses of the data with minimal restrictions and other Members supported approval of all uses by a decision making body. The Workgroup agreed that the future group's membership should be broad, with strong consumer representation alongside providers (including a safety net provider), payers, employers, academic researchers and other stakeholders. The Workgroup also recommended creating a technical group that could contribute specialized expertise in the area of data quality assessment and further development of the data. The Workgroup discussed the role of such a group in developing policies ("guard rails") for evaluating whether specific data requests are appropriate uses for MN APCD data.

## Recommended Actions

1. The Legislature should authorize MDH to develop a Public Use File(s) and summary tables. Initial Public Use Files and summary tables would not include provider or payer identifiers. Such files and tables should be made available to the public, if possible without cost, and with minimally necessary restrictions or barriers.
2. The Legislature should direct MDH to convene a public/private advisory group to shape the iterative approach to broader uses, including topics such as:
  - a. structure and contents of the public use file(s) and summary tables;
  - b. structure and contents of other, more detailed files that could support other types of analysis;

- c. privacy/security provisions that should be in place prior to allowing any access to data that includes identifiers;
  - d. guardrails and guidelines for a rolling, iterative process to guide expanded access to data; and
  - e. process through which access to specific detailed data would be allowed.
3. MDH should establish a technical group to make recommendations to the public/private advisory group regarding:
- a. potential changes to data elements collected to expand types of possible analysis;
  - b. opportunities to improve ability to link MN APCD data to other datasets to expand potential range of analytic applications;
  - c. strategies to monitor and improve quality, accuracy or timeliness of data;
  - d. formats or general content of regular data quality updates;
  - e. methodological or analytical feasibility of specific measures or analyses given the data available;
  - f. public use file contents and summary tables; and
  - g. suitability of de-identified data for expanded uses such as research, quality improvement projects and data validation initiatives.
4. MDH is preparing a series of reports on data quality and should continue this work. MDH should report to the Legislature by February 1, 2016 about the progress of the MN APCD in Year 1 of expanded uses.



# Introduction

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Minnesota’s All Payer Claims Database (APCD) was established as part of the state’s far-reaching bi-partisan health care reform legislation of 2008. Minnesota Statutes section 62U.04 required the collection of a broad array of claims data from public and private payers to inform health system change. Specifically, the MN APCD supported the Provider Peer Grouping (PPG) project, intended to increase transparency about value in purchasing by publishing reports on health care cost and quality in Minnesota hospitals and clinics. In 2014, the Minnesota State Legislature commissioned the creation of a MN APCD Workgroup to explore a framework for expanded uses of the MN APCD--beyond those authorized in current law--that would align with the state’s goals and needs surrounding the health care system. The purpose of this report is to share the discussion and recommendations of the Workgroup on the Legislature’s questions about expanded use of the MN APCD.

This report presents a brief history and background of the MN APCD, including information about APCDs in other states; the role of the MN APCD Workgroup in response to the Minnesota State Legislature’s charge for identifying new and expanded uses for the MN APCD; and the Workgroup’s responses to each of the questions and their implications for next steps in leveraging Minnesota’s APCD.

## Minnesota All Payer Claims Database

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An All Payer Claims Database is a large-scale database that systematically collects and integrates medical claims, pharmacy claims, and eligibility and provider files from private and public payers. Each state’s APCD reflects the unique perspective, needs, and priorities of that state, ranging from concern about value in health care to interest in making thoughtful policy decisions. Uses of an APCD typically evolve as the database matures.

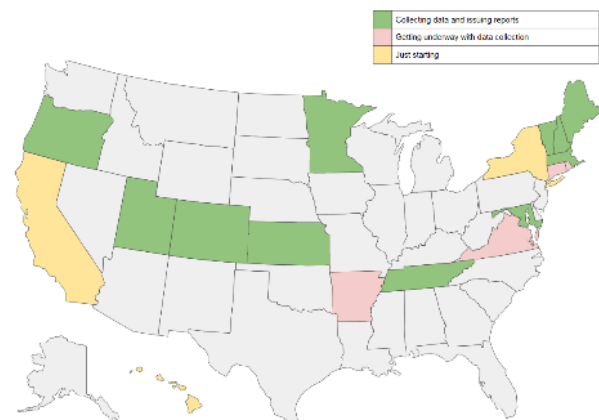
Eleven states, including Minnesota, have active APCDs in place and are currently collecting data and issuing reports (see Figure 1). Four states, including Virginia, Connecticut, Rhode Island, and Arkansas, are in the early stages of data collection. Hawaii, California and New York are initiating development of their APCDs, while 21 additional states are considering APCD legislation.

### History of Minnesota’s APCD

Minnesota was one of the first adopters of the APCD. Minnesota’s APCD is truly an “All Payer” claims database because it incorporates data from Medicaid and Medicare as well as from commercial payers – thus permitting a rich and systematic analysis of health care delivery for the state.

Data submission to the MN APCD began in mid-2009, including de-identified claims data for dates of service beginning on January 1, 2009. The State’s work to support PPG required a significant investment in building the data system, developing risk adjustment methodologies, outlier adjustments, mechanisms to remove add-on payments, and provider directories. Although this project has recently been suspended, the significant investments in data infrastructure and technical and analytic expertise that

Figure 1: APCDs Nationally



the Minnesota Legislature made in this project could create a foundation for potential new uses of data in the future.

In 2014, the Legislature suspended the PPG program and established authority for MDH to use the MN APCD for a select set of projects:

1. evaluating the health care home program;
2. studying hospital readmission trends and rates in partnership with a stakeholder collaborative;
3. analyzing variations in health care costs, quality, utilization and illness burden based on geographical areas or populations;
4. evaluating the state innovation model (SIM) testing grant;
5. conducting a study of chronic pain management services; and
6. determining the suitability of MN APCD data to support risk adjustment in the small group and individual insurance markets.

The Legislature also directed MDH to convene the MN APCD Workgroup to make recommendations related to a framework that would allow a broader set of potential uses for the MN APCD.

### What is in the MN APCD Today?

The MN APCD collects data from over 100 different sources that submit medical, pharmacy and enrollment data. The number of organizations submitting their data into the MN APCD has been increasing over time, as MDH has worked with health plan companies and third party administrators (TPAs) to ensure that they understand and comply with mandatory submission requirements (see Table 1).

The MN APCD collects information about all medical and health services insurance claims paid by a health plan or TPA; Medicare fee-for-service (FFS) data as well as Medicaid and other state FFS claims, including actual amounts paid to providers and the patient's share of the claim cost such as copayments, specific deductible and co-insurance, (as applicable). Submissions also include de-identified demographic information (age, gender, geography) and service information (such as diagnoses, procedures, duration of treatment, dates of service, site of care, provider name, and provider-submitted payment and billing data). See Appendix D for further information.

Recognizing Minnesota's strong protections on individual privacy, the MN APCD does not include direct patient identifiers such as social security number, name, and address. Exempted types of coverage include data from the following forms of insurance: hearing, dental, vision, or disability-only, auto medical or accident-only, insurance supplemental to liability, long term care or Workers Compensation, Medicare Supplemental or Medigap, Veterans Affairs, Indian Health Service, and Tricare. Carriers with less than \$3 million in annual medical claims and/or \$300,000 in annual

### ABOUT THE MINNESOTA APCD

- True "all payer" database, includes data from Medicare and Medicaid
- First and only state APCD to receive certification from Medicare's Qualified Entity Program
- Extensive, ongoing data quality processes
- Collection and management of data from more than 100 payers representing public, commercial, and self-insured markets
- Offers technical assistance to other states

**Table 1: Minnesota APCD Data Submitters over Time**  
**APCD Payer Annual Participation History**

Year	2010	2011	2012	2013	2014
<b>Data Submitters</b>	32	30	83	90	105

Note: 2014 is part-year estimate

pharmacy claims are exempt from data submission requirements of the MN APCD. Data for individuals who are uninsured is also not included in the MN APCD.

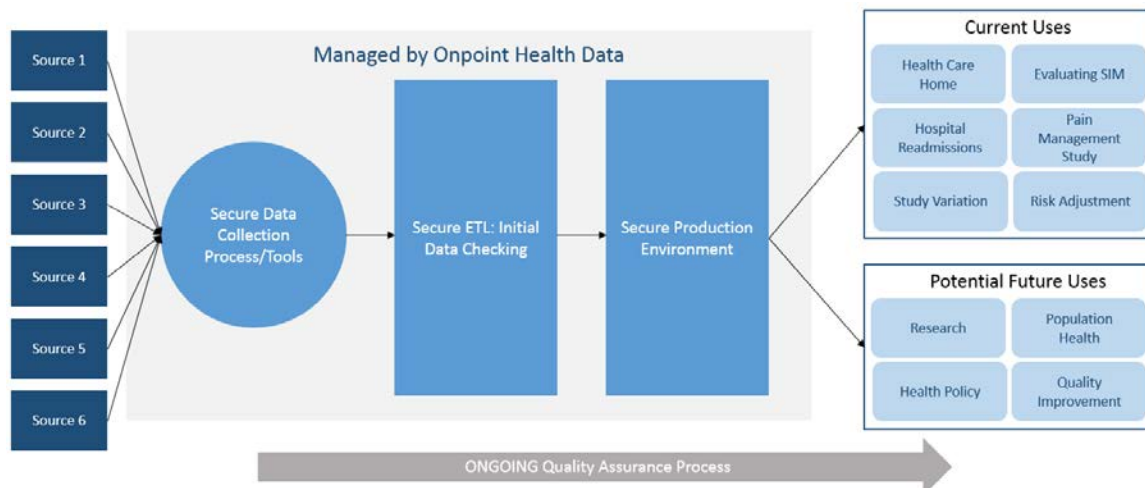
Data in the MN APCD captures enrollment and claims data from 2009 forward, with some data dating back to 2008, for approximately 85% of the state’s population. As data collection is ongoing, Minnesota’s MN APCD continues to become more inclusive every year.

## How Are Data Collected?

The Minnesota Department of Health contracts with a data manager, currently Onpoint Health Data, to collect data for the MN APCD. Onpoint has extensive experience with APCDs, having helped seven states implement APCDs since 2004. Onpoint has developed technical submission instructions and a process that converts all member and subscriber names, numerical identifiers and dates of birth into 128 characters of letters, numbers and symbols. This “hashed string” meets Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>1</sup> standards for de-identification and cannot be reverse-engineered to deduce an individual’s identity. Figure 2 depicts the data collection process for the MN APCD.

