UTAH DEPARTMENT OF HEALTH
Office of Health Care Statistics

Utah Health Data Committee

Utah Health Data Committee (HDC)

Lynette Hansen, Chair of the Utah Health Data Committee, has scheduled a HDC meeting as follows:
Date: Tuesday, September 17, 2019 **Time:** 3:00 PM
Place: Utah Department of Health, 288 N 1460 W, Salt Lake City, Utah 84116; RM 125
Call-in Info: 1-877-820-7831; Participant Code: 299672

AGENDA

	TOPIC	TIME	PRESENTER
1.	Welcome	3:00	Lynette Hansen, HDC Chair
Standing Agenda Items			
2.	Approval of May 21st, 2019 Minutes (Action: Vote)	3:10	Lynette Hansen, HDC Chair
3.	Subcommittee Reports: (Action: Discussion) a. Transparency Advisory Group b. Data Use Subcommittee c. Payer Task Force d. Facilities Task Force	3:20	Norm Thurston, OHCS Director/HDC Executive Secretary Chairs of the subcommittees
Old Business			
4.	Rule Changes a. Dental Carrier Threshold (R428-2-10) b. No Contact Rule (R428-2-8) c. Changes to the APCD DSG (R428-1) • UT APCD DSG (Follow Up) d. Five Year Review (R428-15)	3:30	Norm Thurston, OHCS Director/HDC Executive Secretary
New Business			
5.	Officer Elections (Discussion Only)	3:45	Norm Thurston, OHCS Director/HDC Executive Secretary
6.	Open and Public Meeting Act Training	3:55	Micah Vorwaller, Assistant Attorney General
7.	Data Request, Remedy Partners a. Staff Summary Remedy b. Remedy Partners Data Application for DUS c. Remedy Executive Summary d. Remedy Utah APCD Field Justification	4:10	Norm Thurston, OHCS Director/HDC Executive Secretary
8.	HEDIS Requirements	4:25	Sterling Petersen, Analyst Lead
9.	Legislative a. Building Block Request b. Using Data for Registries (Discussion Only)	4:45	Norm Thurston, OHCS Director/HDC Executive Secretary
10.	Update on Release of Medicaid Data	4:50	Norm Thurston, OHCS Director/HDC Executive Secretary
11.	Handouts: Electronic PDF Form (Discussion Only)	4:55	Norm Thurston, OHCS Director/HDC Executive Secretary

Next Meeting, Tuesday, November 19, 2019 at 3PM

If you will not be able to attend, please contact Mary Dy with OHCS at 801-538-7048 or marymdy@utah.gov

Utah Health Data Committee (HDC) Meeting
Minutes
Tuesday, May 21st, 2019

3:00PM:
Meeting called to order by Vice Chair Sarah Woolsey.
A quorum was established with members who attended in person and via phone.

The meeting took place between 3:00PM and 4:15PM in Room 125 at the Utah Department of Health, 288 N 1460 W, Salt Lake City.

HDC Member Attendance:
Jim Bradshaw (phone)
Mark Bair, MD
Stephen Neeleman, MD (phone)
Jaak Sundberg (for Tanji Northrup)
Sarah Woolsey, MD, MPH, FAAFP
Vaughn Holbrook (phone)
Donna Milavetz, MD, MPH, FACP (phone)
Dave Jackson, SPHR, SHRM-SCP (phone)
Charles Hawley, MA (phone)
Laura Summers, MPP (phone)
Kevin Potts
Russell Trujillo, BS (phone)
NormanThurston, PhD, Executive Secretary for the HDC

Excused:
Lynette Hansen, MS, CPHQ
James VanDerslice, PhD

1. Welcome
Vice Chair Sarah Woolsey called the meeting to order after establishing a member quorum.

2. Approval of March 19th, 2019 Minutes (Action: Vote)
Motion to accept March 19, 2019, meeting minutes by Laura Summers and Stephen Neeleman, Seconded.
Motion carried with all in favor and none opposed.

3. Sub-Committee Reports: (Action: Discussion)

a. Transparency Advisory Group
Report by Sterling Petersen. TAG will need to select three new measures this summer.

b. Data Use Sub-Committee
Report by Mike Martin.
Five meetings were scheduled, two canceled due to lack of applications. Most or all applications were generated through the University of Utah system.

Discussion of the Medicaid data re-release issue. Medicaid data in the APCD can be re-released through APCD in some conditions, e.g. research directly related to the Medicaid program. Requests would be processed by OHCS subject to two criteria (1) researcher must clearly demonstrate that project could not

be completed without Medicaid data, and (2) researcher must articulate how the project would benefit Medicaid. If request meets criteria, then it would move through the normal HDC approval process.

Draft process is now being reviewed with meeting scheduled for the beginning of June. Committee members worked under the hypothesis that a good process would be in place.

c. Payer Task Force
Report by Sterling Petersen
Biggest issue from the meeting was how to address substance abuse data collection under 42 CFR Part 2. OHCS is working on a solution.

d. Facilities Task Force
Report by Sterling Petersen
IHC requested data regarding hospital discharge information to include attending physicians, patient records, and emergency visits identifying the exact practitioner. Data has not been released in the past due to quality issues. OHCS has released APCD data with these identifiers to entities with contractual relationships with the physician.

The difference here would be that hospitals may not have all the information as requested.

Provider data would be accessible to any hospital as long as specific elements were met.
The benefit would be to allow hospitals to observe the volume and outcomes of their physicians in all settings. There is some concern about impact on competition. Several committee members recommended that OHCS reach out to physicians to get their input on this issue.

Action Item: OHCS to get feedback from physicians and report back for further discussions in next meeting.

4. Legislative Update
HB387 (lines 2961 – 2977) required that every executive board prepare and submit reports due by August 1, 2019. Reports would then be submitted to the Governor's board.

Action Item: OHCS to prepare a draft report consistent with the law and circulate to HDC members by July 1 for feedback.

5. APCD DSG Changes
OHCS limits changes to the APCD DSG to once per calendar year. Due to the added burden of switching to a new vendor, no changes were made last year. At the request of insurers, a few changes are proposed for the coming year.

The main changes to be considered are:
- Include an identifier for in-network vs. out-of-network claim
- Add a field for allowed amount (so that it is clear and not estimated)
- Add a voluntary field for pharmacy rebate information at the Point-of-Sale (POS)
- Add a field for whether a claim is protected under 42 CFR Part 2, with values for Y, N, and U

Cutoff for additional changes is the beginning of July for changes going into effect in the beginning of 2020

Action Item: Committee will vote on changes in September 2019.

6. Discussion on Healthcare Quality Measurements
In compliance with statute, the office releases quality measures at clinic level for most clinics in Utah. Data was collected first by geography and then by clinic basis.
Three new measures need to be added each year. On July 1st, the Transparency Advisory Group (TAG) will finalize reporting.

Motion to cancel July 2019 meeting – made by Kevin Potts and seconded by Dr. Bair.
Passed unanimously by all present

Meeting adjourned at 4:27PM.
Next Meeting: September 17, 2019

Transparency Advisory Group (TAG)

The TAG reviewed the annual update to the Clinic Comparison Report, which included four new measures: colorectal cancer screening; proportion of days covered for statins; well-child visits in the third, fourth, fifth, and sixth years; and well-child visits in the firth 15 months. The report was released on July 1, 2019.

OHCS staff presented a brief report on the growing number of Utah providers with all-inclusive, bundled cash prices for various procedures.

The TAG began initial work on meeting the new requirements in statute:
"list, as determined by the committee, the median paid amount for at least the top 50 medical procedures performed in the state by volume" while "compar[ing] and identif[ing] by name at least a majority of the health care facilities, health care plans, and institutions in the state."

Data Use Subcommittee: May 2019-present

The Health Data Committee's Data Use Subcommittee (DUS) is expertly chaired by Jahn Barlow, RGE Director at University of Utah. At least 5 DUS members are invited to each meeting. Quorum requirement is two HDC persons and one public member. Health Data Committee members on DUS for 2019 are: Charles Hawley, Steve Neeleman, Kevin Potts, Laura Summers, and Jim VanDerslice.

Unfortunately there was one resignation from the subcommittee last month. Andrew Knighton, one of the DUS "public" members resigned due to increasing work commitments. His valuable contributions over the past several years will be missed! There are vacancies on the subcommittee so please let staff know if you are interested in serving in this capacity.

Since the last HDC meeting on May 21,2019, the DUS has officially met six times and reviewed 21 requests for All Payer Claims, inpatient, ambulatory or ED data. After thorough review and deliberations, most of these data requests were approved* by DUS; one request was tabled and sent for full HDC consideration at its meeting on 09/17/19.

*A few titles of the approved projects were:

- Morbidity and Mortality from Motor Vehicle Crashes
- Utilizing mass transit networks for air quality and health research: Our lungs on the line
- Burden of opioid-related acute hepatitis C infections in Salt Lake County
- The Role of Depression in Teenage Pregnancy
- Capturing cancer recurrence in the Utah Cancer Registry and with Novel Data Linkages
- Determining Adherence to Colorectal Cancer Screening Recommendations in Utah

DUS is scheduled to meet 7 more times in 2019 with 24 more tentative dates planned for 2020. Staff extends much appreciation and thanks to DUS members for their time, expertise, and

outstanding commitment to ensuring sound policy for appropriate release of data managed by the Utah Department of Health.

Payer Task Force

OHCS hosted a Q&A-style meeting for payers to ask questions about 42 CFR Part 2 and state reporting. OHCS was able to secure a national expert on 42 CFR Part 2 to help with understanding the regulations surrounding the protection of substance abuse data.

OHCS staff presented finalized versions of the revised APCD data submission guide, proposed to be implemented on March 1, 2020.

Facilities Task Force

The Facilities Task Force did not convene since the last HDC meeting. However, 45/46 facilities with emergency departments have successfully transitioned to monthly data submissions. OHCS will shortly make this data available to UDOH researchers for opioid overdose outbreak detection.

Dental Carrier Threshold (R428-2-10)

Appendix 1: Regulatory Impact Summary Table*

Fiscal Costs	FY 2020	FY 2021	FY 2022
State Government	$0	$0	$0
Local Government	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Person	$0	$0	$0
Total Fiscal Costs:	$0	$0	$0
Fiscal Benefits			
State Government	$0	$0	$0
Local Government	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits:	$0	$0	$0
Net Fiscal Benefits:	$0	$0	$0

*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described above. Inestimable impacts for Non-Small Businesses are described below.

Appendix 2: Regulatory Impact to Non-Small Businesses

The Office of Health Care Statistics has approximately 140 facilities and carriers currently supplying data to the office. Each of these entities would be considered a non-small business. This change put existing policy into rule. The rule change is not expected to have any fiscal impact on non-small businesses' revenues or expenditures because the changes are being made to solidify current Department procedure and practice and do not place additional costs on the businesses.

The Executive Director of the Utah Department of Health, Joseph Miner, MD, has reviewed and approved this final analysis.

R428. Health, Center for Health Data, Health Care Statistics.
R428-2. Health Data Authority Standards for Health Data.
R428-2-1. Legal Authority.

This rule is promulgated under authority granted by Title 26, Chapter 33a.

R428-2-2. Purpose.

This rule establishes definitions, requirements, and general guidelines relating to the collection, control, use and release of data pursuant to Title 26, Chapter 33a.

R428-2-3. Definitions.

(1) The terms used in this rule are defined in Section 26-33a-102.

(2) In addition, the following definitions apply to all of Title R428:

(a) "Adjudicated claim" means a claim submitted to a carrier for payment where the carrier has made a determination whether the services provided fall under the carrier's benefit.

(b) "Ambulatory surgery data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a surgical or diagnostic procedure treatment in an outpatient setting into a data record.

(c) "Ambulatory surgical facility" is defined in Section 26-21-2.

(d) "Carrier" means any of the following Third Party Payors as defined in 26-33a-102(16):

(i) an insurer engaged in the business of health care or dental insurance in the state of Utah, as defined in Section 31A-1-301;

(ii) a business under an administrative services organization or administrative services contract arrangement;

(iii) a third party administrator, as defined in Section 31A-1-301, licensed by the state of Utah that collects premiums or settles claims of residents of the state, for health care insurance policies or health benefit plans, as defined in Section 31A-1-301;

(iv) a governmental plan, as defined in Section 414 (d), Internal Revenue Code, that provides health care benefits;

(v) a program funded or administered by Utah for the provision of health care services, including Medicaid, the Utah Children's Health Insurance Program created under Section 26-40-103, and the medical assistance programs described in Title 26, Chapter 18 or

any entity under a contract with the Utah Department of Health to serve clients under such a program;

(vi) a non-electing church plan, as described in Section 410 (d), Internal Revenue Code, that provides health care benefits;

(vii) a licensed professional employer organization as defined in Section 31a-40-102 acting as an administrator of a health care insurance plan;

(viii) a health benefit plan funded by a self-insurance arrangement;

(ix) the Public Employees' Benefit and Insurance Program created in Section 49-20-103;

(x) a pharmacy benefit manager, defined to be a person that provides pharmacy benefit management services as defined in Section 49-20-502 on behalf of any other carrier defined in subsection R428-2-3.

(e) "Claim" means a request or demand on a carrier for payment of a benefit.

(f) "Covered period" means the calendar year on which the data used for calculation of HEDIS measures is based.

(g) "Data element" means the specific information collected and recorded for the purpose of health care and health service delivery. Data elements include information to identify the individual, health care provider, data supplier, service provided, charge for service, payer source, medical diagnosis, and medical treatment.

(h) "Discharge data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single inpatient hospital stay into a discharge data record.

(i) "Electronic media" means a compact disc, digital video disc, external hard drive, or other media where data is stored in digital form.

(j) "Electronic transaction" means to submit data directly via electronic connection from a hospital or ambulatory surgery facility to the Office according to Electronic Data Interchange standards established by the American National Standards Institute's Accredited Standards Committee, known as the Health Care Transaction Set (837) ASC X 12N.

