

**Healthcare Payments Data Program
Review Committee Meeting**

July 18, 2019

Meeting Minutes

Members Attending: Charles Bacchi, California Association of Health Plans (CAHP); Anne Eowan, Association of California Life and Health Insurance Companies (ACLHIC); Terry Hill, California Medical Association (CMA); Amber Ott, California Hospital Association (CHA); Emma Hoo, Pacific Business Group on Health (PBGH); Ken Stuart, California Health Care Coalition; Joan Allen, Service Employees International Union- United Healthcare Workers West (SEIU-UHW); Cheryl Damberg, RAND Corporation; John Kabateck, National Federation of Independent Businesses (NFIB); Mary June Diaz, Health Access California; William Barcellona, America's Physician Groups.

Attending by Phone: No members attended by phone.

Not Attending: All members were present

Presenters: Scott Christman, Chief Information Officer, OSHPD; Jill Yegian, Consultant, OSHPD; Linda Green, Vice President – Programs, Freedman HealthCare; Bobbie Wunsch, Consultant; OSHPD.

Others: Denise Love, Executive Director, National Association of Health Data Organizations; Emily Sullivan, Deputy Director, National Association of Health Data Organizations; Jonathan Mathieu, Senior Policy Consultant, Freedman HealthCare.

Public Attendance: 16 members of the public attended.

Agenda Item	Meeting Minutes
Welcome & Meeting Minutes	<p>The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions.</p> <p>The June 20 Review Committee meeting minutes were approved, with one edit from Scott Christman to add a note to his Deputy Director's report to include mention that premiums were included in Tier 1 because they are a part of the APCD-CDL™.</p> <p>Bobbie Wunsch went over the ground rules for the meeting.</p>
Deputy Director's Report	<p>Scott Christman provided an updated on the June Technical Workgroup Meeting. The discussion was focused on the development of the Supplemental File. The Technical Workgroup Members commented on the complexity associated with calculating total cost of care. The workgroup also previewed the data submitter recommendations, that the Review Committee would be reviewing today, and provided some high-level feedback. Lastly, the workgroup discussed setting up a sub-workgroup to help develop the Supplementary File format for California.</p> <p><i>Ken Stuart, California Health Care Coalition, asked Scott if the OSHPD team could provide</i></p>

	<p>some insight into expectations of the Review Committee into 2020. Scott Christman responded that the team will come back with a proposal. He also noted that the team is actively thinking about the governance chapter, and what the data release committee would look like. He commented that there could be an opportunity for a high level programmatic advisory group, that could be a role for the Review Committee. It would not be a monthly requirement, but it would be an avenue for the HPD program to call on experts for certain topics. Ken Stuart agreed and also noted that during the legislative review OSHPD might want to have experts to touch base with.</p>
<p>Follow-Up from May 16 Meeting</p>	<p>Ken Stuart reviewed the recommendations the Review Committee has approved thus far. They are listed below for reference:</p> <ul style="list-style-type: none"> • The HPD System should establish collection methods and processes specific to three sources of claims and enrollment data: 1) DHCS (for Medi-Cal), 2) CMS (for Medicare FFS), and 3) All other. • The HPD System should pursue the collection of Medi-Cal data directly from DHCS. • The HPD should pursue the collection of Medicare FFS data, in the formats specified by CMS. • The HPD should use the APCD-CDL™ for all other submitters. • The HPD should initially pursue three years' worth of historical Tier I "core" data (enrollment, claims and encounters, and provider) from submitters. • The HPD should collect non-claims-based payments, in order to capture the total cost of care. Since these payments are not included in the APCD-CDL™, OSHPD will work with stakeholders to specify the format(s) and source(s) of the supplemental file(s). • Ensure broad authority for OSHPD to securely collect available personally identifiable information. • The HPD Program should use robust methodologies to match patients, providers, and payers across datasets. <p>Scott Christman also provided a response to Amber Ott's question from the June Review Committee.</p> <p>Question: Do the government payers that participate in the Massachusetts APCD also send their data through the common hashing routine that eliminates direct identifiers prior to submission?</p> <p>Answer: Yes, hashing is the same regardless of the payer, because the data submission specs (format/guidelines/rules) are the same whether its commercial, public, or from the Group Insurance Commission (for commonwealth employees and retirees). Massachusetts has not incorporated Medicare FFS into the APCD.</p>
<p>Mandatory Data Submitters</p>	<p>Jill Yegian and Linda Green led a discussion on defining mandatory data submitters; required and excluded lines of business; the thresholds, frequency and population for data submission; and coordination of data submission. The presentation included both the national experience and California market characteristics related to the topics above, as well as a vote on recommendations for California. The discussion was grounded in the concept "is the juice worth the squeeze?" meaning will the program get meaningful data from the data submitter. The conversation was interspersed in the presentation. To see the full presentation see slides 7-51(https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint_7.18.2019.pdf)</p> <p><i>Ken Stuart, California Health Care Coalition</i>, noted that ERISA plan's dental data will have to</p>