Throughout data collection and storage, the MN APCD maintains ongoing quality assurance processes. In collaboration with MDH, Onpoint establishes standards for incoming files and uses a proprietary process to examine several hundred aspects of data quality at intake and in the data aggregation process. For example, each cell in a submitted file is checked to ensure that the size and type of information conforms to the established specification. Each file is also reviewed to establish that the data submitter has met the state’s expectations for the number of times a particular data cell has information. Please see Appendix E for additional information regarding data quality checks.

Figure 2: Data Flow in the MN APCD



Notes: “ETL” or Extraction, Transformation and Loading refers to the process of loading files into a particular data environment, checking the format and contents of the files, and moving them into a designated location for further analysis and review.

Files that fail to meet all minimum standards are rejected in their entirety. Under state rule, data submitters are required to correct such errors and resubmit until the file passes. Health plans can request

<sup>1</sup> The Health Insurance Portability and Accountability Act of 1996, as implemented by the federal Centers for Medicare and Medicaid Services, created strong protections around the privacy and security of patients’ medical information, including guidelines about de-identification requirements in data files.

variances for the submission of data elements that are either not retained by them or retained at insufficient quality to meet the submission standards.

## MN APCD Workgroup

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In April of 2014, the Minnesota Legislature directed the Commissioner of Health to convene a Workgroup to develop a framework for the expanded use of the MN APCD. The Workgroup represents a variety of health care professionals with a breadth of expertise and insight into the Minnesota health care delivery system, consumer needs, provider communities, and academic researchers (see Appendix A for a full list of Workgroup Members).

The Minnesota Legislature charged the MN APCD Workgroup with providing insight to help guide the Legislature in considering whether and how to allow expanded uses for the MN APCD. The statute directed the Workgroup to discuss the following six questions:

1. What should the parameters be for allowable uses of the MN All Payer Claims Data collected under Minnesota Statutes, section 62U.04, beyond the uses authorized in Minnesota Statutes, section 62U.04, subdivision 11?
2. What type of advisory or governing body should guide the release of data from the Minnesota all payer claims database?
3. What type of funding or fee structure would be needed to support the expanded use of All Payer Claims Data?
4. What should the mechanisms be by which the data would be released or accessed, including the necessary information technology infrastructure to support the expanded use of the data under different assumptions related to the number of potential requests and manner of access?
5. What are the appropriate privacy and security protections needed for the expanded use of the Minnesota all payer claims database?
6. What additional resources might be needed to support the expanded use of the all payer claims database, including expected resources related to information technology infrastructure, review of proposals, maintenance of data use agreements, staffing an advisory body, or other new efforts?

### Workgroup Meetings

The Workgroup held six meetings between July and December 2014. Meetings were held at the MDH Orville L. Freeman Office Building in St. Paul, Minnesota. Members who could not attend in person were given the option to participate in the meeting over conference call. Meetings were open to the public for observation and comment by the public. Workgroup meetings were co-facilitated by Linda Green, Vice President of Freedman HealthCare and Kris Van Amber, Senior Management Consultant at Minnesota Management Analysis & Development, who were retained by MDH for this project.

Each meeting's agenda and materials were distributed to Members prior to meetings and posted on a public website (<http://www.health.state.mn.us/healthreform/allpayer/>).

Members actively participated in fulfilling the Workgroup's Charter (see Appendix C) by contributing their knowledge, expertise and evidence base to the discussion; providing examples and approaches for additional database uses and fully engaging in discussions during meetings.

## Workgroup Guidelines

The Workgroup recognized that achieving its goals and objectives is not dependent upon group consensus. While group consensus was a desired outcome, agreement was not necessarily attainable for each topic given the timeframe. For the topics and issues on which the Workgroup did not reach consensus, Members had an opportunity to express their opinions and provide potential options for the Legislature.

## Summary of Meeting Discussions

Each meeting began with a summary of the discussion from the prior month's meeting. The wide range of Members' opinions and amount of discussion required careful summarization and confirmation by the group. This strategy allowed the Workgroup to identify areas of agreement and revisit topics needing continued consideration. These discussions were followed by a presentation defining the subject for the meeting, how other states or data management organizations approach the issue, and offering Members opportunities to comment and weigh in on their recommended approach. Meetings ended with an opportunity for public comment. Members requested an additional meeting to get a better understanding of data intake, data quality provisions and best practices employed in other states. This section provides a high-level summary of the topics considered at each meeting. For meeting materials and minutes, see Appendix B.

### Meeting 1: Kick-Off Meeting

In its first meeting, the Workgroup discussed Members' perspectives and expectations and established ground rules. Members reviewed the Workgroup Charter (see Appendix C), which outlined questions posed to the Workgroup by the Legislature. Members addressed the scope of the Workgroup and established that consensus, while desired, will not always be possible.

Co-facilitator Linda Green provided the Workgroup with an overview of other states' APCDs and invited the Workgroup to ask clarifying questions. The Workgroup compared different states, including Massachusetts, New Hampshire, and Colorado, based on data uses, types of data collected, and access to the data.

### Meeting 2: Principles for Data Use

The Workgroup reviewed evolving MN APCD data uses, including creating its own definition of "data use," inventorying data use categories and examples, and examining other states' APCD data use concepts. The overview informed the Workgroup's guidance on Legislative Question #1 regarding "parameters for allowable uses."

Key data use concepts discussed by the Workgroup included data accuracy, transparency, auditable inputs, data users, safeguards for data use, a data review body, tiered data, and data linking to other sources. The Workgroup expressed interest in reviewing the Colorado model for data standards and use and desire to learn more about data accuracy, transparency, and the use of an external review body.

### Meeting 3: Data Access/Privacy and Security

Members reviewed the current privacy and security practices of the MN APCD. No data are available for any public use. The group discussed future uses of the data, particularly government needs for data transparency and accountability.

The MN APCD Workgroup focused on developing a framework to address privacy and security concerns for new uses of the MN APCD data. Members identified the utility in linking individual identifiers to the data, but questioned whether this could be done while ensuring the identified data will not be released publicly. Members emphasized that citizens must be assured that personally identified data would never

be made publicly available. In particular, language around privacy should be explicit and understandable to a general audience.

#### Meeting 4: Data Governance

The Workgroup discussed data access governance. The Workgroup reviewed a federal agency’s “data release” definition as a starting point for their work, but recognized that the term “data access” was preferred to “data release.” The Workgroup discussed the possibility of MDH creating a “data enclave” that would allow approved users to securely access data and retrieve only the results of an analysis. There was general consensus among the Workgroup that the body providing oversight to data use and access should ensure that the intended use is consistent with the purpose of the MN APCD.

#### Meeting 5: Sustainability and Resource Needs

The Workgroup considered the additional resources needed to support expanded uses at some point in the future as developed by the governing body. The Workgroup identified additional needs to support expanded data access including information technology infrastructure, data access request forms and process, data use agreement management, and data set design and production. The Workgroup discussed fee structures used in other states’ APCDs.

#### Meeting 6: Review Workgroup’s Guidance

The Workgroup discussed the draft final report and reviewed Members’ feedback provided in advance and during the meeting. The Workgroup emphasized that the report should show the diversity of opinions among its Members and clarify when consensus was (or was not) reached. This feedback was incorporated into the final version of the report.

## Data Quality

In early Workgroup meetings, some Members expressed concern about moving forward with any discussion about potential expanded uses of the MN APCD with limited information about the scope and quality of MN APCD data. To address these concerns, MDH presented a Data Quality Informational Webinar on September 30, 2014 to provide an overview of how the MN APCD data are reviewed during data collection and file development. MDH also prepared an FAQ about the MN APCD featuring a section on data quality (see [Appendix F](#)).

Onpoint Health Data, the MN APCD Data Management vendor, described its processes to examine data submitters’ compliance with technical specifications. The processes examine the several hundred tests that are performed before the files are accepted into the MN APCD, as well as the communication strategy with data submitters. The presentation also described how data submitters securely submit files to the MN APCD.

Representatives from the Massachusetts and Colorado APCDs, two states with robust APCD data access operations, answered questions about their data quality processes.

Work group members indicated that the session contributed to their understanding of the structure and composition of the MN APCD.

# Workgroup Discussion Summary

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This section describes the Workgroup’s guidance, recommendations and discussions about expanding the use of the MN APCD. Each section describes the major themes discussed as the Workgroup considered each topic. Where appropriate, a section may include a sidebar describing applicable state or federal law or other states’ experiences referenced during the topic discussion.

During the meetings, the Workgroup considered formal agenda items as well as associated topics raised by Members. One theme of the discussions was the interconnectedness of the questions posed by the Legislature. Some Members expressed a preference for working through all governance questions at the outset; other Members saw a need for establishing purpose and vision before considering oversight and operations. The Workgroup considered both perspectives at each meeting.

After considerable discussion of the Legislature’s questions, the Workgroup achieved a narrowly defined consensus on the following topics:

- The MN APCD is an important, publicly funded resource that can help Minnesota move towards achieving the Triple Aim for health care: better patient experience, improved population health and lower per capita costs. The MN APCD should be leveraged for a broader range of uses and users, and ultimately provide demonstrable value to Minnesota residents.
- While Members differed to some degree in their ultimate vision for types of allowable uses and extent to which uses would be subject to review or approval, the group agreed that Minnesota should move forward with developing a system of expanded uses based on an iterative process, starting with access to Public Use files and summary data tables and transitioning to more ‘high stakes’ uses over time.
- A public/private advisory or governance body should help shape the transition towards broader uses of the data (beyond the Public Use files and summary tables). Members expressed a range of opinions about such a group. Some Members supported immediate broader uses of the data with minimal restrictions and other Members supported approval of all uses by a decision making body. The Workgroup agreed that the group’s membership should be broad, with strong consumer representation alongside providers, payers, employers, academic researchers and other stakeholders. The Workgroup also recommended creating a technical group that could contribute specialized expertise in the area of data quality assessment and further development of the data.

The sections below provide summaries of the discussions, the areas of agreement and the diverse opinions and insights of Members.

# Question 1 from the Legislature: Allowable Uses

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What should the parameters be for allowable uses of the all payer claims data collected under Minnesota Statutes, section 62U.04, beyond the uses authorized in Minnesota Statutes, section 62U.04, subdivision 11?

**Feedback or Recommendation:** In keeping with achieving the Triple Aim for health care in Minnesota, the Workgroup envisions a broad range of potential uses for the MN APCD that could be pursued over time through an iterative process beginning with the creation of Public Use files and summary tables.