(k) "Eligible Enrollee" means an enrollee who meets the criteria outlined in the NCQA survey specifications.

(l) "Emergency Room Data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single visit and treatment of a patient in an emergency room into an emergency room data record.

(m) "Enrollee" means any individual who has entered into a contract with a carrier for health care or on whose behalf such an

arrangement has been made.

(n) "Health Insurance" has the same meaning as found in Section 31A-1-301.

(o) "Healthcare claims data" means information consisting of, or derived directly from, member enrollment, medical claims, and pharmacy claims that this rule requires a carrier to report.

(p) "Healthcare Facility" means a hospital or ambulatory surgical facility.

(q) "Healthcare Facility Data" means ambulatory surgery data, discharge data, or emergency room data.

(r) "HEDIS" means the Healthcare Effectiveness Data and Information Set, a set of standardized performance measures developed by the NCQA.

(s) "HEDIS data" means the complete set of HEDIS measures calculated by the carriers according to NCQA specifications, including a set of required measures and voluntary measures defined by the department, in consultation with the carriers.

(t) "Hospital" means a general acute hospital or specialty hospital as defined in Section 21-21-2 that is licensed under Rule R432.

(u) "Level 1 data element" means a required reportable data element.

(v) "Level 2 data element" means a data element that is reported when the information is available from the patient's hospital record.

(w) "NCQA" means the National Committee for Quality Assurance, a not-for-profit organization committed to evaluating and reporting on the quality of managed care plans.

(x) "Office" means the Office of Health Care Statistics within the Utah Department of Health.

(y) "Order" means an action of the committee that determines the legal rights, duties, privileges, immunities, or other interests of one or more specific persons, but not a class of persons.

(z) "Patient Social Security number" is the social security number of a person receiving health care.

(aa) "Performance Measure" means the quantitative, numerical measure of an aspect of the carrier, or its membership in part or in its entirety, or qualitative, descriptive information on the carrier in its entirety as described in HEDIS.

(bb) "Public Use Data Set" means a data extract or a subset of a database that is deemed by the Office to not include identifiable data or where the probability of identifying individuals is minimal.

(cc) "Report" means a disclosure of data or information collected or produced by the committee or Office, including but not limited to a compilation, study, or analysis designed to meet the needs of specific audiences.

(dd) "Research and Statistical Purposes" means having the objective of creating knowledge or answering questions, including a systematic investigation that includes development, testing, and evaluation; the description, estimation, projection, or analysis of the characteristics of individuals, groups, or organizations; an analysis of the relationships between or among these characteristics; the identification or creation of sampling frames and the selection of samples; the preparation and publication of reports describing these matters; and the development, implementation, and maintenance of methods, procedures, or resources to support the efficient use or management of the data.

(ee) "Research Data Set" means a data extract or subset of a database intended for use by investigators or researchers for bona fide research purposes that may include identifiable information or where there is more than a minimal probability that the data could be used to identify individuals.

(ff) "Record linkage number" is an irreversible, unique, encrypted number that will replace patient social security number.

(gg) "Sample file" means the data file containing records of selected eligible enrollees drawn by the survey agency from the carrier's sampling frame.

(hh) "Sampling Frame" means the carrier enrollment file as described criteria outlined by the NCQA survey specifications.

(ii) "Submission year" means the year immediately following the covered period.

(jj) "Survey agency" means an independent contractor on contract with the Office of Health Care Statistics.

(kk) "Utah Health Care Performance Measurement Plan" means the plan for data collection and public reporting of health-related measures, adopted by the Utah Health Data Committee to establish a statewide health performance reporting system.

(ll) "Uniform billing form" means the uniform billing form recommended for use by the National Uniform Billing Committee.

(mm) "Utah Healthcare Facility Data Submission Guide" means the document referenced in Subsection R428-1-4(1).

(nn) "NCQA Survey Specifications" means the document referenced in Subsection R428-1-4(2)

(oo) "NCQA HEDIS Specifications" means the document referenced in Subsection R428-1-4(3)

(pp) "Data Submission Guide for Claims Data" means the document referenced in Subsection R428-1-4(4).

R428-2-4. Technical Assistance.

The Office may provide technical assistance or consultation to a data supplier upon request and resource availability. The consultation shall be to enable a data supplier to submit required data according to Title R428.

R428-2-5. Data Classification and Access.

(1) Data collected by the committee are not public, and as such are exempt from the classification and release requirements specified in Title 63g, Chapter 2, Government Records Access and Management Act.

(2) Any person having access to data collected or produced by the committee or the Office under Title 26, Chapter 33a shall not:

(a) take any action that might provide information to any unauthorized individual or agency;

(b) scan, copy, remove, or review any information to which specific authorization has not been granted;

(c) discuss information with unauthorized persons which could lead to identification of individuals;

(d) give access to any information by sharing passwords or file access codes.

(3) Any person having access to data collected or produced by the committee or the Office under Title 26, Chapter 33a shall:

(a) maintain the data in a safe manner which restricts unauthorized access;

(b) limit use of the data to the purposes for which access is authorized;

(c) report immediately any unauthorized access to the Office or its designated security officer.

(4) A failure to report known violations by others is subject to the same punishment as a personal violation.

(5) The Office shall deny a person access to the facilities, services and data as a consequence of any violation of the responsibilities specified in this section.

R428-2-6. Editing and Validation.

(1) Each data supplier shall review each required record prior to submission. The review shall consist of checks for accuracy, consistency, completeness, and conformity.

(2) The Office may subject submitted data to edit checks. The Office may require the data supplier to correct data failing an edit check as follows:

(a) The Office may, by first class U.S. mail or email, inform the submitting data supplier of any data failing an edit check.

(b) The submitting data supplier shall make necessary corrections and resubmit all corrected data to the Office within 10 business days of the date the Office notified the supplier.

(3) The Office or its designee may reject any data submission that fails to conform to the submission requirements. A data supplier whose submission is rejected shall resubmit the data in the appropriate, corrected format to the Office or its designee within 10 state business days of notice that the data does not meet

the submission requirements.

R428-2-7. Error Rates.

The committee may establish and order reporting quality standards based on non-reporting or edit failure rates.

R428-2-8. Data Disclosure.

(1) The committee may disclose data received from data suppliers or data or information derived from this data as specified in Title 26, Chapter 33a.

(2) The Office may prepare reports relating to health care cost, quality, access, health promotion programs, or public health. These actions may be to meet legislative intent or upon request from individuals, government agencies, or private organizations. The Office may create reports in a variety of formats including print or electronic documents, searchable databases, web-sites, or other user-oriented methods for displaying information.

(3) Unless otherwise specified by the committee, the time period for data suppliers and health care providers to prepare a response as required in Subsections 26-33a-107(1) and 26-33a-107(3) shall be 15 business days. If a data supplier fails to respond in the specified time frame, the committee may conclude that the information is correct and suitable for release.

(4) The committee may note in a report that accurate appraisal of a certain category or entity cannot be presented because of a failure to comply with the committee's request for data, edit corrections, or data validation.

(5) The Office may release to the data supplier or its designee any data elements provided by the supplier without notification when a data supplier requests the data be so supplied.

(6) The committee may disclose data in computer readable formats.

(7) The Director of the Office may approve the disclosure of a public use data set upon receipt of a written request that includes the following:

(a) the name, address, e-mail and telephone number of the requester;

(b) a statement of the purpose for which the data will be used;

(c) agreement to other terms and conditions as deemed necessary by the Office.

(8) As allowed by Section 26-33a-109, thecommittee may release identified data for research and statistical purposes. A person requesting a research data set must provide:

(a) the name, address, e-mail and telephone number of the requester and for each person who will have access to the research data set;

(b) a statement of the purpose for which the research data set will be used;

(c) the starting and ending dates for which the research data set is requested;

(d) an explanation of why a public use data set could not be used for to accomplish the stated research purposes, including a separate justification for each element containing identified data requested;

(e) evidence of the integrity and ability to safeguard the data from any breach of confidentiality;

(f) evidence of competency to effectively use the data in the manner proposed;

(g) a satisfactory review from an Office-approved institutional review board;

(h) a guarantee that no further disclosure will occur without prior approval of the Office;

(i) a signed agreement to comply with other terms and conditions as stipulated by the committee.

R428-2-9. Penalties.

(1) The Office may apply civil penalties or subject violators to legal prosecution.

(2) Sections 26-23-6 and 26-33a-110 specify civil and criminal penalties for failure to comply with the requirements of Title R428 or Title 26, Chapter 33a.

(3) Notwithstanding Subsection R428-2-9(2), any person that violates any provision of Title R428 may be assessed an administrative civil money penalty not to exceed $3,000 upon an administrative finding of a first violation and up to $5,000 for a subsequent similar violation within two years. A person may also be subject to penalties imposed by a civil or criminal court, which may not exceed $5,000 or a class B misdemeanor for the first violation and a class A misdemeanor for any subsequent similar violation within two years.

(4) Notwithstanding Subsection R428-2-9(2) and R428-2-9(3), a data supplier that violates any provision of Title R428 may be assessed an administrative civil money penalty for each day of non-compliance. Fines may be imposed as follows:

(a) Not to exceed the sum of $10,000 per violation

(b) Each day of violation is a separate violation

(c) Deadlines established in separate sections of Title R428 are considered as separate provisions.

(5) The Office may impose a fine on any data supplier that misses a deadline to submit data required in Title R428 as follows:

(a) A fine of $250 per violation shall be imposed until the data has been supplied as required

(b) The fines shall increase to $500 per violation for each

violation when any data supplier that is currently in violation misses another deadline

(c) After forty-five consecutive calendar days of violation, the Office may adjust the per day penalty subject to the limits in (4)(a) taking into account the following aggravating and mitigating circumstances:

(i) Prior violation history and history of compliance

(ii) Good faith efforts to prevent violations

(iii) The size and financial capability of the data supplier.

R428-2-10. Exemptions and Extensions.

(1) The committee may grant exemptions or extensions from reporting requirements in Title R428 to data suppliers under certain circumstances.

(2) The committee may grant an exemption to a data supplier when the supplier demonstrates that compliance imposes an unreasonable cost.

(a) A data supplier may request an exemption from any particular requirement or set of requirements of Title R428. The data supplier must submit a request for exemption no less than 30 calendar days before the date the supplier would have to comply with the requirement.

(b) The committee may grant an exemption for a maximum of one calendar year. A data supplier wishing an additional exemption must submit an additional, separate request.

(3) The committee may grant an extension to a data supplier when the supplier demonstrates that technical or unforeseen difficulties prevent compliance.

(a) A data supplier may request an extension for any deadline required in Title R428. For each deadline for which the data supplier requests an extension, the data supplier must submit its request no less than seven calendar days before the deadline in question.

(b) The committee may grant an extension for a maximum of 30 calendar days. A data supplier wishing an additional extension must submit an additional, separate request.

(4) The supplier requesting an extension or exemption shall include:

(a) The data supplier's name, mailing address, telephone number, and contact person;

(b) the dates the exemption or extension is to start and end;

(c) a description of the relief sought, including reference to specific sections or language of the requirement;

(d) a statement of facts, reasons, or legal authority in support of the request; and

(e) a proposed alternative to the requirement or deadline.

(5) A carrier that covers fewer than 2,500 individual Utah

residents as of January 1 of a given year is exempt from all requirements of this title except that once a carrier has covered a cumulative total of 2,500 such individuals during a calendar year, they are no longer considered exempt for the remainder of that year.

(6) A stand-alone dental carrier that covers fewer than 20,000 individual Utah residents as of January 1 of a given year is exempt from all requirements of this title except that once a stand-alone dental carrier has covered a cumulative total of 20,000 such individuals during a calendar year, they are no longer considered exempt for the remainder of that year.

R428-2-11. Contractor Liability.

(1) A data supplier may contract with another entity to submit required data elements on their behalf under Title R428. In such cases, the data supplier must notify the Office of the identity and contact information of the contractor.

(2) Regardless of the existence of a contractor, the responsibility for complying with all requirements of Title R428 remains solely with the data supplier.

R428-2-12. Data Supplier Contacts.

(1) Data suppliers required to submit healthcare claims data or healthcare facility data shall provide current contact information to the Office by September 1 of each year using a web-site provided by the Office for this purpose.

(2) Each data supplier newly required to submit healthcare claims data or healthcare facility data under this rule, including by a change to the rule or because it no longer qualifies for an exemption, shall provide contact information to the Office within 30 days of learning that they will be required to submit data under this rule.

(3) Each data supplier shall designate a person who is responsible for submitting data and a person who is responsible for communicating with the Office regarding the submission of the data. Each data supplier shall notify the Office of changes in this designation within thirty calendar days.

KEY: health, health policy, health planning
Date of Enactment or Last Substantive Amendment: December 13, 2017
Notice of Continuation: November 10, 2016
Authorizing, and Implemented or Interpreted Law: 26-33a-104

No Contact Rule (R428-2-8)

R428. Health, Center for Health Data, Health Care Statistics.
R428-2. Health Data Authority Standards for Health Data.
R428-2-1. Legal Authority.

This rule is promulgated under authority granted by Title 26, Chapter 33a.

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R428-2-3. Definitions.

(1) The terms used in this rule are defined in Section 26-33a-102.

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(iii) a third party administrator, as defined in Section 31A-1-301, licensed by the state of Utah that collects premiums or settles claims of residents of the state, for health care insurance policies or health benefit plans, as defined in Section 31A-1-301;

(iv) a governmental plan, as defined in Section 414 (d), Internal Revenue Code, that provides health care benefits;

(v) a program funded or administered by Utah for the provision of health care services, including Medicaid, the Utah Children's Health Insurance Program created under Section 26-40-103, and the medical assistance programs described in Title 26, Chapter 18 or any entity under a contract with the Utah Department of Health to serve clients under such a program;

(vi) a non-electing church plan, as described in Section 410 (d), Internal Revenue Code, that provides health care benefits;

(vii) a licensed professional employer organization as defined in Section 31a-40-102 acting as an administrator of a health care insurance plan;

(viii) a health benefit plan funded by a self-insurance arrangement;

(ix) the Public Employees' Benefit and Insurance Program created in Section 49-20-103;

(x) a pharmacy benefit manager, defined to be a person that provides pharmacy benefit management services as defined in Section 49-20-502 on behalf of any other carrier defined in subsection R428-2-3.