be requested even if it is from Delta Dental. He also followed up inquiring if student health insurance includes student accident insurance and Jill Yegian confirmed that it does.

Amber Ott, CHA, suggested that an option to consider, in order to receive ERISA Self-Insured data, would be to have network providers mandate in their contract that these plans must submit data to the HPD.

MJ Diaz, Health Access, noted that when looking at the list of proposed mandatory submitters, there are certain entities missing including self-insured public plans, Student Health Insurance, as it is fully compliant with the Affordable Care Act, as well as any risk bearing entities managed by the DMHC. She also noted that there are also specialized health insurance plans and various types of provider organizations that should be included.

Cheryl Damberg, RAND, inquired why Medicare supplemental insurance was excluded as it could represent a significant part of the Medicare population. Jill Yegian commented that there are two ways the list of excluded lines of business was created: 1) what other states exclude, which has a lot of consistency, and 2) the insurance code. She noted that ultimately it comes down to a consideration of whether the “juice is worth the squeeze.”

Terry Hill, CMA, inquired what the split between HMO and PPO is. The team confirmed that the HMO population is at 10.1 million while the PPO population is at 3.3 million for the fully insured populations. Including the self- insured population would add an additional 5.7 million covered lives for PPO, however it was noted that they are not mandatory submitters.

Anne Eowan, ACLHIC, noted that the DMHC and CDI put out a covered lives report. Jill Yegian confirmed that the information used in the presentation comes from those reports, and is summarized by the California Health Care Foundation, which is listed in the footnotes of the slides.

Joan Allen, SEIU-UHW, flagged for the committee that for excluded entities there should be a corresponding section of the Health & Safety Code, to go along with the Insurance Code exclusions. Joan Allen also noted that she feels the committee will need to consider including providers as mandatory data submitters because otherwise the HPD would not be capturing uninsured lives. Jill Yegian noted that the core function of APCDs is to capture claims, and there are no claims for uninsured. Jill Yegian also noted that the thinking to date has been that there might be opportunities to include data on the uninsured through data linkage, however the scope would not include an effort to obtain payment data from uninsured. Joan Allen commented that she is less concerned about payments and more about utilization. She noted that if deciding on mandatory submitters will preclude the HPD from capturing utilization data for the uninsured, it feels like a pretty major choice to make without knowing what the legislature wants to do with the data. Scott Christman confirmed that the strategy is to include uninsured data through linkage, which is why the committee and the team have talked so much about linkage. Denise Love also commented that the committee can acknowledge that this population is very important and that right now the priority should be to get the database set up. However, further down the road the HPD can look to expand to include the uninsured. She noted that Maine set up a process to collect raw encounter data for the uninsured, however there is a lot of work that would need to be done, and Maine was not able to sustain it. Denise Love also noted that NAHDO could bring forth some examples.

Ken Stuart, California Health Care Coalition, suggested that the Review Committee can make recommendations to be included in the legislative report, but ultimately the decision will be

made by the legislature. Denise Love agreed that anything is feasible however, she reminded the committee that both energy and time is finite. Ken Stuart also noted that the committee should want to make the recommendations as comprehensive as possible for near, mid, and far implementation. Scott Christman agreed that the legislative report should memorialize that the strategy to include uninsured and other more difficult to report populations, through data linkage to other data assets.

Bobbie Wunsch commented that a future agenda item should be dedicated to discuss collecting data from the uninsured and how that fits into the scope of the project. Scott Christman also noted that the team can go back to what has already been considered around data linkage and develop a strategy for populations that are not covered to discuss utilization and present the strategy to the Review Committee.

John Kabateck, NFIB, inquired why vision only plans are excluded, noting that it is a commonly utilized form of insurance. Jill Yegian explained that the team could not find any great use cases for vision only plans and it did not seem that the value would outweigh the burden of collecting this data.