The MN APCD Workgroup acknowledges the potential value of an All Payer Claims Database in helping Minnesota improve health care for all its residents. The MN APCD is unique in that the data reflect all settings of care regardless of payer; Minnesota's APCD is a national leader in that data submitters include fully insured commercial plans, self-insured plans, state agencies, Medicaid, and Medicare. The Workgroup recognizes the importance of the MN APCD for academic researchers, payers, providers and the public, and that the MN APCD is a valuable resource that should be available to users beyond state agencies.

At the outset of its meetings, Members offered their initial ideas about potential uses of the MN APCD. Examples of these potential uses included:

- Helping achieve the Triple Aim of improved patient experience, improved population health and lower per capita cost
- Measuring quality of care
- Gaining insight about variations in care, especially disparities
- Informing price transparency initiatives
- Increasing understanding about where to target public health resources
- Presenting the full picture of health care service delivery by showing care across settings
- Reporting to the public about the health care system to drive change and monitor progress
- Responding to the data users' different information needs and purposes

The Workgroup also explored how other states set parameters for allowable data uses for their MN APCDs. A summary of the language used in other APCDs to describe data uses is included in Chart 1; Chart 2 shows the MN statutory language about how the MN APCD is classified (see Charts on page 27).

The Workgroup suggested maximizing the uses and utility of the MN APCD as new health care strategies, analytic technologies and service models emerge. The history of claims data analysis suggests that new tools and methodologies evolve and provide new analytic value. Most Members agreed that the MN APCD could offer insight into trends in care delivery and payment reform and other health care policy development topics. Over the course of its meetings, the MN APCD Workgroup considered different strategies to support expanded data use and access policy. The Workgroup discussed the form and format of different types of files, what types of projects might be supported, and the utility of the data to accomplish the projects. Some Members strongly supported providing broad public access to the data in a manner that continues rigorous protection of patient privacy. Some Members further noted that the MN APCD should not

## Examples of Data Uses in Other APCDs

- Health Benefit Exchange evaluation
- Total cost of care analysis
- Health system modeling
- Coordinated data collection rules across all state agencies
- Modeling effects of alternative payment structures



be withheld from public view or analysis given that it is a publicly funded resource and pointed to the fact that it is classified unusually restrictively compared to other MN state-supported data resources. Analysis and reports built from this data would be subject to scrutiny from peers and reviewers, creating accountability and general oversight.

Members were highly interested in learning more about the contents and structure of the information in the MN APCD through the September 2014 informational webinar. Members interested in research were particularly interested in understanding how the MN APCD might support longitudinal analysis over time and reiterated that behavioral health data should be fully available for analysis in conjunction with physical health claims data.

The Workgroup envisioned that one of the tasks of a governing body would be to develop a plan for expanding access and that this plan would include an iterative approach, in which expanded uses would be rolled out over time.

The Workgroup generally agreed that de-identified data could be made available without restriction to any member of the public. For example, a data analyst could count the number of specific medical procedures performed in a particular year for men and women by age group. This type of data is similar to information that the federal Centers for Medicare and Medicaid services provides on their website at no charge to members of the public. Specific file types are described in the answer to Question 4.

Members held a range of opinions about allowing access to data with payer and provider names:

- Some Members supported including payer and provider names in a broadly accessible Public Use file and summary data tables as a means of supporting price/cost transparency and variations in quality or cost of care.
- Some Members expressed concern about including payer or provider identities in any data that might become available. They cited concerns about the potential for inaccurate and harmful provider performance reporting; others were concerned that such reporting would lead to provider pressure for higher fees.
- A member suggested that only payers and providers be given access to the data for internal quality improvement activities. Other Members were concerned about allowing a private organization to use the data for internal, non-public purposes while withholding access from other public users.
- Members discussed whether the Workgroup could reasonably define objective standards for moving forward with allowing access to this type of information.

Some Members were hesitant to allow use of the data for any provider-specific analysis regardless of whether the providers were publicly identified. These Members indicated that new data uses beyond the initial Public Use File and summary data tables might proceed when a future governing body was satisfied that the MN APCD met as-yet undetermined standards. Members did not specify timelines or particular benchmarks that might guide the introduction of new levels of access, but recognized that such benchmarks would need to be developed.

#### Guard rails

Some Members suggested that the MN APCD establish “guard rails” to differentiate between supported, desirable first uses and future, more “high-stakes” uses that might justify an iterative approach. Some Members were concerned that “guard rails” would become gates or obstacles that prevent new uses from moving forward. Members questioned how and who would establish and measure progress towards milestones that indicate readiness for broader use, especially if the milestones are not well defined in advance.

In earlier discussions, the Workgroup generally agreed that the following data uses would not be appropriate for the MN APCD:

- Marketing to patients or providers
- Anti-competitive activities
- Reselling data obtained for a single, specific purpose
- Unapproved links to other files that could compromise patient privacy.

Members discussed whether the MN APCD could be improved if providers had an opportunity to review and validate the MN APCD's information about their patients. The MN APCD's patient privacy protections require removal of all patient identifiers from files prior to submitting files to the Data Manager; therefore, at this point providers cannot verify records pertaining to their practices. De-identified information in a database supports some types of analysis but not others (see sidebar). Some Members strongly advocated for revisiting the existing de-identification model to allow greater opportunities for linkage to other datasets and to enable a broader range of analyses, although not all Members agreed with this approach. Some Members said that de-identified data limits the ability of providers to validate data.

**De-identified data may support answering questions about:**

- Disease incidence in a state
- Spending trends
- Where patients get care
- Sources of insurance coverage
- Utilization rates

**De-identified data is less useful for:**

- Confirming provider-patient relationships
- Long term health status research
- Outcomes research linked to clinical data

# Question 2 from the Legislature: Data Release Advisory or Governing Body

What type of advisory or governing body should guide the release of data from the all payer claims database?

**Feedback or Recommendation:** The Workgroup agreed that some type of broad advisory or governing body would likely be helpful in an environment of expanded use for files that provide more detail than the Public Use file or summary tables. A technical group would contribute specialized expertise about the database. The Workgroup did not reach consensus on the structure, scope or membership of either a governing or an advisory body or agree upon whether such a body should function in an advisory role or a decision-making capacity.

Members spent considerable portions of each meeting discussing the role, functions and structure of MN APCD governance. Informed in part by what they heard about other state APCDs, Members offered a range of opinions and perspectives about how to manage access to the data if it should ever become available beyond a public use data set or summary data table without provider or payer identifiers. The Workgroup discussed the different functions that governance might encompass, including:

- Policy making and recommendations related to MN APCD operations
- Developing/refining “guard rails” to shield against inappropriate uses
- Reviewing specific requests for the data

The Workgroup also discussed how other states handle APCD governance. Some states convene an advisory committee to keep stakeholders informed about the progress and status of the APCD and to receive guidance about policy and operational decisions, while other states do not find this is needed on an ongoing basis (see Table 2 “Other States’ APCD Governance”). Some states convene a data access review committee to consider specific data use applications on a case-by-case basis.

As described in an earlier section, some Members supported a data access review committee to consider certain requests involving access to more granular data or culminating in publication of results that identify individual providers or payers. Other Members supported a case-by-case review of every data use request due to some Members’ concerns about the need to protect providers or payers from potentially inaccurate analyses or conclusions. Other

Table 2: Other States’ APCD Governance

**Columns:**

**Policy:** High-level guidance, oversight

**Use requests:** case-by-case review of data requests

**Technical advisory group:** data collection insight

**Legend**

- State Agency
- ◆ Advisory Group
- Decision Making Group

	Policy	Use Requests	Technical Group
Colorado	■ ◆	◆	◆
Kansas	■		
Maine	■ ◆	◆	
Maryland	■ ◆		
Massachusetts	■	◆	◆
New Hampshire	■		
Oregon	■ ◆	◆	
Utah	■		
Vermont	■ ◆	◆	

Notes:

States each define the types of requests that require case-by-case review.

Members supported an approach that would allow broad public access to all data currently held by the MN APCD, without a review process, as long as the proposed use was within the ‘guard rails’ or parameters of allowable use that would be established. The Workgroup did not reach consensus on this point.

## Advisory or Decision Making?

The Workgroup did not come to agreement on whether a governance body should operate in an advisory or a decision-making role. Some Members initially envisioned an independent, decision-making body that would control all uses and access to the MN APCD on a case-by-case basis. Others envisioned a public-private body with broad membership that would advise the Legislature or the state agency tasked with responsibility for the data on allowable uses but would not have decision-making authority. By the end of the final Workgroup meeting, most Members had gravitated towards an advisory model rather than a decision-making body, with broad membership including strong consumer representation, providers, payers, employers, academic researchers and others. Other Members supported some form of stakeholder engagement in the development of new MN APCD access and reports. Several Members of the Workgroup were concerned that decisions to grant or deny access to data could be affected by personal or organizational conflicts of interest, particularly if a proposed project would result in publication of analyses or data that identifies individual clinics, hospitals, or payers. The Workgroup discussed whether this topic could be addressed in future policies and procedures and did not come to a group recommendation.

## Technical Advisory Group (“TAG”)

Members also discussed whether the MN APCD should convene a TAG to monitor and advise on data quality, completeness and timeliness issues, and inform the further development of the database. In other states, such meetings have been a useful forum for clarifying definitions, expectations and challenges in providing data to an APCD. Other states also use these meetings to discuss future changes and alert data submitters about upcoming deadlines. Members generally supported this concept.

## Pre-Publication Reviews

Some Members suggested that an independent group review reports and analysis containing payer and provider names to safeguard against errors of data interpretation or methodology. These Members indicated that the review requirement should pertain to reports and analysis produced by any user, including those produced by private organizations, academic researchers and state agencies. Other Members noted that the value of reports and analysis derived from expanded uses of the data should outweigh concerns about misinterpretation of the data, and that such a requirement would serve to dramatically slow progress towards greater use of the data. Members spoke about the difficulty and near impossibility of guarding against all potential misinterpretations of data. They noted that multiple reasonable approaches to analysis of any particular issue exist, making determinations about which analyses should or should not be published very subjective, and that respected data analysts and sources of information will supersede less credible reports. One Member also noted that a report review requirement would be administratively complex and is incongruent with data access provisions employed by other states and the federal government.

The Workgroup did not reach consensus on a recommendation about whether to require a pre-publication review.

# Question 4 from the Legislature: Data Access Mechanisms

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What should the mechanisms be by which the data would be released or accessed, including the necessary information technology infrastructure to support the expanded use of the data under different assumptions related to the number of potential requests and manner of access?

**Feedback/Recommendation:** The Workgroup supports creation of a broadly accessible file known as a “Public Use File” and related summary data tables. In keeping with the iterative approach outlined in Question 1, more types of access to more detailed files might follow based on experience with the initial information.