(e) "Claim" means a request or demand on a carrier for payment of a benefit.

(f) "Covered period" means the calendar year on which the data used for calculation of HEDIS measures is based.

(g) "Data element" means the specific information collected and recorded for the purpose of health care and health service delivery. Data elements include information to identify the individual, health care provider, data supplier, service provided, charge for service, payer source, medical diagnosis, and medical treatment.

(h) "Discharge data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single inpatient hospital stay into a discharge data record.

(i) "Electronic media" means a compact disc, digital video disc, external hard drive, or other media where data is stored in digital form.

(j) "Electronic transaction" means to submit data directly via electronic connection from a hospital or ambulatory surgery facility to the Office according to Electronic Data Interchange standards established by the American National Standards Institute's Accredited Standards Committee, known as the Health Care Transaction Set (837) ASC X 12N.

(k) "Eligible Enrollee" means an enrollee who meets the criteria outlined in the NCQA survey specifications.

(l) "Emergency Room Data" means the consolidation of complete billing, medical, and personal information describing a patient, the services received, and charges billed for a single visit and treatment of a patient in an emergency room into an emergency room data record.

(m) "Enrollee" means any individual who has entered into a contract with a carrier for health care or on whose behalf such an arrangement has been made.

(n) "Health Insurance" has the same meaning as found in Section 31A-1-301.

(o) "Healthcare claims data" means information consisting of,

or derived directly from, member enrollment, medical claims, and pharmacy claims that this rule requires a carrier to report.

(p) "Healthcare Facility" means a hospital or ambulatory surgical facility.

(q) "Healthcare Facility Data" means ambulatory surgery data, discharge data, or emergency room data.

(r) "HEDIS" means the Healthcare Effectiveness Data and Information Set, a set of standardized performance measures developed by the NCQA.

(s) "HEDIS data" means the complete set of HEDIS measures calculated by the carriers according to NCQA specifications, including a set of required measures and voluntary measures defined by the department, in consultation with the carriers.

(t) "Hospital" means a general acute hospital or specialty hospital as defined in Section 21-21-2 that is licensed under Rule R432.

(u) "Level 1 data element" means a required reportable data element.

(v) "Level 2 data element" means a data element that is reported when the information is available from the patient's hospital record.

(w) "NCQA" means the National Committee for Quality Assurance, a not-for-profit organization committed to evaluating and reporting on the quality of managed care plans.

(x) "Office" means the Office of Health Care Statistics within the Utah Department of Health.

(y) "Order" means an action of the committee that determines the legal rights, duties, privileges, immunities, or other interests of one or more specific persons, but not a class of persons.

(z) "Patient Social Security number" is the social security number of a person receiving health care.

(aa) "Performance Measure" means the quantitative, numerical measure of an aspect of the carrier, or its membership in part or in its entirety, or qualitative, descriptive information on the carrier in its entirety as described in HEDIS.

(bb) "Public Use Data Set" means a data extract or a subset of a database that is deemed by the Office to not include identifiable data or where the probability of identifying individuals is minimal.

(cc) "Report" means a disclosure of data or information collected or produced by the committee or Office, including but not limited to a compilation, study, or analysis designed to meet the needs of specific audiences.

(dd) "Research and Statistical Purposes" means having the objective of creating knowledge or answering questions, including a systematic investigation that includes development, testing, and evaluation; the description, estimation, projection, or analysis of

the characteristics of individuals, groups, or organizations; an analysis of the relationships between or among these characteristics; the identification or creation of sampling frames and the selection of samples; the preparation and publication of reports describing these matters; and the development, implementation, and maintenance of methods, procedures, or resources to support the efficient use or management of the data.

(ee) "Research Data Set" means a data extract or subset of a database intended for use by investigators or researchers for bona fide research purposes that may include identifiable information or where there is more than a minimal probability that the data could be used to identify individuals.

(ff) "Record linkage number" is an irreversible, unique, encrypted number that will replace patient social security number.

(gg) "Sample file" means the data file containing records of selected eligible enrollees drawn by the survey agency from the carrier's sampling frame.

(hh) "Sampling Frame" means the carrier enrollment file as described criteria outlined by the NCQA survey specifications.

(ii) "Submission year" means the year immediately following the covered period.

(jj) "Survey agency" means an independent contractor on contract with the Office of Health Care Statistics.

(kk) "Utah Health Care Performance Measurement Plan" means the plan for data collection and public reporting of health-related measures, adopted by the Utah Health Data Committee to establish a statewide health performance reporting system.

(ll) "Uniform billing form" means the uniform billing form recommended for use by the National Uniform Billing Committee.

(mm) "Utah Healthcare Facility Data Submission Guide" means the document referenced in Subsection R428-1-4(1).

(nn) "NCQA Survey Specifications" means the document referenced in Subsection R428-1-4(2)

(oo) "NCQA HEDIS Specifications" means the document referenced in Subsection R428-1-4(3)

(pp) "Data Submission Guide for Claims Data" means the document referenced in Subsection R428-1-4(4).

R428-2-4. Technical Assistance.

The Office may provide technical assistance or consultation to a data supplier upon request and resource availability. The consultation shall be to enable a data supplier to submit required data according to Title R428.

R428-2-5. Data Classification and Access.

(1) Data collected by the committee are not public, and as such are exempt from the classification and release requirements

specified in Title 63g, Chapter 2, Government Records Access and Management Act.

(2) Any person having access to data collected or produced by the committee or the Office under Title 26, Chapter 33a shall not:

(a) take any action that might provide information to any unauthorized individual or agency;

(b) scan, copy, remove, or review any information to which specific authorization has not been granted;

(c) discuss information with unauthorized persons which could lead to identification of individuals;

(d) give access to any information by sharing passwords or file access codes.

(3) Any person having access to data collected or produced by the committee or the Office under Title 26, Chapter 33a shall:

(a) maintain the data in a safe manner which restricts unauthorized access;

(b) limit use of the data to the purposes for which access is authorized;

(c) report immediately any unauthorized access to the Office or its designated security officer.

(4) A failure to report known violations by others is subject to the same punishment as a personal violation.

(5) The Office shall deny a person access to the facilities, services and data as a consequence of any violation of the responsibilities specified in this section.

R428-2-6. Editing and Validation.

(1) Each data supplier shall review each required record prior to submission. The review shall consist of checks for accuracy, consistency, completeness, and conformity.

(2) The Office may subject submitted data to edit checks. The Office may require the data supplier to correct data failing an edit check as follows:

(a) The Office may, by first class U.S. mail or email, inform the submitting data supplier of any data failing an edit check.

(b) The submitting data supplier shall make necessary corrections and resubmit all corrected data to the Office within 10 business days of the date the Office notified the supplier.

(3) The Office or its designee may reject any data submission that fails to conform to the submission requirements. A data supplier whose submission is rejected shall resubmit the data in the appropriate, corrected format to the Office or its designee within 10 state business days of notice that the data does not meet the submission requirements.

R428-2-7. Error Rates.

The committee may establish and order reporting quality

standards based on non-reporting or edit failure rates.

R428-2-8. Data Disclosure.

(1) The committee may disclose data received from data suppliers or data or information derived from this data as specified in Title 26, Chapter 33a.

(2) The Office may prepare reports relating to health care cost, quality, access, health promotion programs, or public health. These actions may be to meet legislative intent or upon request from individuals, government agencies, or private organizations. The Office may create reports in a variety of formats including print or electronic documents, searchable databases, web-sites, or other user-oriented methods for displaying information.

(3) Unless otherwise specified by the committee, the time period for data suppliers and health care providers to prepare a response as required in Subsections 26-33a-107(1) and 26-33a-107(3) shall be 15 business days. If a data supplier fails to respond in the specified time frame, the committee may conclude that the information is correct and suitable for release.

(4) The committee may note in a report that accurate appraisal of a certain category or entity cannot be presented because of a failure to comply with the committee's request for data, edit corrections, or data validation.

(5) The Office may release to the data supplier or its designee any data elements provided by the supplier without notification when a data supplier requests the data be so supplied.

(6) The committee may disclose data in computer readable formats.

(7) The Director of the Office may approve the disclosure of a public use data set upon receipt of a written request that includes the following:

(a) the name, address, e-mail and telephone number of the requester;

(b) a statement of the purpose for which the data will be used;

(c) agreement to other terms and conditions as deemed necessary by the Office.

(8) As allowed by Section 26-33a-109, thecommittee may release identified data for research and statistical purposes. A person requesting a research data set must provide:

(a) the name, address, e-mail and telephone number of the requester and for each person who will have access to the research data set;

(b) a statement of the purpose for which the research data set will be used;

(c) the starting and ending dates for which the research data set is requested;

(d) an explanation of why a public use data set could not be used for to accomplish the stated research purposes, including a separate justification for each element containing identified data requested;

(e) evidence of the integrity and ability to safeguard the data from any breach of confidentiality;

(f) evidence of competency to effectively use the data in the manner proposed;

(g) a satisfactory review from an Office-approved institutional review board;

(h) a guarantee that no further disclosure will occur without prior approval of the Office;

(i) a signed agreement to comply with other terms and conditions as stipulated by the committee.

(9) A person receiving data from the Health Data Committee may not contact or attempt to contact any person or entity included in the data. The Health Data Committee may grant an exception to the prohibition in this subsection (9) if the person receiving the data

i. Has a contractual relationship with the person or entity,

ii. Has written permission from the person or entity to be contacted allowing the contact to occur,

iii. Is required to allow a health care provider or data supplier the opportunity to verify or review information or prepare a response, or

iv. Has legal authority and the practical ability to contact the person or entity using data from other sources and will not use data from the Health Data Committee to identify which persons or entities to contact.

R428-2-9. Penalties.

(1) The Office may apply civil penalties or subject violators to legal prosecution.

(2) Sections 26-23-6 and 26-33a-110 specify civil and criminal penalties for failure to comply with the requirements of Title R428 or Title 26, Chapter 33a.

(3) Notwithstanding Subsection R428-2-9(2), any person that violates any provision of Title R428 may be assessed an administrative civil money penalty not to exceed $3,000 upon an administrative finding of a first violation and up to $5,000 for a subsequent similar violation within two years. A person may also be subject to penalties imposed by a civil or criminal court, which may not exceed $5,000 or a class B misdemeanor for the first violation and a class A misdemeanor for any subsequent similar violation within two years.

(4) Notwithstanding Subsection R428-2-9(2) and R428-2-9(3), a data supplier that violates any provision of Title R428 may be assessed an administrative civil money penalty for each day of non-compliance. Fines may be imposed as follows:

(a) Not to exceed the sum of $10,000 per violation

(b) Each day of violation is a separate violation

(c) Deadlines established in separate sections of Title R428 are considered as separate provisions.

(5) The Office may impose a fine on any data supplier that misses a deadline to submit data required in Title R428 as follows:

(a) A fine of $250 per violation shall be imposed until the data has been supplied as required

(b) The fines shall increase to $500 per violation for each violation when any data supplier that is currently in violation misses another deadline

(c) After forty-five consecutive calendar days of violation, the Office may adjust the per day penalty subject to the limits in (4)(a) taking into account the following aggravating and mitigating circumstances:

(i) Prior violation history and history of compliance

(ii) Good faith efforts to prevent violations

(iii) The size and financial capability of the data supplier.

R428-2-10. Exemptions and Extensions.

(1) The committee may grant exemptions or extensions from reporting requirements in Title R428 to data suppliers under certain circumstances.

(2) The committee may grant an exemption to a data supplier when the supplier demonstrates that compliance imposes an unreasonable cost.

(a) A data supplier may request an exemption from any particular requirement or set of requirements of Title R428. The data supplier must submit a request for exemption no less than 30 calendar days before the date the supplier would have to comply with the requirement.

(b) The committee may grant an exemption for a maximum of one calendar year. A data supplier wishing an additional exemption must submit an additional, separate request.

(3) The committee may grant an extension to a data supplier when the supplier demonstrates that technical or unforeseen difficulties prevent compliance.

(a) A data supplier may request an extension for any deadline required in Title R428. For each deadline for which the data supplier requests an extension, the data supplier must submit its request no less than seven calendar days before the deadline in question.

(b) The committee may grant an extension for a maximum of 30

calendar days. A data supplier wishing an additional extension must submit an additional, separate request.

(4) The supplier requesting an extension or exemption shall include:

(a) The data supplier's name, mailing address, telephone number, and contact person;

(b) the dates the exemption or extension is to start and end;

(c) a description of the relief sought, including reference to specific sections or language of the requirement;

(d) a statement of facts, reasons, or legal authority in support of the request; and

(e) a proposed alternative to the requirement or deadline.

(5) A carrier that covers fewer than 2,500 individual Utah residents as of January 1 of a given year is exempt from all requirements of this title except that once a carrier has covered a cumulative total of 2,500 such individuals during a calendar year, they are no longer considered exempt for the remainder of that year.

R428-2-11. Contractor Liability.

(1) A data supplier may contract with another entity to submit required data elements on their behalf under Title R428. In such cases, the data supplier must notify the Office of the identity and contact information of the contractor.

(2) Regardless of the existence of a contractor, the responsibility for complying with all requirements of Title R428 remains solely with the data supplier.

R428-2-12. Data Supplier Contacts.

(1) Data suppliers required to submit healthcare claims data or healthcare facility data shall provide current contact information to the Office by September 1 of each year using a web-site provided by the Office for this purpose.