Emma Hoo, PBGH, inquired what the rationale was for setting the exclusion threshold at 50,000 covered lives. She noted that it is important to keep in mind that some of the smaller plans may be provider sponsored plans or have a regional concentration for that given market it could be a significant portion of the covered lives that would not be captured in the data. Emma Hoo also commented that one big use case that has been brought up is primary care spending. She noted that so much of the capitation that passes through may be FFS or may be sub-capitated payments, and without provider organizations submitting data we would lose the ability to capture this information. Finally, she inquired where public health and county institutions fit into the schema of submitters. Jill Yegian commented that the presentation will be providing rationale for the 50,000 covered lives threshold, but that it comes down to a cost benefit analysis and recognizing the tradeoffs around cost, and burden of submission. She also commented that for public entities the mandatory submitters recommendation needs to be structured in a way to ensure those public self-insured plans are included. Finally, in terms of risk bearing organizations and provider data, she noted that it is important to assess where the data flows and how the program can capture as many covered lives as possible without having too burdensome of a data submission process.

Charles Bacchi, CAHP, commented that Health & Safety Code (HSC) 1345 defines what a Knox-Keene licensee is, however it is a very broad definition, and also includes specialized, and restricted and limited license plans, as well as other entities that roll into a full-service health plan. He noted that this is important to be clear about how the mandatory submitters recommendation is framed as the proposed recommendation currently has a separate call out for Pharmacy Benefit Managers (PBMs) to be submitting data as well, which contradicts recommendation 2c, that states that data for Behavioral Health Organizations and PBMs will be coordinated by the health plans. Jill Yegian noted that PBMs were a late breaking addition as the team learned that sometimes in the self-insured world an entity, such as CalPERS, might have a direct contract with a PBM, and a separate contract with the health plan, therefore in order to get the data it would have to flow from the PBM. Charles Bacchi followed up noting that we should be clearer about this recommendation to note that the PBMs submit only under the specified exception of “when not otherwise submitted by the health plan.”

Ken Stuart, California Health Care Coalition, added that the recommendation should stipulate if the payer group has the relationship with the PBM, then the data would come from the

PBM.

Jill Yegian also noted that the recommendation on mandatory submitters could also include a part d for Self-insured employers subject to HSC section 1349.2

Emma Hoo, PBGH, noted that there is a lot of interest around pharmacy cost, and there might be more granular data available directly from PBMs than from what the plans would be able to provide. Jill Yegian noted that there is consideration of PBMs submitting rebate data and to date there are only a couple of states that are collecting pharmacy rebate information, though all of them bring this information in through the plans. There is a significant question as to whether any mandate should sit on PBMs, especially as PBMs are only just now registering with the state and entering into regulation and reporting. The HPD program can hopefully piggyback on the current work that DMHC is doing to learn about what PBMs can and should be reporting. Jill Yegian also noted that it might be premature to make a recommendation regarding PBMs, except for filling in the gap.

Anne Eowan, ACLHIC, noted that the committee can consider just adding language that says “unless excluded” in regard to the HSC and Insurance Code definitions used to define mandatory submitters, as the Insurance Code is just as broad as the HSC is. Jill Yegian also noted to Charles Bacchi’s earlier point that exclusions could be another way to address the broad nature of the HSC definition for health plans. Charles Bacchi agreed and noted that he did notice that in the recommendations there were specific exclusions for the insurance code but not for the HSC.

Bill Barcellona, America’s Physician Group, noted that he wanted to revisit Risk Bearing Organizations (RBOs) and restricted Knox Keene licensees as submitters, and inquired if the team made the decision that it is too difficult to include that data? He commented that without data from the RBOs there is potential to lose out on a lot of cost data, as California has a great deal of delegation. Jill Yegian noted that it comes down to a balance of the burden of the submission to the value of the data. As of right now the team did not feel that listing those entities as mandatory submitters and in legislation was feasible, however that does not mean it is not something that could be pursued in the future. She also noted that if there is a recommendation the Review Committee wants to contemplate it could be a future pursuit to be tested out through the Technical Workgroup for feasibility. Linda Green also commented that it would be interesting to see what data would be received through the health plan versus directly from these groups. Bill Barcellona noted that he does not think the plans get cost information.

Charles Bacchi, CAHP, commented that one potential solution might be that the voluntary bucket should be bigger. He noted that to the extent groups want to voluntarily submit data, this could be a short-term solution. Bill Barcellona followed up noting that there are confidentiality issues regarding what can be shared without a mandate. Jill Yegian confirmed and noted that the OSHPD legal team has flagged that there are HIPAA issues with voluntary submitters. This is something that the team is aware of and actively working to find a solution. Jill Yegian also reminded the committee that they are not writing legislation, and if the committee wants to put forth a recommendation that instructs OSHPD to identify ways to collect information from these entities then that is a reasonable recommendation.