The Workgroup discussed the specific types of files that should be created for users. The structure and contents of these files reflect the Workgroup’s thinking about using an iterative approach to broader access to the data; the recommendation is to begin with an initially narrower data set. In developing its position, the Workgroup considered state policy about state funded data collection, concerns about use of sensitive information such as provider names and how to mitigate the potential for misuse of the data. The Workgroup supported moving forward with creating a Public Use File and summary data tables that allow general users to access de-identified data without restriction and extensive approval processes. The HIPAA Privacy Rule describes a Public Use File as a type of file that does not contain any information that identifies a patient. This type of file will support public health assessments and utilization studies. For example, a Public Use File might contain a row for each claim in the database showing the month and year of the service, procedure codes, payment information, the patient’s age and whether the service was provided on an inpatient or outpatient basis. Information that might identify a particular patient would not be included. The Workgroup indicated that the first versions of the Public Use Files and summary tables would not contain payer or provider identifiers.

Summary tables might be based on a Public Use file and for example could show the total number of chest x-rays for different age groups and how utilization varies in different parts of the state. Other examples of summary tables include the annual or average costs of care for care used by “healthy” people or people who have chronic conditions.

National examples include CMS’s Medicare files (see [“Basic Stand Alone Medicare Claims Public Use Files”](#)) and Utah’s recently published [APCD Public Use File](#), the first in the nation.

The Workgroup recommends that Public Use Files and summary tables meet HIPAA standards for de-identified files as described in Safe Harbor guidelines (see [CMS Office of Civil Rights Guidance](#), as discussed more in the Workgroup’s response to [Question 5](#)). These files would not require an additional permission or approval process. One-time costs for developing these public use files include the initial file and documentation design plus costs for creating website access. Technical production costs will vary based on whether the files are updated quarterly or annually. The Workgroup did not make formal recommendations regarding the frequency of updates.

## As defined by HIPAA, what information is in a Limited Data Set?

A Limited Data Set excludes specified direct identifiers of the individual or of relatives, employers, or household members of the individual. Of the list of 18 identifiers (see [“HIPAA Identifiers”](#)), the only two available for inclusion in a MN APCD Limited Data Set are dates of service and member zip code. HIPAA’s list of protected health information does not include provider names and identifiers.

Limited Data Sets: At such time when the MN APCD is authorized to provide access to more detailed data, Members' discussions touched on the following points to guide the process:

- Datasets should include only the information needed to accomplish the project's goal.
- Access to the data must protect patient privacy and protect against re-identification.
- Users must demonstrate an ability to appropriately manage and secure data according to best practices, and must have a data use agreement in place with the State that holds them accountable for securely maintaining data throughout the project period and destroying it afterwards.
- A prospective research project should be reviewed by an institutional review board or the equivalent of a Privacy Board.

To protect protected health information in a Limited Dataset, the Workgroup further recommends that the MDH work towards enhancing its Data Enclave, a secure, permission-based service that approved users could access to perform data calculations and retain only the results of the analysis. As an example of such a model, CMS has established the [Virtual Data Resource Center for Medicare Data \(VRDC\)](#), which, according to CMS, "allows researchers to access and perform their own analysis and [manipulate data] virtually from their independent workstation." In addition, "researchers are only permitted to download summary statistical information. No personally identifiable information or protected health information may be taken out of the VRDC."

# Question 5 from the Legislature: Privacy and Security Protections

What are the appropriate privacy and security protections needed for the expanded use of the Minnesota all payer claims database?

**Feedback/Recommendation:** If the Legislature approves expanded access to the MN APCD, MDH should establish policies and procedures that align with HIPAA with respect to data privacy.

As discussed in the Recommendation for [Question 4](#), above, Members supported HIPAA concepts and standards around access to health care data. Table 3 provides information from other states on available APCD files.

Privacy Protections: The Workgroup expressed confidence that HIPAA privacy protections are necessary and appropriate for expanded uses of the MN APCD. The Workgroup noted that the health care research and data user community is deeply familiar with HIPAA guidance on appropriate data reporting strategies.

For Public Use files and summary tables, file designers should adhere to HIPAA definitions of de-identified files, particularly the “Safe Harbor” standard that lists requirements for each of the identifiers in the database ([Appendix G](#)). Examples of the masking that would be done to construct the Public Use file include:

- No service dates other than year
- Age bands (e.g. “ages 19-44”) rather than age in years; ages greater than 89 shown as “89+”
- First three digits of zip code only

When it comes time for MDH to create data use agreements for data sets containing information beyond a public use dataset, data users would agree to certain privacy/security requirements when presenting results and data summaries. Examples of such the previously mentioned reporting requirements include (but are not limited to):

- Summarizing data for geographic areas with a minimum of 20,000 residents or according to the first three digits of zip codes
- Reporting data for individuals who are 89 years old or more in a single age group
- Suppressing small cell sizes.

Privacy Protections: The MN APCD data collection process converts all Member and subscriber names, numerical identifiers and dates of birth into 128 characters of letters, numbers and symbols. This “hashed string” meets HIPAA standards for de-identification and cannot be reverse-engineered to deduce an individual’s identity. This process offers Minnesota residents and data submitters the assurance that submitted data contain the absolute minimum necessary information to accomplish the purpose of the MN APCD

	■ Public Use Tables on Website	◆ Public Use File Upon Request	● Limited Data Set Upon Request
Colorado	●	■	
Kansas			●
Maine		◆	●
Maryland			●
Massachusetts		◆	●
New Hampshire		◆	●
Oregon		◆	●
Utah		◆	

Security Protections: The Workgroup expects that users granted access to a Limited Data Set or its equivalent will be required to enter into and adhere to the terms of a data use agreement (“DUA”). The DUA is a contract between the MN APCD/MDH and the data user that describes how the user will use, maintain and protect the data. As discussed in the response to [Question 4 “Access to Data,”](#) the Workgroup prefers that access to Limited Data occur through a data enclave or other controlled mechanism.



# Questions 3 and 6 from the Legislature: Funding and Resources

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Question 3: What type of funding or fee structure would be needed to support the expanded use of the Minnesota all payer claims database?

Question 6 from the Legislature: What additional resources might be needed to support the expanded use of the Minnesota all payer claims database, including expected resources related to information technology infrastructure, review of proposals, maintenance of data use agreements, staffing an advisory body, or other new efforts?

**Guidance/Recommendation:** The Workgroup considered Questions 3 and 6 together. The Workgroup agreed that additional resources would be required to support expanded access to the data and that the MN APCD should be able to charge fees to cover the cost, if possible, of producing the data and supporting any advisory or governance processes that are established.

The Workgroup discussed the need to invest additional resources to provide expanded access to the data. Members identified the following areas that would require additional resource investments:

- Developing and updating the Public Use files, summary tables and limited use files
- Supporting the MN APCD governance process
- Creating a data use application and review process
- Establishing and monitoring data use agreements
- Providing user support
- Updating documentation
- Annual or quarterly updates and refreshes
- Maintaining or enhancing the data enclave or other IT infrastructure
- Providing reports on MN APCD use to the Legislature and other stakeholders

User Fees: The Workgroup agreed that the MN APCD should have the ability to charge fees to organizations or individuals accessing the data for allowable uses. Fees would be used to cover costs including but not limited to those listed above. Members generally agreed that fees for access to Limited Data Sets or custom requests could be charged to recover the costs of file production, while Public Use files and summary tables are intended to be freely available at no charge to the public. The Workgroup also agreed that there could be different fee schedules for different user types (e.g., separate fee schedules for academic researchers and for-profit organizations). The Workgroup did not make a recommendation on the appropriate level at which these fees should be set, in recognition of the fact that many decisions that could impact the cost to maintain an expanded-use MN APCD have not yet been made.

# Recommended Actions

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In summary, the Workgroup makes the following recommendations to the Legislature:

1. The Legislature should authorize MDH to develop a Public Use File(s) and summary tables. Initial public use files and summary tables would not include provider or payer identifiers. Such files and tables should be made available to the public, if possible without cost, and with minimally necessary restrictions or barriers.
2. The Legislature should direct MDH to convene a public/private advisory group with a charge that includes advising on issues such as:
  - a. structure and contents of the public use file and summary tables;
  - b. structure and contents of other files – beyond the public use files and summary tables -- that could support more detailed analysis, including payer and provider names;
  - c. general parameters for allowable data uses of more detailed data, and privacy/security provisions that should be in place prior to allowing any access data that includes identifiers;
  - d. guardrails and guidelines of a rolling, iterative process to guide expanded access to data.
  - e. process and fees through which specific requests for access to more detailed data would be allowed.
3. MDH should establish a technical group to make recommendations on issues such as:
  - a. potential changes to data elements collected;
  - b. opportunities to improve ability to link MN APCD data to other datasets to expand potential range of analytic applications;
  - c. strategies to monitor and improve quality, accuracy or timeliness of data;
  - d. formats or general content of regular data quality updates;
  - e. methodological or analytical feasibility of specific measures or analyses given the data available;
  - f. public use file contents and summary tables; and
  - g. suitability of de-identified data for expanded uses such as research, quality improvement projects and data validation initiatives.
4. MDH is preparing a series of reports on data quality and should continue this work. MDH should report to the Legislature by February 1, 2016 about the progress of the MN APCD in Year 1 of expanded uses.

# Charts

Chart 1: Data Uses & Language Used in Other APCD Statutes

	PUBLIC HEALTH	QUALITY	COSTS	POLICY / PLANNING	CHOICES/ COMPARE	SYSTEM CAPACITY
<b>Colorado</b>	Safe	Performance	Cost Effective		Compare	
<b>Kansas</b>			Price & Cost Trends	Decision making		Access
<b>Maine</b>	Improve health					
<b>Maryland</b>		Performance	Total Medical Cost			
<b>Massachusetts</b>	Research		Cost and Utilization	Planning	Compare	
<b>New Hampshire</b>	Continuous review	Performance	Cost Effective	Continuous review	Choice	
<b>Oregon</b>			Costs and Effectiveness	Policy	Choices	Resources
<b>Tennessee</b>		Performance	Expenditures	Continuous review		
<b>Utah</b>		Quality	Cost effective			Access
<b>Vermont</b>	Program Effectiveness	Quality	Costs	Policy	Compare	Resources
<b>Virginia</b>	Prevention	Quality			Compare	

Chart 2: Data Privacy in the MN APCD

**Privacy of Certain Data in Minnesota State Law**  
**APCD Law:** Section 62U.04(4)(c) Data on providers collected under this subdivision are **private data on individuals or nonpublic data**, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data....  
**Data Privacy Practices** Section 13.02  
 Subd. 9. Nonpublic data. "Nonpublic data" are data not on individuals made by statute or federal law applicable to the data: (a) not accessible to the public; and (b) accessible to the subject, if any, of the data.  
 Subd. 12. Private data on individuals. "Private data on individuals" are data made by statute or federal law applicable to the data: (a) not public; and (b) accessible to the individual subject of those data.  
 Subd. 19. Summary data. "Summary data" means statistical records and reports derived from data on individuals but in which individuals are not identified and from which neither their identities nor any other characteristic that could uniquely identify an individual is ascertainable.