(2) Each data supplier newly required to submit healthcare claims data or healthcare facility data under this rule, including by a change to the rule or because it no longer qualifies for an exemption, shall provide contact information to the Office within 30 days of learning that they will be required to submit data under this rule.

(3) Each data supplier shall designate a person who is responsible for submitting data and a person who is responsible for communicating with the Office regarding the submission of the data. Each data supplier shall notify the Office of changes in this designation within thirty calendar days.

KEY: health, health policy, health planning
Date of Enactment or Last Substantive Amendment: December 13, 2017
Notice of Continuation: November 10, 2016

Authorizing, and Implemented or Interpreted Law: 26-33a-104

Changes to the APCD DSG (R428-1)

R428. Health, Center for Health Data, Health Care Statistics.
R428-1. Health Data Plan and Incorporated Documents.
R428-1-1. Legal Authority.

This rule is promulgated in accordance with Title 26, Chapter 33a.

R428-1-2. Purpose.

This rule adopts and incorporates documents related to the collection, analysis, and dissemination of data covered in this title.

R428-1-3. Health Data Plan Adoption.

As required by Section 26-33a-104, the Health Data Committee adopts by rule the health data plan dated October 3, 1991.

R428-1-4. Incorporation by Reference.

The following documents are adopted and incorporated by reference:

(1) "Utah Healthcare Facility Data Submission Guide" means:

(a) Utah Healthcare Facility Data Submission Guide, Version 2 for data submissions required on or after February 16, 2018;

(b) Utah Healthcare Facility Data Submission Guide, Version 2.1 for data submissions required on or after May 16, 2019;

(2) "NCQA Survey Specifications" means:

(a) HEDIS 2017, Volume 3: Specifications for Survey Measures, published by NCQA for data submissions required before January 1, 2018, and

(b) HEDIS 2018, Volume 3: Specifications for Survey Measures, published by NCQA for data submissions required on or after January 1, 2018;

(3) "NCQA HEDIS Specifications" means:

(a) HEDIS 2017, Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures, published by NCQA for data submissions required before January 1, 2018, and

(b) HEDIS 2018, Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures, published by NCQA for data submissions required on or after January 1, 2018;

(4) "Data Submission Guide for Claims Data" means:

(a) [~~Utah All-Payer Claims Database Data Submission Guide Version 3.0 for data submissions required before March 1, 2018, and~~

~~(b)~~]Utah All-Payer Claims Database Data Submission Guide Version 3.1 (as corrected on March 15, 2018) for data submissions required [~~on or after~~]before March 1, 2020, and

(b) Utah All-Payer Claims Database Data Submission Guide Version 4.0 for data submissions required on or after March 1, 2020.

KEY: APCD, health, health policy, health planning

Date of Enactment or Last Substantive Amendment: May 1, 2019
Notice of Continuation: November 10, 2016
Authorizing, and Implemented or Interpreted Law: 26-33a-104

Utah All Payer Claims Database (APCD) Data Submission Guide (DSG) Draft Changes

Proposed to be Effective March 1, 2020 as Version 4

General Changes

- Removed "required" element column from format tables and incorporated specific requirements in element descriptions.
- Revised "Required Element" language in instructions.
- Replaced large lookup tables with reference to national standard.
- Incorporated language from the December 2016 "Technical Guidance - Rolling Three Month Eligibility Files"
- Added table of contents.
- Minor reorganization.
- Corrected minor typographical errors.

Eligibility File Changes

- Added 5 empty fields to eligibility table.
    - ME990
    - ME991
    - ME992
    - ME993
    - ME994

Medical Claims File Changes

- Added "In Plan Network Indicator" field to medical claims table.
    - MC916
- Added "Allowed Amount" field to medical claims table.
    - MC955
- Added 5 empty fields to medical claims table.
    - MC990
    - MC991
    - MC992
    - MC993
    - MC994
- Added "42 CRF Part 2 Flag" to medical claims table.
    - MC999

Pharmacy Claims File Changes

- Added "In Plan Network Indicator" field to pharmacy claims table.
    - PC915
- Added "Allowed Amount" field to pharmacy claims table.
    - PC907
- Changed PC043 from "unassigned" to "Pharmaceutical Company Rebate".

    - PC043
- Added 5 empty fields to pharmacy claims table.
    - PC990
    - PC991
    - PC992
    - PC993
    - PC994
- Added “42 CRF Part 2 Flag” to pharmacy claims table.
    - PC999
- Added “Prescription Number” to pharmacy claims table.
    - PC906

Provider File Changes

- Added 5 empty fields to provider table.
    - MP990
    - MP991
    - MP992
    - MP993
    - MP994

Complete Proposed All Payer Claims Database (APCD) Data Submission Guide (DSG) available here:

- https://gitlab.com/UtahOHCS/APCD_DSG

Five Year Review R428-15

R428. Health, Center for Health Data, Health Care Statistics.
R428-15. Health Data Authority Health Insurance Claims Reporting.
R428-15-1. Legal Authority.

This rule is promulgated under authority granted in Utah Code Title 26, Chapter 33a and in accordance with the Utah Health Data Plan as adopted in Rule R428-1.

R428-15-2. Purpose.

This rule establishes requirements for certain entities that pay for health care to submit data to the Utah Department of Health.

R428-15-3. Reporting Requirements.

(1) Each carrier shall submit health care claims data described in the Data Submission Guide for Claims Data for each covered person where Utah is the covered person's primary residence, regardless of where the services are provided.

(2) Each carrier shall submit data for all fields contained in the Data Submission Guide for Claims Data if the data are available to the carrier. Each carrier shall notify the Office or its designee of any data elements that are required to be reported under this rule, but that are not available to the carrier.

(3) Each carrier shall submit the health care claims data on a monthly basis.

(4) Each monthly submission is due no later than the last day of the month following the month in which the carrier adjudicated the claim.

R428-15-4. Testing of Files.

(1) Prior to February 14, 2014, each carrier required to report under this rule shall meet with the Office or its designee to establish a data submission testing plan and time line. Each carrier shall contact the Office to arrange this meeting by January 15, 2014.

(2) Each carrier shall, according to its data submission testing plan, submit to the Office or its designee a test dataset for determining compliance with the standards for data submission and participate in testing. This test dataset must be in the same format as required by the Data Submission Guide for Claims Data as of May 15, 2014.

(3) Carriers that become subject to this rule after January 15, 2014 shall submit to the Office a dataset for determining compliance with the standards for data submission no later than 90 days after the first date of becoming subject to the rule.

R428-15-5. Rejection of Files.

The Office or its designee may reject and return any data submission that fails to conform to the submission requirements. A carrier whose submission is rejected shall resubmit the data in the appropriate, corrected format to the Office, or its designee within 10 state business days of notice that the data does not meet the submission requirements.

R428-15-6. Limitation of Liability.

As provided in Section 26-25-1, any data supplier that submits data pursuant to this rule cannot be held liable for having provided

the required information to the Department.

KEY: data, payers, claims, transparency
Date of Enactment or Last Substantive Amendment: March 25, 2016
Notice of Continuation: October 10, 2014
Authorizing, and Implemented or Interpreted Law: 26-33a; 26-25

5. Officer Elections (Discussion Only) – Norman Thurston

Open and Public Meetings Act

A Summary of Key Provisions | June 2019

The Open and Public Meetings Act (OPMA) requires that members of a public body be "provided with annual training on the requirements of [the Open and Public Meetings Act]" (Section 52-4-104). This document is intended to facilitate compliance with that requirement. Key terms are defined at the end of the document.

OPMA's stated goal is to ensure that the state, its agencies, and its political subdivisions deliberate and take action openly *(Section 52-4-102)*. Requires all meetings to be open to the public, unless, there is a statutory allowed purpose for closure *(Section 52-4-201)*.

Public Notice

(Section 52-4-202)

A public body is required to provide public notice of a meeting at least 24 hours before the meeting. The public notice is required to:

- specify the date, time, and place of the meeting;
- include an agenda that specifies the topics the public body will consider;
- be posted on the Utah Public Notice Website and at the location of the meeting; and
- be provided to a newspaper or local media correspondent.

A public body may discuss an item raised by the public that is not listed on the agenda but may not take final action on the item at the meeting.

Minutes and Recordings

(Section 52-4-203)

- A public body is required to keep written minutes and an audio recording of all meetings unless the meeting is a site visit or traveling tour where no vote or action is taken.
- A recording of the open portions of the meeting must be posted on the Utah Public Notice Website within three business days after the public meeting.
- Draft minutes are required to be made available to the public within 30 days after the meeting.
- The approved minutes and any public materials distributed at the meeting must, within three business days after their approval, be:
  - posted on the Utah Public Notice Website; and
  - made available at the public body's office.

2019 Amendments to OPMA

- 2019 S.B. 27 authorizes a governmental nonprofit corporation to close a meeting to discuss trade secrets under certain circumstances.
- 2019 S.B. 72 provides clarification regarding the application of OPMA to a quorum of a large public transit district.
- 2019 S.B. 165 amends the definition of "quorum" so that a quorum is not present when two elected members of a three-member public body meet if they take no action, regardless of whether the action relates to a subject over which the public body has advisory power.

Closed Meetings

(Sections 52-4-204, 52-4-205 and 52-4-206)

A public body may vote to hold a closed meeting only for certain purposes, including to discuss:

- a person's character, competence, or health;
- pending or imminent litigation;
- certain matters regarding acquisition or sale of real property, including water rights or shares;
- the deployment of security personnel, devices, or systems;
- an investigation of alleged criminal conduct;
- collective bargaining;
- certain deliberations involving trade secrets involving procurement; and
- certain other deliberations and decision making involved in the procurement process.

A public body may close a meeting only by a two-thirds vote with a quorum present, except that a majority vote is sufficient for closing a meeting of:

- the Health and Human Services Interim Committee to review a fatality review report;
- the Child Welfare Legislative Oversight Panel to review a fatality review report/individual case; or
- a Legislature ethics committee to receive legal advice or deliberate on a complaint.

A public body that closes a meeting is required to announce and record in the minutes the reasons for closing the meeting.

An ordinance, resolution, rule, regulation, contract, or appointment may not be approved during the closed portion of a meeting.

Record of Closed Meetings – If a public body closes a meeting, it still must keep written minutes and an audio recording. Exceptions are, if the meeting is closed to discuss a person's character, competence, or health; the deployment of security personnel, devices, or systems; or specific legislative or HHS oversight purposes. The presiding person must sign a sworn affidavit affirming the reason for closing the meeting. Records in these closed meetings are protected under GRAMA.

Emergency Meetings

(Section 52-4-202)

A public body may hold an emergency meeting and is not required to give 24-hour notice if unforeseen circumstances arise that require the public body to consider matters of an emergency or urgent nature. However, a public body may not hold an emergency meeting unless it attempts to notify all members of the public body and a majority of its members approve the meeting.

Electronic Meetings

(Sections 52-4-207)

A public body may not convene or conduct a meeting by electronic communications unless it has adopted procedures to govern electronic meetings. UDOH's rule for electronic meetings is found in Admin. Code R380-42.

Miscellaneous Provisions

Chance or Social Meetings - do not fall under the statute unless used to circumvent the statute. *(Section 52-4-208)*

Disruption of Meetings - statute allows for removal of person who willfully disrupts the meeting to extent order is seriously compromised. *(Sections 52-4-301)*

Penalties

(Sections 52-4-302 and 52-4-305)

Open Meetings - Any final action taken in a meeting that is in violation of certain open-meeting provisions of OPMA is voidable by a court.

Closed Meetings - It is a class B misdemeanor to knowingly or intentionally violate the closed meeting provisions of OPMA.

Definitions *(Section 52-4-103)*

Meeting means a convening of a public body with a quorum present to discuss, receive public comment about, or act upon a matter over which the public body has jurisdiction or advisory power.

Meeting does not mean a chance or social gathering or a convening of a public body that has both legislative and executive responsibilities in certain circumstances.

Public Body means an administrative, advisory, executive, or legislative body of the state or its political subdivisions that:

- is created by the Utah constitution, state statute, rule, ordinance, or resolution;
- expends, disburses, or is supported in whole or in part by tax revenue; and
- is vested with the authority to make decisions regarding the public's business.

Public body does not include a political party, political group, or political caucus, or a conference committee, rules committee, or sifting committee of the Legislature.

Data Request Staff Summary

Title: Provider Level Price and Quality Transparency Through the Lens of Episodes of Care in Public and Commercially Insured Populations

Researcher: Dr. Peter Hayward

Institution: Remedy Partners

Staff Review: Sterling Petersen

Staff Recommendation:

There is no precedent for the release of natural person NPIs without a pre-existing contractual relationship between the entity and the identified provider. Assuming no other issues, recommend full committee hearing.

Research Question:

"Remedy will use the data to develop and refine provider-level cost and quality metrics for episodes of care, compare high and low cost and quality providers, and benchmark the provider-level outcomes against their other data using episodes of care as the unit of measurement."

Research Method:

"The analytic sample will include any individual with at least one episode of care. Episodes will be identified from Remedy's episode grouper software which relies on the combination of diagnostic and procedure codes on member claims to trigger episodes and assign relevant services. All episodes will be attributed to either the operating surgeon (if a procedure) or the provider accounting for the plurality of office visits (if a condition). Procedure episodes will also be attributed to the facility where it was performed. Costs will be defined as the sum of payments for services assigned to an episode. Analyses will examine cost metrics at the total episode level and within sub-groupings, such as types of care (radiology, office visits), site of care (inpatient vs outpatient), and phase (pre-operative, intra-operative, and post-operative). Quality will be measured based on Remedy's preventable and potentially avoidable event definitions, which constitute complications that occurred during a particular episode which could have been avoided with optimal care. All analyses will be conducted separately for each population in the data. When appropriate, provider-level analyses or reports produced from the data will be risk-adjusted to account for potential differences in patient case-mix."