Terry Hill, CMA, noted that physicians are paid in a mash up of incentives, Per Member Per Month, and Fee-for-Service. He also commented that he is not confident that there is a way to standardize this payment information to be reported in a meaningful way.

Bill Barcellona, America's Physician Group, also noted that so far no one has tried to collect this information from these entities and that there could potentially be a conversation to assess what is doable.

Cheryl Damberg, RAND, followed up that she has been doing a study on the breakdown of physician payments and she noted that for front line providers, it is still a predominantly FFS set up. She offered to share the breakdown with the committee at a later date.

Ken Stuart, California Health Care Coalition, noted that with the proposed legislative changes that VEBA has put forth, all the HPD would be doing would be harmonizing with what is legislatively mandated. He also commented that in an ideal world it would be great to build up from true cost.

MJ Diaz, Health Access, noted that consumer groups struggled with the question if RBOs and providers should be identified as mandatory submitters, since health plans do get a great deal of this data and they are highly regulated by DMHC and CDI. However, as was mentioned the health plans do not capture all of the data, especially the cost data that is delegated, but the consumer groups do support a staggered approach where entities voluntarily submit the data. Jill Yegian noted that this speaks to a recommendation that, as a part of the long-term strategy that OSHPD develops, would include a strategy to link data to access utilization data for the uninsured and a process for capturing the capitated data from RBOs.

Joan Allen, SEIU-UHW, voiced her concern in substantially expanding the voluntary bucket, noting that it will be challenging to find incentives for organizations to submit data if it is not mandated. She noted her general preference for mandatory submission over voluntary. Jill Yegian commented that the current mandatory submitters encompass pretty much everyone who can be mandated. Charles Bacchi also added that it is possible to make a list of voluntary subscribers, and to note that there should be a path to become mandatory submitters. He offered a potential process where the governance committee would do a feasibility analysis of voluntary submitters and present a report to the legislature noting if these entities should be considered for mandatory submission. Scott Christman noted that part of the strategy is that OSHPD already has existing mandates that it can leverage to incorporate some of this missing information. For example, additional information that is needed regarding the uninsured population could also be brought in via another asset that OSHPD already has.

Anne Eowan, ACLHIC, noted that in regards to recommendation 2c on coordination of data submission, it needs to be clarified that the health plan is not always the owner of the data. Anne Eowan provided the following proposed edits to the recommendation (shown in red) Coordination of submission: The mandatory submitters are responsible for ~~ensuring~~ coordinating complete data submissions from appropriate data owners, including data feeds from pharmacy benefit management companies, behavioral health organizations, subsidiaries and other services carved out to a subcontracting organization.

Emma Hoo, PBGH, noted that the usage of the word "coordinating" makes it seem like this is a voluntary option. Anne Eowan noted that if the health plans are not the data owners, so they are not able to "ensure", and they are instead "coordinating" across their subsidiaries and data owners. She also noted that this process will be different from company to company.

Cheryl Damberg, RAND, inquired regarding the graphic on slide 20, if it can be clarified how

the files would come. Charles Bacchi noted that it would be different from plan to plan depending on who owns the data and can do the Q&A on the data. If the plan is the owner, the data would come to the HPD from the plan. If the PBM or Behavioral Health Organization is the owner, the data would come from the contracted entity.

Bobbie Wunsch provided a suggestion to add a phrase, supporting what Emma commented on to say, “complete data submissions” or “coordinating complete data submissions.”

Anne Eowan, ACLHIC, agreed that would be an amenable phrase to add she commented that her primary concern was to provide flexibility for the different set ups that plans have. Scott Christman agreed and noted that OSHPD will work with health plans to understand which method makes the most sense for their individual contracting arrangements.

Ken Stuart, California Health Care Coalition, suggested if the word “facilitate” would work better rather than ensuring or coordinating. Emma Hoo noted that Charles Bacchi makes a good point that mandatory submitters are mandatory as it is, however ensuring mandatory submission is important.

MJ Diaz, Health Access, noted her support for Anne Eowan’s proposed amendment, noting that in the experience of Health Access, they do not always know who the data owner is, and the suggested amendment allows for flexibility to ensure that the data comes from the data owner, so that OSHPD can validate that data.