# Appendix A. Members of the MN APCD Workgroup

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**Thompson Aderinkomi**

Founder and CEO  
RetraceHealth  
Consumer Representative

**Justin Bell**

Government Relations Director  
American Heart Association Midwest Affiliate  
Consumer Representative

**Laurie Beyer-Kropuenske**

Director of Community Services  
Minnesota Department of Administration  
Dept. of Administration Data Practices Representative

**Dr. John Chandler**

Chief Health Information Office for Analytics & Informatics  
Hennepin County Medical Center  
Minnesota Medical Association Representative

**Kathryn Correia**

President & CEO  
HealthEast Healthcare System  
Minnesota Hospital Association Representative

**Dr. Bryan Dowd**

Professor, Division of Health Policy & Management  
*University of Minnesota School of Public Health*  
Academic Representative

**Nancy Garrett, Ph.D.**

Chief Analytics Officer at Hennepin County Medical Center  
Minnesota Health Care Safety Net Coalition  
Representative

**Dr. Roger Kathol**

Founder and President  
*Cartesian Solutions, Inc.*  
Minnesota Medical Association Representative

**Susan Knudson**

Vice President for Health Informatics  
HealthPartners  
Minnesota Council of Health Plans Representative

**Dr. Larry Lee**

Vice President and Executive Medical Director for Provider Relations and Quality  
Blue Cross Blue Shield of Minnesota  
Minnesota Council of Health Plans Representative

**Nathan Moracco**

Interim Assistant Commissioner for Health Care  
Department of Human Services  
State Agency Representative

**Dr. Jim Naessens**

Associate Professor of Health Services Research  
*Mayo Clinic College of Medicine*  
Academic Representative

**Dr. Michael Oakes**

Associate Professor, Division of Epidemiology & Community Health  
University of Minnesota School of Public Health  
Academic Representative

**Britta Orr**

Executive Director  
Local Public Health Association of MN  
Consumer Representative

**Diane Rydrych**

Director, Division of Health Policy  
*Minnesota Department of Health*  
State Agency Representative

**Mark Sonneborn**

Vice President for Information Services  
Minnesota Hospital Association  
Minnesota Hospital Association Representative

# Appendix B. Meeting Materials and Notes

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Please see this website for all the meeting materials:

[All Payer Claims Database website http://www.health.state.mn.us/healthreform/allpayer/meetings.html](http://www.health.state.mn.us/healthreform/allpayer/meetings.html)

# Appendix C. Workgroup's Charter

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## MN All payers Claims Database Workgroup Charter - July 8, 2014

### **Workgroup Purpose**

In April 2014, the Minnesota Legislature directed the Commissioner of Health (MDH) to convene a work group to develop a framework for the expanded use of the All payer Claims Database (MN APCD). ([Sec. 4. Minnesota Statutes 2012, section 62U.04](#)).

The MN APCD work group would develop recommendations based on the following questions and other topics as identified by the work group:

- What should the parameters be for allowable uses of the Minnesota all payer claims data collected under Minnesota Statutes, section 62U.04, beyond the uses authorized in Minnesota Statutes, section 62U.04, subdivision 11?
- What type of advisory or governing body should guide the release of data from the Minnesota all payer claims database?
- What type of funding or fee structure would be needed to support the expanded use of the Minnesota all payer claims data?
- What should the mechanisms be by which the data would be released or accessed, including the necessary information technology infrastructure to support the expanded use of the data under different assumptions related to the number of potential requests and manner of access?
- What are the appropriate privacy and security protections needed for the expanded use of the Minnesota all payer claims database?
- What additional resources might be needed to support the expanded use of the all- payer claims database, including expected resources related to information technology infrastructure, review of proposals, maintenance of data use agreements, staffing an advisory body, or other new efforts?

### **Guiding Value**

Any potential expansion of the database would be guided by what is in the public's best interest.

### **Workgroup Scope**

**What's in:** The workgroup will offer insight and expertise with MDH in the areas of:

- Community perspectives on opportunities for reports and analysis based on the MN APCD
- Priorities and gaps in current health care reporting; what do we wish we knew?
- Appropriate privacy and security protections,
- MN APCD governance options,
- Opportunities for ongoing advisory input, and
- Ideas for enhancing the data to accommodate potential broader uses.

**What's out:** Specific technical specification for report development, data submission protocols, encryption methods and other technical specifics.

### **Workgroup Roles and Responsibilities**

**Champion:** Stefan Gildemeister, Director, Health Economics Program, MDH

**Team Leader:** Kevan Edwards, Health Services Research Director, Health Economics Program, MDH

**MDH Lead Analyst:** Chelsea Georgesen

**Research & Policy Facilitator:** Linda Green, Freedman HealthCare

**Group Process Facilitator:** Kris Van Amber, Management Analysis and Development

**MDH responsibilities:**

Provide timely information to the workgroup regarding:

- Current operations of the MN APCD,
- Similar activity in other initiatives both in Minnesota and nationally,
- Research on issues raised by the group,
- Present the report of recommendations to the MN House of Representatives and MN Senate by February 1, 2015.

**Workgroup members:**

- Thompson Aderinkomi, Founder and CEO, RetraceHealth
- Justin Bell, Government Relations Director, American Heart Association Midwest Affiliate
- Laurie Beyer-Kropuenske, Director of community Services, Minnesota Department of Administration
- Dr. John Chandler, Chief Health Information Officer for Analytics & Informatics, Hennepin County Medical Center
- Kathryn Correia, President & CEO, HealthEast Healthcare System
- Dr. Bryan Dowd, Professor, Division of Health Policy & Management, University of Minnesota School of Public Health
- Dr. Roger Kathol, Founder and President, Cartesian Solutions, Inc.
- Susan Knudson, Vice President for Health Informatics, HealthPartners
- Dr. Larry Lee, Vice President and Executive Medical Director for Provider Relations and Quality, Blue Cross Blue Shield of Minnesota
- Nathan Moracco, Interim Assistant Commissioner for Health Care, Department of Human Services
- Dr. Jim Naessens, Assistant Professor of Biostatistics, Mayo Clinic College of Medicine
- Dr. Michael Oakes, Associate Professor, Division of Epidemiology & Community Health, University of Minnesota School of Public Health
- Britta Orr, Executive Director, Local Public Health Association of MN
- Diane Rydrych, Director, Division of Health Policy, Minnesota Department of Health
- Michael Scandrett, President, LPaC Alliance
- Mark Sonneborn, Vice President of Information Services, Minnesota Hospital Association

**Workgroup responsibilities:**

The workgroup's responsibility is to consult with MDH on the questions and legislative report the MDH has been charged by the Legislature to complete. The workgroup will bring expertise and evidence to the discussion, provide examples and approaches for additional database uses, fully engage in discussions during meetings and complete any requested between-meeting assignments, and provide recommendations that are responsive to the Legislature's request and in alignment with this Charter.

**Level of Agreement**

The goals and objectives of the workgroup are not dependent upon group consensus. Although consensus would be optimal, it may not be attainable given the timeframe and the nature of the questions that the workgroup will be discussing. For the topics and issues where the workgroup members do not reach consensus, members will have an opportunity to express their opinions. In those cases, the legislative report will note that consensus was not achieved, and will include a summary of the workgroup's discussions.

**Duration**

Approximately six workgroup meetings before January 2015



# Appendix D. Data Elements Included in the MN APCD

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Please see the document below for information about data elements collected by the MN APCD:  
[Onpoint data elements http://www.onpointcdm.org/pdf/onpoint\\_mhccrs\\_ccp\\_v2-1\\_2012-07.pdf](http://www.onpointcdm.org/pdf/onpoint_mhccrs_ccp_v2-1_2012-07.pdf)

# Appendix E. Data Quality and the MN APCD

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## Minnesota's All Payer Claims Database Frequently Asked Questions

### Data Submission and Data Quality October 2014

#### DATA SUBMISSION

**Who is required to submit data to the MN APCD via MDH's data aggregation vendor, Onpoint?**

According to state regulations, a health plan company or a third-party administrator (TPA) must submit data to the MN APCD if total claims for MN residents exceed \$3 million per year. Pharmacy benefit managers are also required to submit data if total claims for MN residents exceeds \$300,000 per year.

**How many payers submit data into the MN APCD?**

Currently, over 100 different sources submit medical, pharmacy and enrollment data to the MN APCD. The number of organizations submitting data into the MN APCD has been increasing over time, as MDH has worked with health plan companies and TPAs to understand and comply with submission requirements.

Six payers alone submit about 80% of the claims volume (HealthPartners, Medica, Blue Cross Blue Shield of Minnesota, UCare, The Centers for Medicare & Medicaid Services, and the Department of Human Services).

**What types of data are submitted?**

Data submitters are required to provide monthly files containing member information, paid claims for all covered services and pharmacy claims. Types of coverage include:

- All medical and health services insurance claims paid by a health plan company or TPA, including:
- Commercial products;
- Managed care products for Medicaid and Medicare;
- Medicare fee for service products; and
- Medicaid and other state fee for service products

The following types of health insurance policies or sources of coverage are not included:

- Hearing, dental, vision, or disability-only;
- Auto medical or accident-only;

- Insurance supplemental to liability;
- Long term care or Workers Compensation;
- Medicare Supplemental and Medigap insurance;
- Veterans Affairs, Indian Health Service, Tricare;
- Carriers with less than \$3 million in annual medical and/or \$300,000 in annual pharmacy claims
- Non-Minnesota residents

In addition to non-included coverage sources, the MN APCD does not include health care utilization information about people without health insurance.