Output:

Tabulations for Remedy's "suite of clinical decision and performance solutions", ultimately marketed to "healthcare organizations (such as payers, hospitals, and physician groups)" to provide them with "operational solutions to improve quality and reduce episode costs."

Sensitive Information Requested:

- Member Age
- Full Dates for Admissions and Services
- Member ZIP Codes
- All National Provider Identifiers (NPIs)
- All Tax IDs
- DEA Number

Plan for Securing the Data:

"Access rights are granted based on least access privilege and minimum data necessary required for an individual to perform a job function. All data access requests include the specific reason for the need for access as well as manager review and approval. Additional separation of duties controls are in place to limit access to environments - providing a second layer of access control to covered information.

"Any additional access must be requested for manager approval by submitting a JIRA ticket.

"Per Remedy's Access Establishment and Modification Policy, access to covered information is only granted based on the nature and duties of the workforce member's work. Access is modified when the nature of the job changes and requires a different level of access, whether greater or lesser. Data analyst's access to data sets is granted through the request and approval process on the central ticketing system. All Remedy employees receive documented initial onboarding training in Compliance, Security and Privacy. Employees sign acceptance of their security and privacy responsibilities at the new hire +++++training, and on two follow up policies, the "Remedy Hardware Acceptable Use Policy" and "Handling and Protection of Confidential Info." Automated emails and and Compliance Office follow-up ensures full workforce compliance.

"All Remedy offices are protected with key card entry systems as well as CCTV. All access is logged and monitored. Remedy does not store any paper records of PHI. Confidential information is stored in locked cabinets when needed, but in general all confidential information is stored in the cloud on designated systems with access controls.

"Remedy uses Amazon Web Services (AWS) to host all Remedy infrastructure. AWS manages all physical controls including: physical security, maintenance, environmental controls, and key

management. As part of the AWS shared security model, Remedy manages all technical controls including: access control, system administration, performance monitoring, and security event monitoring. Remedy's Safeguards are HITRUST Certified as of March 2018, and are assessed annually by Coalfire, an independent third-party security assessment firm.

"AWS has multiple certifications for their physical and operating procedures. Included are: CSA, SOC2 Type2, and ISO 27001. See: https://aws.amazon.com/compliance/programs/"

Office of Health Care Statistics Data Application ▸ #1448

Date last modified	190813-1487
Part A. Requesting Entity Information	
Name:	Remedy Partners, Inc.
Entity Address	800 Connecticut Ave. Norwalk, Connecticut 06854 United States
Phone	(475) 214-1756
Organization Type	Profit/Private Sector Agency
Specific Organization Type	Other health care provider [provide fill in box]
Other, please specify	Awardee Convener
Applicant Information	
Name	Peter Hayward
Address	✔ Applicant address same as requesting entity
Applicant Address	 United States
Phone	(475) 214-1756
Email	phayward@remedypartners.com

Other Users of the Data
John Lang - SVP, Technology Infrastructure jlang@remedypartners.com
Samantha Szewczyk - Analyst, Performance Analytics sszewczyk@remedypartners.com
Jeffrey Dunn - Manager, Performance Analytics jdunn@remedypartners.com

Project Summary

Briefly describe the purpose of your project and how you will use the requested Hospital Discharge, APCD, or other OHCS data products.

Title of Data Use
The Role of Insurance Benefit Design in Treatment, Utilization/Spending Patterns, and Related Health Outcomes among Providers

Description of Data Use

This research examines the extent to which insurance benefit design impacts geographic variation both in health outcomes and in the provision of health care services. We will assess health outcomes and utilization in four steps: (1) Measuring the parameter of interest; (2) Identifying the treatment and comparison groups based on the insurance product; (3) Defining a "region"; and (4) Accounting for regional variation in patient case mix. Our observational study will rely on proprietary episode of care definitions, national and local benchmark comparisons, and site of care algorithms to identify the root causes of variation. Our analysis will highlight patient differences in the inpatient and post-acute care patterns and in the health outcomes achieved based on the type of insurance product.

Data User Competency

In addition to being the largest awardee convener under Medicare's BPCI program, Remedy Partners develops episode programs and builds and manages bundled payment networks. We operate in almost 50 states in more than 1,000 healthcare locations and are used to working with providers and using data to help improve performance. We frequently ingested large amounts of data from our partners on a quarterly basis as part of the BPCI program, and now ingest BPCI-A Reconciliation data from CMA on a bi-annual basis.

Start Date for Using Data	Mar 15, 2019
End Date for Using Data	Mar 14, 2020
Part B. Data Set Selection	
Type of data set being requested	✔ Limited Use Data Set

***Note: The HDC classifies data sets as follows:**

1. Limited Use Data Set does not include direct identifiers.

2. Research Data Set includes direct identifiers or identifiable health data where the identity of individuals is readily available.

Please use the pricing information below to estimate the cost for each data set requested. After calculating the price for each selected data set enter the amount in the corresponding "Estimated Price" field.

Available Data Sets (old field)	✔ Claim Centric (APCD Limited Use Data Set)
	✔ APCD Patient Centric Limited Use Data Set ✔ Latest
	4
	$20000.00
Please email any additional materials that you'd like to include to mikemartin@utah.gov	
Billing, Shipping, and Payment Information	
Billing Information	
Name	Peter Hayward
Organization	Remedy Partners
	800 Connecticut Ave.

	Norwalk, Connecticut 06854 United States
Phone	(475) 214-1756
Email	phayward@remedypartners.com
Shipping Information	
Mode of Delivery	Shipping (FedEx)
Is shipping address different to the billing address?	No
Address	United States

Payment
Mail your payment to:
Utah Department of Health
Office of Health Care Statistics
PO Box 144004
Salt Lake City, Utah 84114

Part C. Terms and Conditions
This agreement permits data collected under the authority of the Utah Heath Data Commitee (HDC) and maintained by the Utah Department of Health (UDOH), Office of Health Care Statistics (OHCS) to be used as permitted by state statute and must be completed before access to such data is granted to entities or persons who are not employees of the State of Utah nor contractors performing work on behalf of the State of Utah.

Public Data Set Use and Disclosure Stipulations

1. OHCS agrees to disclose non-identifiable health data to the Requesting Entity. The Requesting Entity agrees to use the non-identifiable health data only for the purposes described in Part A.

2. The Requesting Entity may not:
a. Attempt to learn the identity of any person whose information may be contained in the non-identifiable health data;

b. Attempt to link or permit others to link any record from the non-identifiable health data with identifiable health data from another database or any other source of information; Use or disclose the identity of any persons discovered inadvertently; or

c. Release or permit others to release the non-identifiable health data or any subset of that data to any person or entity not listed in Part A without prior written permission of OHCS.

Part D. Terms and Conditions
This agreement permits data collected under the authority of the Utah Heath Data Commitee (HDC) and maintained by the Utah Department of Health (UDOH), Office of Health Care

Statistics (OHCS) to be used as permitted by state statute and must be completed before access to such data is granted to entities or persons who are not employees of the State of Utah nor contractors performing work on behalf of the State of Utah.

Limited Use Data Set and Research Data Set Use and Disclosure Stipulations

1. **Definitions**

a. "Requesting Entity" means the organizations or persons identified in Part A and its workforce members.

b. "Workforce members" means employees, officers, partners, agents, volunteers, trainees, and other internal persons of the Requesting Entity who need access to the data to enable the Requesting Entity to perform its responsibilities under the agreement.

2. **Data Description**

OHCS maintains health data within the All Payer Claims Database and Facilities Database that are classified as confidential in accordance with U.C.A. § 26-33a-108. OHCS recognizes that it may become necessary in the course of conducting bona fide research on key healthcare issues, questions, and problems, for a researcher or specifically authorized person to obtain potentially identifying information from the confidential information held by OHCS. The Requesting Entity acknowledges that, in connection with this request, it may acquire or have access to such confidential information including, but is not limited to, patient-level health information, payer coverage information, claims payment information, and eligibility and plan enrollment information, as well as other "identifiable health data" as defined in U.C.A. § 26-33a-102 (collectively, "Data").

3. **Data Ownership**

OHCS retains all ownership rights in and to the data. The Requesting Entity does not obtain any right, title, or interest in or to the data. The Requesting Entity will not disclose, release, reveal, show, sell, rent, lease, loan, submit, present or otherwise grant access to the OHCS Data unless specifically approved in writing by OHCS. OHCS makes no representations or warranties, either implied or express, regarding the accuracy or completeness of the data. OHCS will provide the most current data available at the time of the Requesting Entity's inquiry; however, OHCS cannot guarantee the data has not changed or will not change.

OHCS may notify the Requesting Entity if it becomes aware of data corrections or modifications to the data OHCS previously provided under this Agreement. If OHCS provides the Requesting Entity replacement or supplemental data, OHCS may require the Requesting Entity to securely destroy all or part of the data previously provided to the Requesting Entity. The Requesting Entity agrees to destroy the previously provided data in accordance with the methods set forth in Section 9.

4. **IRB Approval**

If applicable, the Requesting Entity must receive approval for a research study from an OHCS-approved Institutional Review Board (IRB). The Requesting Entity agrees to provide OHCS with a copy of the research study protocol and the following documentation: IRB review approval status, procedures to be used to ensure confidentiality of the data, and the form in which, and to whom, results of the study results will be released. The Requesting Entity also agrees to submit to OHCS any change in research study protocol, waiver status, or conditions for IRB approval of the research study.

5. **Permitted Uses and Limitations of Use**

A. OHCS agrees to provide Requesting Entity with the data as listed in Part B. The Requesting Entity agrees to use the data only for the approved purposes that support the Requesting Entity's research and statistical analyses. The Requesting Entity represents it is requesting only the minimal amount of information necessary to accomplish the purposes set forth herein.

B. The Requesting Entity agrees not to disclose, sell, copy, reproduce, assign, license, market, transfer, or otherwise dispose of, give, or grant access to the data or any portion thereof covered by the agreement to any other person or entity, except with prior written approval of OHCS.

C. The Requesting Entity may not contact or attempt to contact any entities, providers, payers, or persons included in the data. The Requesting Entity may not attempt or allow others to attempt to discover specific terms of contracts, discounts, or fixed reimbursement arrangements, or other specific reimbursement arrangements between an individual provider and a specific payer.

D. The Requesting Entity shall limit access to the data to those persons identified in Part A. Data may not be provided to any other persons or entities. Any changes in the list of persons who will have access to the data, including additions or deletions, must be reported to OHCS within five (5) business days of such change. The Requesting Entity must ensure that all persons who will have access to the data are trained on confidentiality and security of data.

E. The Requesting Entity may not release a compilation or report that compares and identifies health care providers or data suppliers without the express written consent of OHCS. OHCS may permit health care providers or data suppliers an opportunity to review and correct comparative data and prepare a response prior to release of such report.

F. Cell Suppression: The Requesting Entity agrees that any use of OHCS data in the creation of any document (manuscript, table, chart, study, report, etc.) concerning the specified purpose of the research and statistical analyses must adhere to UDOH cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services, others) with less than 11 observations may be displayed to any person or entity not specified in this agreement. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell displaying less than 11 observations. Individual level records may not be published in any form, electronic or printed. Reports and analytics must use complementary cell suppression techniques to ensure that cells with fewer than eleven observations cannot be identified by manipulating data in adjacent rows, columns or other manipulations of the report. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

6. **Safeguarding the Data and Protecting Privacy**

The Requesting Entity shall implement and maintain administrative, technical, and physical safeguards necessary to protect the confidentiality of the data and to prevent unauthorized use or access. Such safeguards include, as appropriate and without limitation: (i) securing the Requesting Entity's facilities, data centers, paper files, servers, back-up systems and computing equipment, including all mobile devices and other equipment with information storage capability; (ii) implementing network, device application, database and platform security; (iii) securing information transmission, storage and disposal; (iv) implementing authentication and access controls within media, applications, operating systems and equipment; (v) encrypting identifiable data stored on any mobile media and devices and computers/servers that allow remote access; (vi) encrypting identifiable data transmitted over public or wireless networks; (vii) strictly segregating identifiable data from information of other unauthorized customers so that OHCS data is not commingled with any other types of information where required; (viii) implementing appropriate personnel security and integrity procedures and practices, including, conducting background checks consistent with applicable law; (ix) providing appropriate privacy and information security training to Requesting Entity's employees; and (x) any other measures reasonably necessary to prevent unauthorized use or access. change.

7. **Reporting of Unauthorized Use or Disclosure**

The Requesting Entity shall promptly notify OHCS of any unauthorized use or disclosure of the data of which it becomes aware. Notification should be directed to OHCS Privacy Officer by calling 801-538-9205 or 801-538-7048. OHCS, in its sole discretion, may require the Requesting Entity to: (a) investigate and respond to OHCS's concerns regarding any alleged misuse or unauthorized disclosure; (b) mitigate any effects identified in the investigation; (c) take reasonable steps to prevent any future unauthorized use or disclosure of the data; and (e) return or destroy the data.

The Requesting Entity understands that as a result of OHCS's determination or reasonable belief that unauthorized uses or disclosures have taken place OHCS may refuse to release further data to the Requesting Entity for a period of time to be determined by OHCS.

8. **Term and Termination**
The agreement remains in effect until the research and statistical analyses are complete. OHCS may conduct periodic reviews. The agreement may be terminated by either party at any time for any reason upon thirty (30) calendar days written notice.

9. **Disposition of Data at Termination**
Upon termination of this agreement, the Requesting Entity shall securely destroy all data, including any copies or compilations derived from the data, in any form or medium, and at any location such data resides. The Requesting Entity shall render the data completely unusable, unreadable, and undecipherable. The Requesting Entity agrees to provide OHCS with written certification that all the data has been destroyed within thirty (30) calendar days of termination. The written certification of destruction must contain the date of disposal, method of disposal, description of data disposed of, and the signatures of the individuals supervising or witnessing the disposal.