Amber Ott, CHA, inquired where the county data, such as indigent, County Medical Services Programs (CMSPs), County Mental Health and Corrections, would be captured. Jill Yegian commented that they are not mandatory submitters. Medi-Cal data would come through DHCS. The committee discussed that CMSP and Indigent data could go with the RBOs and be a possible Tier 2 data collection. However, in terms of the Department of Corrections, Jill Yegian noted that there is a lot of other things to put into place prior to including Corrections data. Linda Green agreed and noted that there is a lot of interest in what goes into Corrections, but we do not know if the data will be in the format to do claims level analysis. Charles Bacchi commented that there is a need to assess health care at our prison level, but it is a very complicated system and would be a very large lift for the HPD. Amber Ott noted that patients in the prison systems do end up in hospitals. Scott Christman noted that OSHPD would be able to capture that data on the hospital discharge side.

Terry Hill, CMA, noted that he was a former CEO of California Prison Medical System and that he agreed with the prior comments that this would be a very complicated and messy undertaking.

Cheryl Damberg, RAND, inquired if it is typical for Medicare supplemental to only cover co-payments and out of pocket reimbursements, while not adding medical benefits. Emma Hoo responded that in her experiences there are some services that are captured such as Durable Medical Equipment (DMEs) and add-ons but there would be some duplication in the data. She did note that however if the HPD wants to capture out of pocket costs collecting Medicare Supplemental insurance would be helpful. Emma Hoo also noted that because of the concentration of members in a handful of carriers there would be a volume split where you would capture 90% of the population through a few carriers.

Anne Eowan, ACLHIC, noted that Medicare Supplement is standardized, and she did not know if it will provide much more data than the cost sharing. In terms of additional benefits

that can be purchased they are normally not benefits covered by Medicare and this is a new product line. She did disagree with the comment that there are just a handful of carriers and commented that there is a lot of companies that are not in the health space that sell Medicare Supplement. Emma Hoo commented that there is also group Medicare Supplemental and employers can choose benefits that are over and above. Anne Eowan also noted it would be interesting to hear from other states if they have tried to include Medicare Supplement and if they discovered if the “juice was worth the squeeze.”

Joan Allen, SEIU-UHW, also inquired if we have a sense of how much Medicare Supplemental would be captured above the proposed 50,000 covered lives threshold. Anne Eowan noted that she was not sure.

Ken Stuart, California Health Care Coalition, noted that there are Medicare Supplementals for dental vision, and prescription drug which are all separate. Cheryl Damberg noted that 60% of the Medicare population is in FFS and they purchase supplemental, therefore there is utilization that would not be tracked. Jill Yegian noted that pharmacy will come through the Prescription Drug Plan and dental would come through as well, so it is really an issue if it is worth the burden to collect this data if the utilization data is already coming through other threads, the supplemental would only provide data on the cost sharing.

Terry Hill, CMA, noted that Long Term Care is enormously costly, and it will be helpful if the HPD could get Medical Long-Term Services and Supports data, which would provide some insight. However, he recognized that this should be excluded as there is no practical way to get at this cost data but wanted to note that Long Term Care is a huge portion of Total Cost of Care.

Charles Bacchi, CAHP, noted that chiropractic and acupuncture products are often bundled. Jill Yegian noted that the list of excluded lines of business was based on the DMHC categorization, and that there are 6 buckets of specialized plans: discount, vision, chiropractic, dental, pharmacy, and psychology (behavioral health).

Emma Hoo, PBGH, noted that she would be interested in which plans are excluded based on the threshold cut off of 50,000 covered lives. Specifically, she was concerned that certain regions would be excluded. Jill Yegian noted that two of the biggest regional providers, Western Health and Sharpe, are both over the threshold. Additionally, she noted that Medi-Cal plans tend to be regional, and there is no threshold on Medi-Cal plans. Emma Hoo followed up noting that Medi-Cal covered lives should be combined with the commercial covered lives when calculating threshold cutoffs. Since those plans are already submitting for Medi-Cal it would not be a huge burden on them. She also suggested to lower the threshold to 25,000 covered lives.

Charles Bacchi, CAHP, noted that he appreciates this recommendation regarding a threshold because otherwise the HPD would be chasing insignificant amounts of data. Jill Yegian also noted that the Review Committee does not need to land on a specific number for a recommendation but that they could say that there will be a recommendation that would be defined in regulation and sit somewhere between 10,000 and 100,000 covered lives for example.