**What file formats do data submitters use? Does MDH require all data submitters to use the same formats and tools for data submission?**

MDH, by rule, specifies the format, content and code tables for each of the files. Onpoint provides each data submitter with a secure file transmission protocol. Files are encrypted at the data submitter’s site by a software tool provided by Onpoint to provide security during transit. Onpoint, in collaboration with MDH, establishes standards that are used to measure whether the submitted specific information (the data element) conforms to the state’s requirements. The most recent data submission layout is available online: [http://www.onpointcdm.org/pdf/onpoint\\_mhccrs\\_ccp\\_v2-1\\_2012-07.pdf](http://www.onpointcdm.org/pdf/onpoint_mhccrs_ccp_v2-1_2012-07.pdf).

**Why doesn’t the MN APCD use the Medicare file format?**

The MN APCD data file layout is designed to meet Minnesota’s statutorily defined analytic needs; it closely tracks the core data element recommendations of the MN APCD Council, a nonprofit organization, focused on providing states with a range of technical and policy guidance as they develop and deploy MN APCDs. Over time, these core element recommendations have evolved into the minimum standards for MN APCDs, with the goal harmonizing data collection standards as a basis for robust analytics and to minimize data submission cost of insurance carriers.

**How often are files submitted?**

At minimum data submitters must submit a data file once every six months), but most carriers submit monthly files of adjudicated claims and member enrollment. Data extracts are generated at least twice a year, resulting in a lag of data between nine months and 12 months, depending on payer, following the end of the observation period.

**Do the files contain aggregated information?**

Data submitters provide adjudicated claims line detail. Initially denied claims are not included. When a claim is adjusted, that transaction is also submitted in the file. When building a data extract, Onpoint reviews the data to provide the latest, final version of the entire claim.

**What types of files are submitted, and what is in them?**

Depending on data submitters’ lines of business, they provide the following files:

Member eligibility: All data submitters must provide a member level file showing hashed patient identifiers and demographics.

Claims data: All adjudicated (paid and adjusted) claims for covered services reported during the observation period. Examples of covered services include but are not limited to inpatient and outpatient care, behavioral health, therapies, durable medical equipment, rehabilitation and home health. When a data submitter subcontracts with another entity to provide a covered service, for instance for behavioral health services, the risk holder is responsible for data submission.

Pharmacy data: All adjudicated claims for prescription medications

**What kinds of payments are included in a claims file?**

A claim shows the amount paid to the provider for a particular service. Like an “Explanation of Benefits” sent to a member, the claim shows submitted charges, allowed amount, payment to provider and patient responsibility, or deductibles and other cost-sharing. As is typically the case, the specific claim does not include payments outside the insurance and remittance process, including incentives, withholds or shared savings.

#### **Where does the MN APCD obtain Medicare data?**

MDH has a data use agreement with the Centers for Medicare and Medicaid to use Medicare data files for state-sponsored research and reporting projects. Onpoint serves as the data custodian and loads the Medicare data into the MN APCD. The Medicare files are updated on a rolling schedule, generally quarterly.

#### **Do the carriers edit or change the data that they receive from providers?**

Data submitters are required to provide claims line detail, including payment, for each record for a covered service provided to a member. Each carrier provides data from their claims adjudication system which contains all the information that each carrier deems necessary to pay a claim and consistent with variables submission requirements and pre-defined data value ranges. The benefit of a data aggregation process is that it takes data streams from carriers with varying claims management practices and integrates them along a single standard.

#### **What types of problems have led to resubmission of data?**

Onpoint reviews data submitters’ files according to standards established in the data submission guide, including assessment of each record’s data elements on format, frequency and consistency criteria. When the file does not meet minimum standards, the file is typically rejected and the data submitter must correct all errors and resubmit. For example, the data submission guide for the claims file ([http://www.onpointcdm.org/pdf/onpoint\\_mhccrs\\_ccp\\_v2-1\\_2012-07.pdf](http://www.onpointcdm.org/pdf/onpoint_mhccrs_ccp_v2-1_2012-07.pdf)) specifies a 100% threshold (completion rate) for member gender. A file with fewer than 100% of the fields with a valid value would be rejected and returned to the submitter for correction.

## **DATA QUALITY**

#### **How many years of data are stored?**

The MN APCD has been collecting data since 2009, with some data dating back to calendar year 2008.

#### **What does Onpoint do to review the incoming data?**

Onpoint uses a proprietary process that examines over 500 aspects of data quality at intake and in the data aggregation process. Each cell in a submitted file is checked to ensure that the size and type of information conforms to the established specification. Each file is also reviewed to establish that the data submitter has met the state’s expectations for the number of times a particular data cell has information (also called “checking completeness against thresholds”). See Onpoint’s presentation to the Workgroup on September 30 for a description of the process: [http://www.health.state.mn.us/healthreform/allpayer/MN\\_APCDonpointpresentation093014.pdf](http://www.health.state.mn.us/healthreform/allpayer/MN_APCDonpointpresentation093014.pdf)

#### **When are files rejected?**

Files that fail to meet all minimum standards are rejected in their entirety. By state rule, data submitters are required to correct such errors and resubmit until the file passes. Health plans can request variances for the submission of data elements that are either not retained by them or retained at insufficient quality to meet the submission standards.

#### **Can member information be linked to claims information at the member level?**

Data submitters are required to provide the same member identifiers across the three member-specific file types (member eligibility, claims, pharmacy). These identifiers are hashed within the data submitter’s system before the files are submitted, using a standardized tool (algorithm) provided by Onpoint. Hashed

fields include member and subscriber name, date of birth and plan specific contract number. This ensures that personal identifiers are never submitted.

An example of hashing may be found on slide 28 of Onpoint's presentation, available here: [http://www.health.state.mn.us/healthreform/allpayer/MN\\_APCDonpointpresentation093014.pdf](http://www.health.state.mn.us/healthreform/allpayer/MN_APCDonpointpresentation093014.pdf)

Minnesota's protections create limitations in ensuring the accuracy of the data. Hashing is a one-way process and cannot be "undone." Member data cannot be audited or validated. While the hashing logic reliably produces the same results for the same set inputs, a misspelled name or transposed number in a member record will produce a different string that cannot be matched to other records.

### **Can linkages be done with hashed data?**

Minnesota state law requires hashing all personally identifiable information. Theoretically, information from other data sources could be hashed using the same process. The accuracy of the hash depends on accurately typed names and dates of birth. Unlike other states, MN hashes date of birth, eliminating a point of comparison needed for robust matching and data accuracy.

### **What are the challenges of data submission?**

During the September 30 presentation, Onpoint identified the following opportunities to improve the MN APCD:

- Add patient identifiers to create a more robust unique patient ID
- Add an alphanumeric "group number" for each payer/employer combination to support validation processes
- Add a primary insurance indicator is needed to understand which claims are subject to coordination of benefits
- Add discharge dates for hospital stays, needed for readmissions studies
- Add Present on Admission field
- Add Claim Status field
- Add Pharmacy location field

### **What is the difference between claims data and encounter data?**

Claims data comprise records of payment to a provider based on the provider's billing and contains patient identifiers, procedure codes, diagnosis, dates of service, and provider information.

Encounter data comprise records of services provided regardless of the provider's payment arrangement with the payer. Encounter data usually include much of the same information as on a claim, with the exception of information on payment.

### **Do data aggregators or other vendors in Massachusetts or Colorado who conduct data analytics use other data sources to audit and verify data submitted?**

Similarly to Minnesota, these APCD administrators use a variety of sources for comparisons, such as hospital discharge data, birth registries, and census data. Both states cautioned that there are many reasons that there remain differences between the data sources, including but not limited to absence of data for the uninsured, federal employees, military members, and veterans. MDH has recently contracted with an outside vendor to provide external validation services for the MN APCD, which will include among other things a formal effort to benchmarking Minnesota data against other local and national sources. This work began in November 2014.

### **Are providers permitted to access and audit claims feeds for their own patients across all payers and across all providers to better manage their patients?**

This is not currently possible in Minnesota due to lack of individual identifiers and statutory limits governing data use. At an aggregated level, MDH has provided data to hospitals at various levels of aggregation, including at the Diagnosis-Related Group, for readmissions specifically, and at various cost

levels. Similarly, Massachusetts and Colorado have provided de-identified volume and utilization reports to providers prior to public reporting projects.

### **What steps have states taken to review the accuracy of their data?**

In Massachusetts, the APCD implemented a suite of quality reports to the carriers in conjunction with developing the ACA alternative risk adjustment methodology for the small and individual group markets. After the carriers reviewed the report, the APCD and the state Division of Insurance met jointly with carriers to discuss standardizing the data feeds all reporting. Through these meetings, the APCD was able to improve definitions of file elements and selection criteria that align with Division of Insurance reporting needs. This alignment will ensure that the carriers can reliably review the periodic APCD quality reports against their records. In Colorado, validation of data in partnership with select providers occur for specific projects.

### **Is there a master provider index?**

Onpoint builds a Master Provider Index based on information submitted by carriers on claims.

Challenges in building and updating the Index include:

- provider may be identified by more than one National Provider ID (NPI).
- blank NPIs
- reporting NPI at the health system level and not for the practitioner.

For additional information, please see the webinar slide deck here: [Onpoint Master Provider Index http://www.health.state.mn.us/healthreform/allpayer/APCDonpointpresentation093014.pdf](http://www.health.state.mn.us/healthreform/allpayer/APCDonpointpresentation093014.pdf)

Minnesota has done extensive supplemental work on building provider linkages and a robust master provider index. For additional information, please see this presentation sponsored by the MN APCD Council: [Onpoint webinars and presentations http://www.APCDcouncil.org/webinars-and-presentations#](http://www.APCDcouncil.org/webinars-and-presentations#)

<http://www.apcdouncil.org/sites/apcdouncil.org/files/Provider%20Linkage%20in%20Minnesotas%20APCD.pdf>

## **DATA GOVERNANCE**

### **How do states deal with conflict of interest (individual or organizational) if they have bodies reviewing/approving proposed uses?**

State rules typically dictate the membership of a data release review committee. Each member represents a specific stakeholder community, including but not limited to trade organizations, advocacy groups, researchers and health policy experts. Under participation agreements signed at the outset, committee member must disclose conflicts when the individual member has a self-interest or personal financial stake as well as the conflicts stemming from the member's role as an employee or representative of an entity named in the rule. Committee members are usually required to sign non-disclosure agreements as well.