If the Requesting Entity believes destruction of the data is not feasible, the Requesting Entity shall provide OHCS written notification of the conditions that make destruction infeasible. Upon mutual agreement of the Parties that destruction is not feasible, the Requesting Entity may retain the data for the specific and limited purposes that make destruction of data not feasible. The Requesting Entity shall extend the protections of the agreement for so long as the Requesting Entity maintains the data. This provision shall survive termination of the agreement.

10. **Publications and Secondary Release**
The Requesting Entity may publish papers, reports, studies, analyses, or other publications consistent with academic standards related to the use as outlined in the research study as long as it does not violate other terms of the agreement regarding data disclosure. The Requesting Entity may not present or publish any information in which persons may be identified either directly or indirectly. OHCS may withhold approval for publication if it determines that the format in which data are presented may result in identification of persons.

Any data or conclusions the Requesting Entity intends to publish in an academic journal or similar research outlet must be provided to OHCS at least forty-five (45) calendar days before the Requesting Entity's submission for publication. The Requesting Entity owns any analyses, interpretations, and conclusions derived from the data. OHCS may request the Requesting Entity to cite OHCS as the source of the data in any studies, reports, or other publications in which data are used.

Secondary release is not authorized unless the Requesting Entity receives prior written approval of OHCS.

11. **Access to Books and Records Regarding Data**
Upon reasonable request by OHCS, Requesting Entity agrees to make its internal practices, systems, books and records relating to the use and disclosure of data available for review by OHCS in order to determine Requesting Entity's compliance with the agreement.

12. **Indemnification**
The Requesting Entity shall be fully liable for the actions of its workforce members. The Requesting Entity shall fully indemnify, defend, and save harmless OHCS and the State of Utah from all claims, losses, suits, actions, damages, and costs of every name and description arising out of the Requesting Entity's performance of the agreement caused by any intentional act or negligence of Requesting Entity's workforce member, without limitation; provided, however, that the Requesting Entity shall not indemnify for that portion of any claim, loss, or damage arising hereunder due to the sole fault of OHCS.

13. **Violations**
The Requesting Entity acknowledges that any violation of this agreement may subject it to liability or penalties under state and federal law, including but not limited to U.C.A. § 26-33a-110, as well as any other remedies available at law. Additionally, at OHCS's discretion, OHCS may require the Requesting Entity to destroy the data in the event of any violation.

14. **Amendments**
No amendment to this agreement will be effective unless it is in writing and signed by both parties.

15. **Entire Agreement**
The agreement constitutes the entire agreement between the parties and supersedes any and all other prior and contemporaneous agreements and understandings between the parties, whether oral or written.

Part E. Signatures	
	✔ In witness whereof, the parties have caused this agreement to be signed and entered into by their authorized representative, per stipulations listed in the above Terms and Conditions.
Name	Peter Hayward
Draw your signature into the box below.	
For Administrative Use	
Date Application Received	Mar 14, 2019
Internal Invoice Created	No
Application Status	In Review

Application Notes:
Can do without Medicaid data, per applicant. Will send through normal review process.

Payment Details

Amount	$15 USD
Status	UNPAID

Entry Info

Date Created	14 Mar 2019 - 12:17:19 PM
Date Updated	13 Aug 2019 - 09:43:18 AM
IP Address	168.177.89.8

Remedy
Powering the Potential™

Remedy Partners Executive Summary

Utah APCD Application

1) The overall purpose or objective of your project

Provider Level Price and Quality Transparency Through the Lens of Episodes of Care in Public and Commercially Insured Populations

Proposal: Remedy's solutions empower healthcare providers to develop and operate episode of care payment programs to improve clinical outcomes, lower costs and increase patient satisfaction. We succeed by establishing partnerships with healthcare organizations (such as payers, hospitals, and physician groups) and providing them with operational solutions to improve quality and reduce episode costs. The suite of clinical decision and performance solutions provided by Remedy establish transparency about cost and quality performance within an episode of care relative to benchmarks, allowing providers and their patients the ability to make more informed, value-based health care decisions.

In order to deliver a more complete and rich set of information into its analytics, Remedy will use the data to: 1) Develop and refine provider-level cost and quality metrics for episodes of care, 2) Establish benchmarks around these metrics, 3) Compare high and low cost providers as well as high and low quality providers in the data and identify opportunities for care improvement, and 4) Benchmark these provider-level outcomes against Remedy's Medicare BPCI data to identify consistencies or inconsistencies in cost and quality across public and commercially insured populations.

Methods
The analytic sample will include any individual with at least one episode of care. Episodes will be identified from Remedy's episode grouper software which relies on the combination of diagnostic and procedure codes on member claims to trigger episodes and assign relevant services. All episodes will be attributed to either the operating surgeon (if a procedure) or the provider accounting for the plurality of office visits (if a condition). Procedure episodes will also be attributed to the facility where it was performed. Costs will be defined as the sum of payments for services assigned to an episode. Analyses will examine cost metrics at the total episode level and within sub-groupings, such as types of care (radiology, office visits), site of care (inpatient vs outpatient), and phase (pre-operative, intra-operative, and post-operative). Quality will be measured based on Remedy's preventable and potentially avoidable event definitions, which constitute complications that occurred during a particular episode which could have been avoided with optimal care. All analyses will be conducted separately for each population in the data. When appropriate, provider-level analyses or reports produced from the data will be risk-adjusted to account for potential differences in patient case-mix.

2) How OHCS data will be used in your project

Remedy will use the data to: 1) Develop and refine provider-level cost and quality metrics for episodes of care, 2) Establish benchmarks around these metrics, 3) Compare high and low cost providers as well as high and low quality providers in the data and identify opportunities for care improvement, and 4) Benchmark these provider-level outcomes against Remedy's Medicare BPCI data to identify consistencies or inconsistencies in cost and quality across public and commercially insured populations.

3) What data will be needed for your project (also note you have provided feedback for the provider identifier policy)

All commercial Detail for the following data types:

Enrollment Data
Provider Data
Medical Claims Data
Pharmacy Claims Data

We are applying for the most recent 4 years of data, and understand the limitation for not being able to release Medicaid data.

We are requesting several years of data because of the sample size necessary for the scope of this study and to achieve the underlying purpose. In order to establish utilization benchmarks nationally, a significant sample size is required in each individual geographic location. These utilization benchmarks will require granular level data specific to local geographies on a national level to present providers the information they need to understand their population care patterns.

4) Who will have access to the data

Stephen Kennedy, VP, CISO (skennedy@remedypartners.com)
Vincent Fitts, SVP Analytics (vfitts@remedypartners.com)
Brian Cotter VP Opportunity Analytics (bcotter@remedypartners.com)
Samantha Szewczyk, Senior Analyst, Opportunity Analytics (sszewczyk@remedypartners.com)
Jeffrey Dunn, Manager, Opportunity Analytics (jdunn2@remedypartners.com)

Remedy follows all requirements as specified in the Data Use Agreement, including rules for sharing, transmission, and distribution. All movement of data is approved and tracked in Remedy's central ticketing system.

Access rights are granted based on least access privilege and minimum data necessary required for an individual to perform a job function. All data access requests include the specific reason for the need for access as well as manager review and approval. Additional separation of duties controls are in place to limit access to environments - providing a second layer of access control to covered information.

Any additional access must be requested for manager approval by submitting a JIRA ticket.

Per Remedy's Access Establishment and Modification Policy, access to covered information is only granted based on the nature and duties of the workforce member's work. Access is modified when the nature of the job changes and requires a different level of access, whether greater or lesser. Data analyst's access to data sets is granted through the request and approval process on the central ticketing system. All Remedy employees receive documented initial onboarding training in Compliance, Security and Privacy. Employees sign acceptance of their security and privacy responsibilities at the new hire training, and on two follow up policies, the "Remedy Hardware Acceptable Use Policy" and "Handling and Protection of Confidential Info." Automated emails and and Compliance Office follow-up ensures full workforce compliance.

All Remedy offices are protected with key card entry systems as well as CCTV. All access is logged and monitored. Remedy does not store any paper records of PHI. Confidential information is stored in locked cabinets when needed, but in general all confidential information is stored in the cloud on designated systems with access controls.

Remedy uses Amazon Web Services (AWS) to host all Remedy infrastructure. AWS manages all physical controls including: physical security, maintenance, environmental controls, and key management. As part of the AWS shared

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AWS has multiple certifications for their physical and operating procedures. Included are: CSA, SOC2 Type2, and ISO 27001. See: https://aws.amazon.com/compliance/programs/

5) What research question or problem will be analyzed or answered by your project?

Remedy will use the data to develop and refine provider-level cost and quality metrics for episodes of care, compare high and low cost and quality providers, and benchmark the provider-level outcomes against their other data using episodes of care as the unit of measurement.

6) Any other description of your data use that you think will help the committee understand your objectives and goals

Remedy Partners research objectives are to investigate the cost and quality of care at the provider level in the state of Utah. By bundling the claims data into episodes of care, Remedy Partners can better understand cost and care variations across individual providers and facilities and share these results with the state of Utah. Independent research using the Utah APCD may allow for unique insights that can benefit the consumer by educating the members seeking care in the state, as well as informing providers of their success or room for improvement.

Remedy

Utah APCD Request: Field Justifications

Longitudinal Member ID

The analytic sample will include any individual with at least one episode of care. Identifiable information pertaining to the member is not required. Certain member information (such as gender and age) are required to properly attribute a member to a bundle. The name and address of the member is not required; however, a unique encrypted identifier is necessary to correctly track all claims, as well as generate an episode of care. An episode of care is constructed of multiple claims (diagnosis, procedure, pharmacy) that are pulled together with our episode construction logic.

Unique Service Dates

We use claims data to construct patient-centered episodes of care for the treatment of an illness or condition. Our episodes include all covered services related to the care of the procedure or condition as determined by tested, medically accepted clinical practice guidelines or expert opinion. They are time-delimited with look back and look forward windows to capture more than just the procedure itself, and trigger off of ICD Diagnosis codes, ICD Procedure codes, CPT/HCPCS codes, and relevant pharmacy codes are included. Because our episodes are time delimited, unique service dates are required in order to construct the episodes, these service dates will serve as the time window of the episode. They will define the start of the trigger window and the end of the trigger window for the episode. In addition to being required for episode construction, the service dates and episode length will be used to help assess provider quality (ex. Length of stay).

Provider ID

The goal of our analysis is to be able to identify high/low quality costa and high/low quality providers. In order to do so, we need provider level information for our provider attrubtion strategy. This granular information will also help us see and understand any geographic trends amongst providers within the state.

Episodes will be identified from Remedy's episode grouper software which relies on the combination of diagnostic and procedure codes on member claims to trigger episodes and assign relevant services. All episodes will be attributed to either the operating surgeon (if a procedure) or the provider accounting for the plurality of office visits (if a condition). Procedure episodes will also be attributed to the facility where it was performed. Providers and facilities will be identified within the data using the National Provider Identifier (NPI) field. Costs will be defined as the sum of payments for services assigned to an episode. Costs will be defined as the sum of payments for services assigned to an episode. Analyses will examine cost metrics at the total episode level and within sub-groupings, such as types of care (radiology, office visits), site of care (inpatient vs outpatient), and phase (pre-operative, intra-operative, and post-operative).

For the purposes of this study, we will examine cost at comprehensive and granular levels. The episodes allow us to analyze the total cost of care and resource use by episode and examine metrics such as Emergency Department and IP utilization rates, costs and volume of care, cost variation, complication rates, and readmission rates. Total and average costs per episode per individual

provider and facility will be established. Within that comprehensive episode cost, we will drill down into typical versus complication costs attributed to the episode, and furthermore, readmission costs as part of the complication bucket. Episode complications, or as we refer to them, actionable adverse events (AAEs), will be analyzed by individual provider or facility to identify which complications are the most common along with their resulting costs. Additionally, we will be able to see which codes are the most frequently associated with the top complications for each episode. While the patients of certain providers may have high complication rates, it is important to understand the severity of the individual complications which contribute to that complication rate.

Additional Field Justifications

Below is a list of additional claims data fields and their justifications for Remedy's analysis purposes.