Colorado publishes data release review committee policies and procedures here:

[\(http://www.civhc.org/getmedia/13204cf0-0cb8-4415-8dde-06214136c42e/CIVHC-DRRC-Policies-and-Procedures-2-3-12.pdf.aspx/\)](http://www.civhc.org/getmedia/13204cf0-0cb8-4415-8dde-06214136c42e/CIVHC-DRRC-Policies-and-Procedures-2-3-12.pdf.aspx/)

### **If the MA and CO governance bodies are advisory and not decision-making, who ultimately makes the decision about whether a proposed use is allowed?**

In Massachusetts, the final decision about whether to approve a data use application rests with the agency's executive director. Massachusetts has prepared a flow chart describing its data release process here: [State of MA website http://www.mass.gov/chia/docs/p/APCD/release2/data-release-regulation-flowchart-final-pdf.pdf](http://www.mass.gov/chia/docs/p/APCD/release2/data-release-regulation-flowchart-final-pdf.pdf)

In Colorado, as authorized under state rule, the final decision rests with the APCD Administrator.

**Do other states have groups that oversee the quality of the data?**

Massachusetts established a technical advisory committee that is responsible for providing insight about the design and operation of the APCD. Areas of discussion include: APCD file specifications, current and future needs; new field edits and intake rules and quality assurance measures; public use files and reporting tools and reports. It is not a venue for explaining data for analytical purposes; users and analysts have a separate workgroup.

In Colorado, the APCD consults with its APCD Advisory Committee and CIVHC's Data and Transparency Committee on measurement methodology.

**Examples of data documentation:**

Massachusetts: <http://www.mass.gov/chia/docs/p/APCD/release2/release2-appendices.pdf>

Colorado: <http://www.civhc.org/getmedia/b0dd78c5-511d-4ca3-8029-5bd82cb84b30/Data-Element-Dictionary-14.0.xls.aspx>

# Appendix F. Onpoint Data Quality Presentation

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Please see the document below for information about Onpoint Health Data quality assurance activities:

<http://www.health.state.mn.us/healthreform/allpayer/APCDonpointpresentation093014.pdf>

<http://www.health.state.mn.us/healthreform/allpayer/dataqualityQA10814final.pdf>



# Appendix G. HIPAA Identifiers

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The HIPAA “Safe Harbor” approach permits a covered entity to consider data to be de-identified if it removes 18 types of identifiers (e.g., names, dates, and geocodes on populations with less than 20,000 inhabitants) and has no actual knowledge that the remaining information could be used to identify an individual, either alone or in combination with other information.

The 18 types of identifiers are:

- (A) Names
- (B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes
- (C) All elements of dates (except year) for dates that are directly related to an individual, including birth date; admission date; discharge date; death date; and all ages over 89, including all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- (D) Telephone numbers
- (E) Fax numbers
- (F) Email addresses
- (G) Social security numbers
- (H) Medical record numbers
- (I) Health plan beneficiary numbers
- (J) Account numbers
- (K) Certificate/license numbers
- (L) Vehicle identifiers and serial numbers, including license plate numbers
- (M) Device identifiers and serial numbers
- (N) Web Universal Resource Locators (URLs)
- (O) Internet Protocol (IP) addresses
- (P) Biometric identifiers, including finger and voice prints
- (Q) Full-face photographs and any comparable images
- (R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section

\*<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/deidentificationworkshop2010.html>

# Appendix H: Comments and Letters Regarding the Final Report

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January 8, 2015

The American Heart Association was honored to play a role in making recommendations to the Minnesota State Legislature for expanded use of the All-Payer Claims Database (APCD). Like most areas of healthcare, the world of chronic disease treatment, management and prevention is in constant need of additional and better data. Organizations like ours use public health data to design programs and prioritize resources to best fit the needs of specific populations. The APCD has the potential to be a much more valuable tool in this endeavor.

Allowing for more public access and increasing the ability to connect the APCD with other data sources should be priority actions for the future of the MN APCD. Easy (and ideally free) access to “low-stakes” Public Use Files, free of patient, payer and provider identifiers is an important first step towards transparency and accessibility of this publicly funded information resource.

The recommendations contained in this report are in line with striking a balance between data privacy and public access to important and useful information. Though the workgroup did not always find consensus, the themes that emerge from the report show a clear desire to better utilize this resource for the improvement of healthcare delivery and outcomes for all Minnesotans.

**Justin Bell – J.D.**

Government Relations Director

**American Heart Association  
Midwest Affiliate**

4701 W. 77<sup>th</sup> St. | Minneapolis, MN 55435

[justin.bell@heart.org](mailto:justin.bell@heart.org) | [www.heart.org](http://www.heart.org)

P 952.278.7921

*“Building healthier lives,  
free of cardiovascular  
diseases and stroke.”*

life is why™ es por la vida™ 全为生命™

Please remember the American Heart Association in your will.





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January 8, 2015

Linda Green, Vice President, Programs  
Freedman Health Care  
29 Crafts Street, Suite 470  
Newton, MA 02458

Re: Comments to All-Payers Claims Database Workgroup draft report

Dear Ms. Green:

I am writing to express my sincere thanks for all the superb facilitation work provided by you and Ms. Van Amber. Convening a group of stakeholders with such a wide range of roles, experiences and viewpoints can be very daunting. I was so impressed by your ability to guide the group, probing for clarity as we discussed the questions posed by the Legislature. The report draft does an excellent job summarizing the groups' many hours of discussion and the diverse viewpoints and perspectives of that were shared.

Please contact me at 651.201.2501 with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Laurie Beyer-Kropuenske".

Laurie Beyer-Kropuenske  
Director of Community Services

C: Kristin Van Amber, MMB

---

Department of Administration  
200 Administration Building, 50 Sherburne Avenue, Saint Paul, MN 55155  
Phone: 651.201.2535 / Fax: 651.297.7909 / Website: [mn.gov/admin](http://mn.gov/admin)



To: MN Legislature  
From: Thompson Aderinkomi, CEO, RetraceHealth  
Re: All Payer Claims Database Workgroup Final Report  
Date: January 15, 2015

A counter argument to an unrestricted APCD might be, "sometimes governments need to collect data that they cannot make public, such as Medicare patient data, national security data, and IRS tax records" This is not the same as the APCD, since, even without sharing the data, the general public benefits greatly from Medicare, National Security Efforts, and the IRS in excess of whatever benefits sharing private information might create. The purpose and value of these other government functions extends far beyond data storage, in fact, their primary roles have nothing to do with data storage. Data storage is a means to an end. The primary and only purpose of the APCD is to store and release data. With the APCD, it is only as valuable as the data elements it stores and the level of access to those data elements it provides. It has no other function. A tax paying citizen derives zero utility from a data element stored in the APCD that is restricted from public use. The same cannot be said for National Security efforts and other similar government functions. Therefore, given the APCDs narrow focus of pure data storage, it should not store anything that cannot be made public due to the fact it is publicly funded.

Section 4 states that the group as a whole agreed that a public use file should not include payer and provider identifiers. This is not true, at least one (me) if not more members of the group do believe that a first version of the public use file should include payer and provider identifiers. Without these two elements, the APCD is useless. I am not exactly sure how MDH is funded, but I am guessing it is with public dollars. As such, it is neither ethical, moral, or even cordial for a publicly funded asset to have its public access restricted. As long as public dollars are used to capture, cleanse and store data in the MN APCD, all the data should be made public. If the data cannot be made public, for whatever reason, it should not be stored in the MN APCD at all. If public funds were used to build a park, playground, road, zoo, or building and then a small subset of the population claimed that the publicly funded object was not fit for public use, there would be riots in the streets, and I would be among the rioters. The notion is absurd that we would use public dollars to build a multi-million dollar asset and then allow a few private sector entities to prohibit its public use.

One can see that if we adhere to what is just and true as outlined above, the APCD becomes much less unwieldy. There is no need for secretive and all-powerful groups composed of "stakeholders" to determine what is safe for mere mortals in regards to healthcare data. Many of the trappings and complexities native to the current

Thompson Aderinkomi, CEO, RetraceHealth \* Email: [taderinkomi@retracehealth.com](mailto:taderinkomi@retracehealth.com) \* Web: [www.retracehealth.com](http://www.retracehealth.com)



disgustingly broken healthcare system have sadly and insidiously germinated amongst the first fruits of true consumer friendly public health policy born out of the APCD. The healthcare system seeks to abort these first fruits. Yet, by simply focusing on the fact that public dollars should only be used to build publicly accessible assets that are not controlled or even guided by private interests, we can be free of these trappings. I hope MN does the right thing. Naturally, if certain data elements are need for certain types of analysis, that cannot be shared with the public, then the private industry should use their own funds to create such assets.

Sincerely,

A handwritten signature in black ink, appearing to read "T. Aderinkomi", enclosed within a large, stylized letter "D" that forms a signature flourish.

Thompson Aderinkomi  
Founder and CEO  
RetraceHealth

## Emails Received Regarding the Report Draft from Work Group Members:

### 1. Laurie Beyer-Kropuenske

-----Original Message-----

From: Beyer-Kropuenske, Laurie C (ADM) [mailto:laurie.beyer-kropuenske@state.mn.us]

Sent: Thursday, January 08, 2015 5:46 PM

To: Linda Green

Cc: Van Amber, Kristin (MMB)

Subject: letter

Hi Linda, Thanks again for all the incredible work! Much appreciated. I'm awed at how well you were able to summarize the conversations! Take care, LBK

-----Original Message-----

From: Admin Commisioner's Office [mailto:scan@state.mn.us]

Sent: Thursday, January 08, 2015 4:44 PM

To: Beyer-Kropuenske, Laurie C (ADM)

Subject: Send data from MFP07680015 01/08/2015 16:43

Scanned from MFP07680015

### 2. Nancy Garret

**From:** Garrett, Nancy [mailto:Nancy.Garrett@hcmcd.org]

**Sent:** Thursday, January 08, 2015 6:36 PM

**To:** Linda Green

**Cc:** Van Amber, Kristin (MMB) (Kristin.Van.Amber@state.mn.us)

**Subject:** FW: Reminder: APCD Final Draft Report Comments

**Importance:** High

Linda, thank you for the report. Well done. Here are my comments:

It is important that the public /private advisory group represents the diverse communities in Minnesota. One way to do this would be to ensure a seat for a safety net provider representative, but there may be others as well.

P 14 – I don't think the last paragraph on de-identified info is right. I think ALL members agreed that de-identified data limits the ability of providers to validate data. I also think MOST members strongly advocated for revisiting the existing de-identification model. I would take out the sentence saying we had no recommendation.

P 28- the list of workgroup members lists Michael Scandrett and not me. Perhaps you want to list both since he attended the first meeting or two? I am Nancy Garrett, Ph.D. or Dr. Nancy Garrett if that's how you're doing it.

Thanks!