File Type	Field Name	Justification
Member	Insurance Type / Product Code ID	This is important is more than one line of business is included in the dataset so that we can differentiate between them
Member	Member Coverage Start Date	Very important to have member eligibility dates to identify members who may not have full coverage during an episode and, thus, could be "missing" claims
Member	Member Coverage Start Date	Very important to have member eligibility dates to identify members who may not have full coverage during an episode and, thus, could be "missing" claims
Member	Internal Member ID	Each member must have a unique identifier that is exactly the same across all claim types. This is a payer-generated ID and would not be found on a claim form. The member ID can be encrypted, but it must be unique and identical across all claim types. This is required in order to bundle all claims for and/or identify all services provided to or diagnoses related to a given member.
Member	Member Gender Code	Gender is an important component in risk adjustment and quality checks.
Member	Member Age (90+ Aggregate)	Age is important for risk adjustment, termination criteria, and quality checks.
Member	Member ZIP Code	Zip of the member is not required but is preferred to help understand care patterns - which hospitals they end up going to
Member	Coverage Type Code	Insurance type or product code that indicates the type of insurance coverage the individual has
Member	Market Category Code	Understanding which market category a member belongs to is important for differentiation
Provider	PCP NPI	Necessary for our provider attribution strategy.
Provider	Attending Provider ID	Necessary for our provider attribution strategy.
Provider	Service Provider Tax ID	Necessary for our provider attribution strategy.
Provider	Service Provider NPI	Necessary for our provider attribution strategy.
Provider	Service Provider Entity Type	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Service Provider Name	Having access to the name in addition to the NPI will prevent us from having to attempt this crosswalk on our own.
Provider	Service Provider Specialty	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Service Provider Address	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Billing Provider ID	Necessary for our provider attribution strategy.
Provider	Billing Provider NPI	Necessary for our provider attribution strategy.
Provider	Billing Provider Name	Having access to the name in addition to the NPI will prevent us from having to attempt this crosswalk on our own.
Medical	Claim Number	Necessary to properly interpret duplicate claim lines
Medical	Claim Version Number	Necessary to properly interpret duplicate claim lines

Medical	Date of Service (From and Through)	This is a required variable to establish the episode timeframe
Medical	Admission Date	Will define start of trigger window for inpatient-triggered episodes.
Medical	Discharge Date	Will define end of trigger window for inpatient-triggered episodes, we only need the date not the time.
Medical	Discharge Status Code	This is used to identify death & LAMA (leave against medical advice) termination criteria.
Medical	Type of Bill Code	This is a useful variable for provider category mapping & quality assurance.
Medical	Place of Service Code	Can be used to help identify orphan episodes that would be removed before risk adjustment.
Medical	Claim Status Code	Need to know if claim is final or not, want to prevent duplicate counting of costs and/or services.
Medical	Diagnosis Code - Admitting	Our Prometheus episode definitions often require confirming ICD diagnosis for a trigger code in an episode. Included claims in a Prometheus episode also may require a confirming diagnosis alongside a procedure code.
Medical	ICD Version Indicator	We require this variable for all outpatient & professional claims
Medical	Diagnosis Code - Principal	Our Prometheus episode definitions often require confirming ICD diagnosis for a trigger code in an episode. Included claims in a Prometheus episode also may require a confirming diagnosis alongside a procedure code.
Medical	Diagnosis Code - Other 1-6	Our Prometheus episode definitions often require confirming ICD diagnosis for a trigger code in an episode. Included claims in a Prometheus episode also may require a confirming diagnosis alongside a procedure code.
Medical	Revenue Code	This is a useful variable for QA and is also used in unit cost. Helps us to check the fill rate for institutional claims
Medical	Outpatient Provider Code	Necessary for identifying outpatient services
Medical	Procedure Code	We require this variable for all outpatient & professional claims.
Medical	ICD Procedure Code - 1-3	We require this variable for all outpatient & professional claims.
Medical	Procedure Modifier Code (1-4)	We prefer to see at least 1 procedure code modifier variable in a dataset. Checks fill rate for outpatient & professional claims. Checks for a match to standard HCPCS/CPT modifier codes.
Medical	DRG	Necessary to properly interpret duplicate claim lines
Medical	Present on Admission	We would like to have a POA indicator to understand whether the diagnosis is a patient comorbidity or a complication of care.
Pharmacy	National Drug Code	Necessary to identify the type of drug
Pharmacy	Pharmacy Number	Necessary for our provider attribution strategy.
Pharmacy	Pharmacy Tax ID	Necessary for our provider attribution strategy.
Pharmacy	Pharmacy Name	Having access to the name in addition to the NPI will prevent us from having to attempt this crosswalk on our own.
Pharmacy	Pharmacy Address	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Pharmacy	Prescribing Provider ID	Necessary for our provider attribution strategy.
Pharmacy	Prescribing Physician NPI	Necessary for our provider attribution strategy.
Pharmacy	Prescribing Physician Name	Having access to the name in addition to the NPI will prevent us from having to attempt this crosswalk on our own.
Pharmacy	Prescribing Provider DEA Number	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Pharmacy	Date Prescription Filled	Important for the timeline of the episode
Pharmacy	Drug Name	We prefer to have the name of the drug so we do not have to crosswalk from the NDC code.
Pharmacy	Drug Code	Important for QA to make sure the NDC code matches the name

Pharmacy	Quantity	Quantity Dispensed/Days Supply - Important to keep track of how much was dispensed to the patient and the # of days
Pharmacy	Generic Drug Indicator	Important for tracking patterns in generic versus brand name prescription patterns
Medical	Charge Amount	Because we are evaluating total episode spend, it must be present.
Medical	Paid Amount	Because we are evaluating total episode spend, it must be present.
Medical	Prepaid Amount	Because we are evaluating total episode spend, it must be present.
Medical	Copay Amount	Because we are evaluating total episode spend, it must be present.
Medical	Coinsurance Amount	Because we are evaluating total episode spend, it must be present.
Medical	Deductible Amount	Because we are evaluating total episode spend, it must be present.
Provider	Provider ID	Necessary for our provider attribution strategy.
Provider	Provider Tax ID	Necessary for our provider attribution strategy.
Provider	Provider NPI	Necessary for our provider attribution strategy.
Provider	Provider Entity Type	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Provider Name	Having access to the name in addition to the NPI will prevent us from having to attempt this crosswalk on our own.
Provider	Provider Specialty	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Provider Address	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Provider Office Address	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.
Provider	Provider DEA Number	We prefer to have it. It makes understanding who we are attributing a bundle to much easier.

HEDIS Requirements

Section 106.5 (Comparative analyses) of the Utah Health Data Authority Act (https://le.utah.gov/xcode/Title26/Chapter33A/26-33a-S106.5.html) requires the Health Data Committee (HDC) to "publish compilations or reports" that "compare and identify by name at least a majority of the … health care plans … in the state."

To meet this requirement, health plans have been historically required by administrative rule (https://rules.utah.gov/publicat/code/r428/r428-013.htm) to submit to the Office of Health Care Statistics (OHCS) Healthcare Effectiveness Data and Information Set (HEDIS) data on an annual basis. OHCS compiles this information and presents it on a website (http://stats.health.utah.gov/reports/hedis/).

While most health insurers operating in Utah would tabulate HEDIS data regardless of state mandate to meet accreditation and other internal requirements, some health insurers would not. Tabulating HEDIS measures generally requires health insurers to contract with external vendors for medical chart review, analysis, and auditing. Two health insurers indicated that their costs associated with creating HEDIS data to meet the state mandate exceed $100,000 per year.

FY 2019 / FY 2020 BUSINESS CASE

Agency: Department of Health

Request Title: Calculating the Cost of Waste in Healthcare

Request Amount & Source:

FY 2019 One-time	FY 2020 One-time	FY 2020 Ongoing	Total Request
$80,000	$0	$95,000	$0

Performance Improvement Specialist & Contact Information: [*Required for cabinet agencies*]

1. **What system or program is the focus of this request?**
   All Payer Claims Database - APCD (Office of Health Care Statistics)

2. **What are the current performance metrics for the system or program, including a measure for QT/OE?** [*Cabinet agencies are required to identify the system's quality, throughput, and operating expenses (QT/OE) for all requests. QT/OE measures must be specified below, but don't have to be entered in SMIS until the funding request is approved. Note that QT/OE measures should be defined at the system level, which may include a broader range of activities than those addressed by this specific request.]*

Currently, the primary performance metric for the APCD is the number of users of the database. OHCS measures this by tracking and monitoring the number of approved requests for extracts from the database for research and statistical purposes.

In addition to this primary performance metric, the program has statutory obligations to inform policy makers and the public on issues relating to cost and quality. OHCS monitors compliance with the requirements of the statute and reports directly to legislative committees and the Utah Health Data Committee.

The proposed budget request is related to the ability of the program to perform and meet these obligations.

While the plain language of the statute could be interpreted (and indeed is interpreted by some) to require OHCS to use APCD data to identify areas for potential cost reduction, the system is unable to produce measures of waste. Creating this new capability would add to the portfolio of actionable information produced by the APCD.

In the SUCCESS framework, the following concepts apply:

- Quality – the addition of this capability would provide a meaningful and new opportunity for policy makers and the public to derive value from the system
- Throughput – It is expected that the addition of this capability would allow the program to publish at least one more major public-facing report, which translates into a significant increase in throughput
- Operational efficiency – Since the program is not currently able to provide this service, by definition, the addition of this tool would make a major impact on the operational efficiency of the program. We have examined alternatives to this tool and believe that given our current operational structure, this is the most efficient and cost-effective way to achieve this new capability.

3. Summarize the current budget for this system or program. If this is a new system or program, summarize the current budget for the line item and appropriation code(s) in which this new system or program will operate.

This program is funded through 1000-270-LAE-1304. The budgeted amounts for the current fiscal year are as follows:

Funding Sources for FY2020:

$585,500	General Fund
$150,000	Fee Revenues
$122,200	Federal Medicaid Match

Major Expense categories:

$458,500	Contract with Milliman MedInsight
$336,200	Personnel
$60,000	DTS-provided services
$3,000	Current Expenses

4. What problem would be solved with additional funding? Show historical data to support and quantify problem statement.

Problem Statement: A major driver of health care costs is related to the fact that many patients receive low value and wasteful healthcare. This results in added pressure on healthcare costs, including public spending. Low value and wasteful care also puts patients at risk.

Data that support and quantify the problem:

(1) Our current vendor, Milliman, reports that, on average, 20% of a given population's members are exposed to one or more unnecessary services based on their analysis of other client data.

(2) Other states that have looked at wasteful and low value care have found that wasteful spending is a key component of the rising cost of care. For example, the Washington Health Alliance uses the Milliman Health Waste Calculator and estimates that 50.1% of individuals receiving services received low value services. (*First, Do No Harm: Calculating Health Care Waste in Washington* State, Washington Health Alliance, December 2018)

(3) The Washington Health Alliance study found that wasteful healthcare is a problem in both commercial and Medicaid coverage.

(4) While Utah's cost of healthcare is rising faster than the rest of the nation. (*Staying ahead of the curve: Utah's future health care needs,* Laura Summers*, Gardner Business Review,* January 2019), no detailed data on healthcare waste is currently available for Utah.

5. What has been done to solve this problem with existing resources? What were the results?

(1) Total Cost of Care Project – This project created indices for health care resource utilization and cost for clinics across the state. Each clinic was informed regarding whether their patients tended to be above or below average in terms of utilization and cost.

(2) Choosing Wisely - Comagine Health (formerly HealthInsight) was funded by the American Board of Internal Medicine to conduct a campaign with health care systems and consumers in 2014. The interventions chosen by participants (payers, health care systems and consumers) based on their own internal interest but data was not available at the community level to assess impact or target the most important areas of overuse or low value serve use.

The effectiveness of these two programs on bending the cost curve has been limited. Due to the lack of specific information about the nature of wasteful services, providers have not engaged in a meaningful way to reduce over-utilization and other wasteful care.

6. How will new funding be utilized? What operational changes will be made to maximize new resources? Also, please summarize any legislation needed in conjunction with this incremental budget change request. [*Cabinet agencies must coordinate all legislation through the Governor's general counsel.*]

The funding would be used to:

- Add the Health Waste Calculator to our system
- Produce public-facing reports
- Engage stakeholders in developing appropriate private and public interventions
- Measure the impact of the interventions on the cost of care

Add the Health Waste Calculator to our system

Under our current contract with Milliman MedInsight, the Milliman Health Waste Calculator is available as an optional service. The following information provided by Milliman MedInsight describes the value of this tool:

> *Improving the efficiency of healthcare is an ongoing challenge that must be tackled in order to get costs under control. Helping healthcare payers identify and quantify wasteful spending can have a significant impact on healthcare efficiency. As a result, MedInsight has teamed with VBID Health to create an analytical tool to quantify and report on these potentially unnecessary services. The results in the MedInsight Health Waste Calculator.*
>
> *The MedInsight Health Waste Calculator is a standalone software tool designed to help healthcare organizations leverage value-based principles by identifying wasteful services as defined by national initiatives such as Choosing Wisely and the U.S. Preventive Services Task Force. The tool can add significant value to existing cost and quality reporting capabilities, specifically those efforts designed for efficiency and effectiveness measurement.*

The tool would identify and flag potentially inefficient services provided to Utah's residents as well as adding a "degree of appropriateness" for the care provided – Necessary, likely to be wasteful, or wasteful.

Produce Public-facing Reports

The corresponding data provided by the tool would be used to create publicly available and actionable information and reports on waste in Utah's healthcare system. OHCS would work with the Utah Health Data Committee (and it's Transparency Advisory Group) to refine the structure and content of the public-facing reports to ensure that they are actionable and usable by policymakers and healthcare organizations.

Engage stakeholders in developing appropriate private and public interventions

As we know, data informs action. By uncovering unknown waste in Utah's healthcare system, we will create opportunities to identify multi-stakeholder (payer, provider, patient) interventions that reduce wasteful care. Through our work with the Transparency Advisory Group and in previous efforts led by Comagine Health, we are confident that many public and private organizations are ready to join in this effort, including the Utah Medical Association, Utah Hospital Association, Comagine Health, and patient advocacy groups.

Measure the Impact of the interventions on the cost of care

The funding also would be sufficient to create and operationalize tracking and monitoring of the impact of the interventions on the cost of care.

- No operational changes will be needed because the feature is an off-the-shelf solution that can be immediately incorporated into existing workflows and processes.
- No legislation is needed.

7. What are the anticipated results or outcomes of how the new funding will be utilized? What measure(s), including quality, throughput, and costs, will be used to track the change over time? Is data currently available to support these measures?

As a result of collecting and publicizing data on wasteful spending and the associated multi-stakeholder action plans and interventions, we anticipate the following specific outcomes:

- A significant reduction in wasteful care received by Utahns
- A reduction in the rate of healthcare cost increase and public spending (including for state employees, Medicaid enrollees, and others receiving taxpayer funded care)
- As patients and consumers are better informed about the seeking high value care, it is likely to result in better decision-making in other areas of healthcare.

In determining whether to continue funding the use of the tool over time, we propose the following SUCCESS framework metric:

- Quality – The most important consideration relating to the addition of this service is whether policy makers and the public perceive additional value. While this is difficult to quantify directly, we can measure the downstream impact of stakeholder engagement in using the tool and adopting meaningful interventions.
  Measurement of the impact would be done as follows:
  a. Using the tool, we would establish a baseline by measuring the total amount and value of wasteful care in the system.
  b. We would then track this same measure going forward on a semi-annual (or potentially quarterly) basis.
- Cost – While this intervention will not reduce the cost of the system or program itself, it should lead to cost savings in other areas of the state budget, including spending on health care for pubic employees and Medicaid enrollees

If the calculator was added to the system, all necessary data to establish the baseline and track the change over time would be readily available.