### 3. Roger Kathol

**From:** Roger Kathol [mailto:rogerkathol@icloud.com]

**Sent:** Friday, January 09, 2015 5:38 AM

**To:** Linda Green

**Subject:** Re: APCD

Linda, at this point, my comments will not alter the direction that is in the report. I just wish that the development of a public-private decision-making partnership of knowledgeable individuals who had been vetted for conflicts of interest would have been mentioned as a serious option for group leadership of the APCD moving forward. It would have helped mitigate the fickle impact that politics has on use of the APCD with it in charge.

It has also be enjoyable working with you. Best in the future.

Roger

On Jan 8, 2015, at 4:36 PM, Linda Green <[lgreen@freedmanhealthcare.com](mailto:lgreen@freedmanhealthcare.com)> wrote:

Roger, thank you. Would you like me to include your comments (in yellow, the second and third sentences) in the attachment to the report?

I appreciated your involvement and attention to the conversations of the group. You added a lot to the discussion and, from my perspective, reminded the group about what could be learned from this data.

Best wishes for the new year!

Linda

-----Original Message-----

**From:** Roger Kathol [mailto:rogerkathol@icloud.com]

**Sent:** Thursday, January 08, 2015 6:51 AM

**To:** Linda Green

**Subject:** APCD

Linda, nice job. While I do not agree that the leadership group involved with the APCD (as opposed to the State) came down on the side of “advisory” vs. “decision-making” I was not at all meetings so may have missed a final discussion. Regardless, this is a good start for MN.

Thanks for your help.

Best.

Roger



#### **4. Mark Sonneborn**

**From:** Mark Sonneborn [mailto:msonneborn@mnhospitals.org]

**Sent:** Thursday, January 08, 2015 4:05 PM

**To:** Linda Green

**Cc:** Van Amber, Kristin (MMB)

**Subject:** APCD draft

Linda,

I read through the document, but paid most of my attention to the recommended actions. This may come as a shock, but I'm quite pleased with them and would wholeheartedly support them. They strike a reasonable and pragmatic tone for moving forward with expanded use of the APCD. I have a preference for moving a little faster into accessibility for the "non-public use file" uses, but if we can create a roadmap to get there, we're moving in the right direction.

I suspect there will be workgroup members that are less enamored with these recommendations. How will you choose to (or not to) incorporate dissenting views? If you choose to amend your recommended actions significantly based on those comments, I assume you will let us know, but it is my hope that these recommendations stand.

Thank you for all your work in this (you too, Kris).

*Mark A. Sonneborn, MS, FACHE*

*VP, Information Services*

*Minnesota Hospital Association*

*2550 University Ave. W, Suite 350-South*

*St. Paul, MN 55114*

*651-659-1423*

#### **5. Justin Bell (pdf of his letter also included)**

January 8, 2015

The American Heart Association was honored to play a role in making recommendations to the Minnesota State Legislature for expanded use of the All payer Claims Database (APCD). Like most areas of healthcare, the world of chronic disease treatment, management and prevention is in constant need of additional and better data. Organizations like ours use public health data to design programs and prioritize resources to best fit the needs of specific populations. The APCD has the potential to be a much more valuable tool in this endeavor.

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Justin Bell – J.D.

Government Relations Director

American Heart Association

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P 952.278.7921

## 6. Sue Knudson

APCD Final Report Comments

Sue Knudson, Minnesota Council of Health Plans Representative

P1. Third bullet point describing the TAG...”expertise in the area of data quality assessment and further development of the data”: Beyond the data quality and development, the task force discussed the TAG also providing advice to the governing body regarding requests and their respective match to the use of the APCD (e.g. . considering guard rails and other topics mentioned in the body of the report). This should be added to the description of the TAG.

P2. Items listed under advisory group process (e.g. #2). These should be footnoted to indicate they will be made with advisement from the TAG on these issues.

P17. Related to the comment for P2 above, text about advisory or decision making on the bottom of P17 indicates the advisory group would ‘advise the State or the Legislature on allowable uses...’. I don’t think discussion explicitly identified the State, meaning MDH, as having sole decision making authority. The “or” statement introduces that possibility. Rather, this concession was made based on the Senator’s advisement that the Legislature would be the final decision maker putting this group in an advisory function. The group discussed on several occasions the need for a public/private approach, not one that puts the State (i.e. MDH and DHS) in a decision making capacity alone. Given this, strike the words ‘State or the’ from the text.

P4. Omit the terms in the history of APCD section that state “and remains ahead of the curve”. This gives the reader the impression our workgroup did an analysis and objectively came to this finding, which we did not. All APCDs are not equal and were generated for different uses thus this seems overbroad and too subjective to include. If it stays, it should be balanced with statements of value indicating all cost and investments to-date along with successful uses, of which there have been none that have advanced the triple aim.

P5. First paragraph, the last sentence subjectively positions the use of the APCD. Please omit this subjective statement to keep the report fact based. Again, only with the inclusion of transparency on the cost investment of the APCD thus far and ongoing annually expenses would give this statement factual basis. The balance of this section is factually based and stands on its own for background.

P6. Edit the statement regarding the “APCD does not include most PHI or direct patient identifiers”. This is misleading. It does, in fact, include PHI (diagnosis, procedures, for example) and is one-way hashed to protect patient identification. This section should be clearly rewritten to be factual and clear. Referencing lab results, clinical notes, EMR information is misleading because this is clinical data from medical records, not claims data. These references should be omitted.

P13. First paragraph references the APCD is “classified unusually restrictively”. Again, this seems subjective. Please restate factually indicating the legislature allowed creating the MN for PPG use, which is now suspended.

P15. Remove lock box sidebar paragraph entirely. It is out of context and was not thoroughly discussed.

P22. Public use files should pre-suppress small cell sizes, and summarize (example, 3 digit zip) the data file to usable levels. Safe harbor guidelines should be implemented by the original steward of the data, not left to the user to implement.

P25.

See previous comments on advisory group and technical group and clarify accordingly.

3b: omit or restate because it is not clear that this requires patients to be identified. Without being clear, the legislature could agree with intent but not understand the detailed requirement. Rather the legislature should make the decision about identifying patients in the data to allow linking to other files. As currently written, it is not clear that identification is required to make the linkages.

## 7. Thompson Aderinkomi

**From:** Thompson Aderinkomi [mailto:thompson.aderinkomi@gmail.com]

**Sent:** Saturday, January 03, 2015 7:17 PM

**To:** Linda Green

**Cc:** Van Amber, Kristin (MMB); Kathryn Correia; Stefan (MDH) Gildemeister; Diane (MDH) Rydrych; Edwards, Kevan (MDH); Moracco, Nathan A (DHS)

**Subject:** Re: APCD Final Draft Report

Happy New Year,

Thanks for providing us with this final draft. It looks good and does a good job of capturing all the divergent recommendations. None the less, I have some comments that I would like appended to the final report. I will try and keep it brief.

Section 4 states that the group as a whole agreed that a public use file should not include payer and provider identifiers. This is not true, at least one (me) if not more members of the group do believe that a first version of the public use file should include payer and provider identifiers. Without these two elements, the APCD is useless.

I am not exactly sure how MDH is funded, but I am guessing it is with public dollars. As such, it is neither ethical, moral, or even cordial for a publicly funded asset to have its public access restricted. As long as public dollars are used to capture, cleanse and store data in the APCD, all the data should be made public. If the data cannot be made public, for whatever reason, it should not be stored in the APCD at all. If public funds were used to build a park, playground, road, zoo, or building and then a small subset of the population claimed that the publicly funded object was not fit for public use, there would be riots in the streets, and I would be among the rioters. The notion is absurd that we would use public dollars to build a multi-million dollar asset and then allow a few private sector entities to prohibit its public use.

One can see that if we adhere to what is just and true as outlined in my bullet 2 above, the APCD becomes much less unwieldy. There is no need for secretive and all powerful groups composed of "stakeholders" to determine what is safe for mere mortals in regards to healthcare data. Many of the trappings and complexities native to the current disgustingly broken healthcare system have sadly and insidiously germinated amongst the first fruits of true consumer friendly public health policy born out of the APCD. The healthcare system seeks to abort these first fruits. Yet, by simply focusing on the fact that public dollars should only be used to build publicly accessible assets that are not controlled or even guided by private interests we can be free of these trappings. I hope MN does the right thing.

Naturally, if certain data elements are need for certain types of analysis, then the private industry should use their own funds to create such assets.

A counter argument might be, "sometimes governments need to collect data that they cannot make public, such as Medicare patient data, national security data, and IRS tax records" This is not the same as the APCD since even without sharing the data, the general public benefits greatly from Medicare, National Security Efforts, and the IRS in excess of whatever benefits sharing private information might create. With the APCD, it is only as valuable as the data elements it stores and the level of access to those data elements it provides. It has no other function. A tax paying citizen derives zero utility from a data element stored in the APCD that is restricted from public use. The same cannot be said for National Security efforts and other similar government functions. Therefore, given the APCDs narrow focus of pure data storage, it should not store anything that cannot be made public due to the fact it is publicly funded.

And yes, I actually want this appended, I am not joking, not even a little bit. I take price transparency and the appropriate use of tax dollars very seriously. I plan on sharing this email response with others not on the recipient list. I promise not to share the report itself :)

Cheers,

Thompson Aderinkomi

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## 8. Jim Naessens

**From:** Naessens, James M., Sc.D. [mailto:naessens@mayo.edu]  
**Sent:** Friday, January 02, 2015 3:00 PM  
**To:** Linda Green  
**Cc:** 'Van Amber, Kristin (MMB)'  
**Subject:** APCD Final report

Linda,

You and Kristin (and team?) did a nice job summarizing our mutual activity over the last few months. I just had a couple of detailed corrections you may want to address:  
Page 9, second line under Meeting 1 – It should say “Appendix C”  
The Table on page 20 and statements on page 22 for Public Use files have two discrepancies:  
Member zip code says “No” in the table under Public Use, but states “first three digits” on page 22  
Date of service says “Yes” in the table, but states “no service dates other than year” on page 22  
In Appendix A, I should be listed as “Associate Professor of Health Services Research” instead of “Assistant Professor of Biostatistics”. Not your fault as that was what was submitted by our group, but it’s old information.

The one editorial comment I would make would be to take out the word “likely” from the second line of the Feedback on page 16. We can be a little more conclusive.

I agree with the statements in the Executive Summary.

Thanks, and Happy New Year.

Jim Naessens

## 9. Kathryn Correia

**From:** Mark Sonneborn [mailto:msonneborn@mnhospitals.org]  
**Sent:** Thursday, January 08, 2015 6:19 PM  
**To:** Linda Green  
**Subject:** Fwd: APCD draft report

FYI - Kathryn Correia agreed with my assessment.