8. What are potential negative effects if the funding is not received?

Without this intervention, Utah will continue to push resources toward low value spending.

9. Legislative

(b) Using Data for Registries (Discussion Only) – Norman Thurston

Utah Department of Health

Policy Regarding Requests for Access to Medicaid Data for the Purpose of Research

DRAFT

Background

The Utah Department of Health is responsible for compliance with all HIPAA and Medicaid regulations regarding Medicaid applicant and beneficiary information.

HIPAA and Research

The HIPAA Privacy Rule established conditions under which protected health information may be used or disclosed by covered entities for research purposes. Research is defined in the Privacy Rule as, “a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.” See 45 CFR 164.501. A covered entity may use or disclose for research purposes health information which has been de-identified (in accordance with 45 CFR 164.502(d), and 164.514(a)-(c) of the Rule)

Under the Privacy Rule, covered entities are permitted to use and disclose protected health information for research with individual authorization, or without individual authorization under limited circumstances set forth in the Privacy Rule.

Research Use/Disclosure Without Authorization. To use or disclose protected health information without authorization by the research participant, a covered entity must obtain documentation that 1) the waiver or alteration of the authorization requirement is approved by an IRB, or 2) an appropriate data sharing agreement to disclose a limited data set has been obtained, or 3) the data set has been de-identified, or 4) research involves decedents' phi.

- **Documented Institutional Review Board (IRB) or Privacy Board Approval Restricted.**

Documentation that an alteration or waiver of research participants' authorization for use/disclosure of information about them for research purposes has been approved by an IRB or a Privacy Board. See 45 CFR 164.512(i)(1)(i). A covered entity may use or disclose protected health information for research purposes pursuant to a waiver of authorization by an IRB or Privacy Board, provided it has obtained documentation of all of the following:

  - Identification of the IRB or Privacy Board and the date on which the alteration or waiver of authorization was approved;
  - A statement that the IRB or Privacy Board has determined that the alteration or waiver of authorization, in whole or in part, satisfies the criteria in 45 CFR 46.116.;
  - A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or Privacy Board;
  - A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures; and
  - The signature of the chair or other member, as designated by the chair of the IRB or the Privacy Board, as applicable.

An IRB or a Privacy Board must approve a waiver of authorization pursuant to 45 CFR 46.116. The covered entity must enter into a data sharing agreement with the researcher prior to disclosing PHI.

- **Limited Data Sets with an appropriate Data Use Agreement.** A data use agreement entered into by both the covered entity and the researcher, pursuant to which the covered entity may disclose a limited data set to the researcher for research, public health, or health care operations. See 45 CFR 164.514(e). A limited data set excludes specified direct identifiers of the individual or of relatives, employers, or household members of the individual. The data use agreement must:
  - Establish the permitted uses and disclosures of a limited data set by the recipient, consistent with the purposes of the research, and which may not include any use or disclosure that would violate the Rule if done by the covered entity;
  - Limit who can use or receive the data; and

- Require the recipient to agree to the following:
  - Not to use or disclose the information other than as permitted by the data use agreement or as otherwise required by law;
  - Use appropriate safeguards to prevent the use or disclosure of the information other than as provided for in the data use agreement;
  - Report to the covered entity any use or disclosure of the information not provided for by the data use agreement of which the recipient becomes aware;
  - Ensure that any agent, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set; and
  - Not to identify the information or contact the individual.

Medicaid and Disclosure of Applicant and Beneficiary Information

In addition to the requirements of HIPAA, the HITECH Act and other federal regulations specify how and when states may disclose Medicaid applicant and beneficiary information.

42 CFR §431.300 Basis and purpose.

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

42 CFR §431.301 State plan requirements.

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

42 CFR §431.302 Purposes directly related to State plan administration.

Purposes directly related to plan administration include—

(a) Establishing eligibility;
(b) Determining the amount of medical assistance;
(c) Providing services for beneficiaries; and
(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

42 CFR §431.304 Publicizing safeguarding requirements.

(a) The agency must publicize provisions governing the confidential nature of information about applicants and beneficiaries, including the legal sanctions imposed for improper disclosure and use.
(b) The agency must provide copies of these provisions to applicants and beneficiaries and to other persons and agencies to whom information is disclosed.

42 CFR §431.305 Types of information to be safeguarded.

(a) The agency must have criteria that govern the types of information about applicants and beneficiaries that are safeguarded.
(b) This information must include at least—
(1) Names and addresses;
(2) Medical services provided;
(3) Social and economic conditions or circumstances;
(4) Agency evaluation of personal information;
(5) Medical data, including diagnosis and past history of disease or disability; and
(6) Any information received for verifying income eligibility and amount of medical assistance payments (see §435.940 through §435.965 of this subchapter). Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data, including section 6103 of the Internal Revenue Code, as applicable.
(7) Any information received in connection with the identification of legally liable third party resources under §433.138 of this chapter.
(8) Social Security Numbers.

UDOH Policy

Human subjects research in which UDOH is engaged or for which UDOH IRB review is required by statute, rule, or policy must also be submitted to the UDOH IRB for review. Human subjects research that doesn't meet that criteria would need external IRB review and approval or determination of exemption from IRB.

PROPOSED CRITERIA FOR ACCESSING MEDICAID INFORMATION FOR RESEARCH PURPOSES

Based on requirements under federal regulation, disclosure and sharing of Medicaid applicant or beneficiary information may only be done when the following criteria are met:

- The Researcher must meet all HIPAA requirements stated above.

- UDOH must approve that the request for the use of data is directly related to Medicaid plan administration (42 CFR 431.302):
  (a) Establishing eligibility;
  (b) Determining the amount of medical assistance;
  (c) Providing services for beneficiaries; and
  (d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

- Limited or de-identified can be released only with a data use agreement or MOA that outlines adequate data security provisions that have been approved by the UDOH Chief Privacy and Security Officer.

- Restricted data can only be accessed in the University of Utah's Population Database (UPD) limited use environment, this includes the virtual machines at the Huntsman Cancer Institute, the University's Center for High Performance Computing and the Utah Cancer Registry housed in the University of Utah's Downtown Data Center. Restricted data cannot be removed to Researcher's work site.

- The Researcher must provide the Division of Medicaid and Health Financing with results from their research.

PROCEDURE FOR ACCESSING MEDICAID DATA

Note: This is not the correct process for users that solely need Medicaid data. Such requests should be made directly to the Division of Medicaid and Health Financing.

Any data request for an extract from the APCD that includes Medicaid data must include detailed responses to the following three questions:

1) Is the inclusion of Medicaid data essential for the successful completion of the research or statistical analysis? If so, please provide a detailed justification?
2) Will the project include an analysis of a Medicaid-specific cohort? If not, explain how the project will benefit the Medicaid program. The requester should reference one or more specific relevant ways in which the proposed research will directly benefit the Medicaid program.
3) How will the user report the results of their study specifically to the Medicaid program?

Review Process

Step 1 - Initial Review (OHCS privacy officer or designee)

- Scope Review - Is the request for Medicaid data only or does the request include Medicaid data along with data from other sources?
- Users requesting Medicaid-only are referred to the Medicaid director.
- Review of Application Structure and Form
    - Is the application complete? Incomplete applications are not acceptable
    - Is the request for a Medicaid Deidentified Extract (MDE) or a limited or restricted data Medicaid Research Extract (MRE)? If it is an MRE, does it have the required successful IRB review?

Step 2 Advanced Review (OHCS director or designee)

- Compare data request against Review Criteria Checklist (see attached) and make a determination regarding a) need for Medicaid data and b) benefit to the Medicaid program.

Step 3 Medicaid Review

- The Medicaid director or designee (Medicaid) will determine if the use of Medicaid data has a direct benefit to the Medicaid program using the Review Criteria Checklist.
- If Medicaid determines the use of Medicaid data **will have** a direct benefit to the Medicaid program, Medicaid will approve the use of Medicaid data.
- If Medicaid determines that the use of Medicaid data will have little or no direct benefit to the Medicaid program, Medicaid will deny the request for use of Medicaid data.
- Medicaid will make a decision on the request within ten (10) business days from the date of the request,
- Medicaid's decision will be in writing to the requestor stating the reason for the denial.

Step 4 - Health Data Committee (HDC) Review

- If approved by Medicaid, OHCS staff places the request in the appropriate queue for Health Data Committee consideration, using the current review process guidelines.

Step 5 - Notification to Executive Director

- If Medicaid denies the request or fails to respond within ten (10) business days, the request will be reviewed by the Executive Director, Department of Health. The Executive Director will make a final determination within ten (10) business days from receipt of Medicaid's denial or failure to timely review the request.

Evaluating Data Requests that Include Medicaid Data

Advanced Review Form

For use by UDOH personnel that are tasked with reviewing requests for appropriateness.

Part 1. Considerations for Approval

Does the application meet the following criteria?

Criteria	Yes/No	If Yes, explain
Is the inclusion of Medicaid data essential for the successful completion of the research or statistical analysis? If so, please provide a detailed justification.		
Will the project include an analysis of a Medicaid- specific cohort? If not, explain how the project will benefit the Medicaid program. The requester should reference one or more specific relevant ways in which the proposed research will directly benefit the Medicaid program.		

How will the user report the results of their study specifically to the Medicaid program?

Part 2. Review Criteria Checklist

Researchers should indicate one Primary research category describing the type of research and up to two Secondary research categories.

Category	Criteria	Yes/No	If Yes Explain
1. Program Evaluation	**Will the project evaluate one or more Medicaid programs and provide actionable information about the benefit or design of the program to**		

	be evaluated?		
2. Direct Provision of Services	**Will the project identify individuals in the Medicaid population that would benefit from additional services, targeted services or other customized approaches to services?**		
3. Aggregate Reporting	**Will the project create aggregate metrics either at the statewide level or another appropriate level for comparison?**		
4. Clinical Research	**Will the project "produce knowledge valuable for understanding human disease, preventing and treating illness, and promoting health"[1] in at least one of the following research categories:** **a. Disease mechanisms (etiopathogenesis)** **b. Bi-directional integrative research** **c. Clinical knowledge, detection, diagnosis, and natural history of disease** **d. Therapeutic interventions** **e. Prevention and health promotion** **f. Behavioral research** **g. Health services research, including outcomes and cost-effectiveness** **h. Epidemiology** **i. Community-based or managed care-based trials**		
5. Economic Burden of Disease or	**Will the project provide information of the adverse impact of disease or health risks on human welfare?[2]**		

Underlying Health Risks			
6. Benefit Design	**Will the project provide information on how to improve the design of Medicaid benefits?**		
7. Adverse Events Due to Medical Care	**Will the project provide information on identifying and reducing the incidence of adverse events due to medical care?**		
8. Population Studies	**Will the project provide useful insights into the health or healthcare of a particular group of individuals taken from the general population who share a common characteristic, such as age, sex, or health condition?**		
9. Health Care Disparities[3]	**Will the project provide information that identifies differences in the health status of different groups of people?**		

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https://www.ncbi.nlm.nih.gov/books/NBK220717/
https://www.who.int/choice/economicburden/en/
https://medlineplus.gov/healthdisparities.html

Supplemental Information for Requests that Include Medicaid Data

For use by researchers that are requesting Medicaid data as part of a data request

Instructions: Per Utah Department of Health policy and federal regulation, Medicaid data (including identified, limited, and de-identified data) may only be released to researchers under certain circumstances. To facilitate the review of the inclusion of Medicaid data in your request, please provide the following information.

A. Is the inclusion of Medicaid data essential for the successful completion of the research or statistical analysis? If so, please provide a detailed justification.

B. Will the project include an analysis of a Medicaid- specific cohort? If not, explain how the project will benefit the Medicaid program. The requester should reference one or more specific relevant ways in which the proposed research will directly benefit the Medicaid program.

C. How will the user report the results of their study specifically to the Medicaid program?

D. Using the attached reference list, please identify the type of research or statistical analysis that best describes your project. Please indicate **one** primary research category and (optionally) up to **two** secondary research categories.

Research and Statistical Analysis General Categories

1. **Program Evaluation** - Will the project evaluate one or more Medicaid programs and provide actionable information about the benefit or design of the program to be evaluated?
2. **Direct Provision of Services** - Will the project identify individuals in the Medicaid population that would benefit from additional services, targeted services or other customized approaches to services?
3. **Aggregate Reporting** - Will the project create aggregate metrics either at the statewide level or another appropriate level for comparison?
4. **Clinical Research** - Will the project "produce knowledge valuable for understanding human disease, preventing and treating illness, and promoting health" in at least one of the following sub-categories:
    a. Disease mechanisms (etiopathogenesis)
    b. Bi-directional integrative research
    c. Clinical knowledge, detection, diagnosis, and natural history of disease
    d. Therapeutic interventions
    e. Prevention and health promotion
    f. Behavioral research
    g. Health services research, including outcomes and cost-effectiveness
    h. Epidemiology
    i. Community-based or managed care-based trials
5. **Economic Burden of Disease or Underlying Health Risks** - Will the project provide information of the adverse impact of disease or health risks on human welfare?
6. **Benefit Design** - Will the project provide information on how to improve the design of Medicaid benefits?
7. **Adverse Events Due to Medical Care** - Will the project provide information on identifying and reducing the incidence of adverse events due to medical care?
8. **Population Study** - Will the project provide useful insights into the health or healthcare of a particular group of individuals taken from the general population who share a common characteristic, such as age, sex, or health condition?
9. **Health Care Disparities** - Will the project provide information that identifies differences in the health status of different groups of people?

11. Handouts: Electronic PDF Form (Discussion only)