MJ Diaz, Health Access, inquired if the threshold stays at 50,000 covered lives, what is the percentage of the claims being excluded. Jill Yegian noted that at a threshold of 50,000 covered lives, 97.1% of the population is captured. If you lower the threshold to 25,000 you

capture 98.6% of covered lives. She noted there are also other buckets such as Medi-Cal and Medicare FFS.

Ken Stuart, California Health Care Coalition, clarified that the question was if there is a one to one ratio of covered lives to claims, noting that if we drop the threshold to 25,000 the increase in the claims volume might not be statistically significant.

Cheryl Damberg, RAND, agrees that there is a need for a threshold, but would encourage dropping the threshold. She noted that the smaller plans serve very different types of populations and the HPD should collect data on those populations as well.

Charles Bacchi, CAHP, noted that he is not comfortable dropping the threshold to 25,000 covered lives. He also noted that the threshold level could be linked to frequency of reporting. If the threshold is lowered, smaller plans may not be submitting data as frequently.

Jill Yegian noted for the committee to consider two things. 1) the issue of dental and do we want to hold them to the same thresholds and 2) do we want to distinguish the self- insured plans as there is less data on them.

Discussion and Vote on Recommendations 1 & 2

Jill Yegian noted that there were slight changes to the recommendations based on the conversation that was had prior to the vote.

Recommendation as Presented to Review Committee

1. The Review Committee recommends that definitions for the types of organizations required to submit data as previously defined to the HPD (“mandatory submitters”) should be based on existing California laws and definitions, and include:

- a. Health care service plans and health insurers
- b. The California Department of Health Care Services, for Medi-Cal managed care plan and fee for service data
- c. Self-insured entities not subject to ERISA
- d. Third party administrators
- e. Dental plans and insurers

Cheryl Damberg, RAND, made a motion to move the recommendation as written.

Joan Allen, SEIU-UHW, seconded Cheryl Damberg’s motion.

Public Comment:

Adam Francis, California Association of Family Physicians, noted this version of the recommendation was an improvement to what was first proposed. He noted however that he would like more explanation on the term Third Party Administrator and what that would include.

Dina Mendelson, Consumer Reports, noted that the point of the APCD is that we have a well-rounded data set. She noted that Consumer Reports is requesting that the benchmark be brought lower than 50,000. She noted that 25,000 covered lives would be better and 10,000 covered lives would be preferable especially when considering if those plans are already submitting data to the HPD for other lines of business. She also noted that in order for the

HPD to have a well-rounded set of data they want to ensure that dental, pharmacy and mental health data is included, to the extent allowed under privacy laws. Finally, she noted that Consumer Reports understands that self-insured plans subject to ERISA cannot be mandated to submit, however, Consumer Reports recommends that there be a process to ensure that these plans are aware of the voluntary reporting option and provided with information as to why submitting this data could be beneficial to them and others.

Carrie Sanders, California Pan-Ethnic Health Network, commented her appreciation for this well thought out process to garner input for the successful development of the HPD. She noted that California Pan- Ethnic Health Network supports the prior comments of Consumer Reports, noting that they see the value of getting as many submitters as possible, in order to help us improve quality, monitor costs and improve equity. She noted that they support a lower threshold, around the 10, 000 covered lives mark.

End of Public Comment:

Anne Eowan, ACLHIC, noted that on the addition of TPAs as mandatory submitters, she understands why they are being included, however she noted that they are only able to provide the information that their self -insured plans give them. Jill Yegian agreed that that is a great point and noted that the reasoning behind including TPAs was to ensure that there were no gaps.

Ken Stuart, California Health Care Coalition, commented that TPAs are any entity other than a health plan that makes claim payments for a group. He noted that there are entities other than plans that make these claim payments that could be submitted to the database.

Charles Bacchi, CAHP, noted that he is unsure of how he feels about the addition of TPAs because there are a number of different ways to define TPAs. He noted that this addition was made after the materials had been shared out and has not been fully vetted for the committee to vote on. He commented that he does not disagree with the recommendation but is not comfortable including a term without knowing how it would be interpreted by the legislature.

Ken Stuart, California Health Care Coalition, noted that ultimately it will be up to legislature to make the distinction and there are large TPAs that do have a lot of data that would be relevant to the HPD.

Charles Bacchi, CAHP, agreed with Ken Stuart's comments, however the term TPA covers such a large swath that he is not sure what it represents and what would be captured.

Joan Allen, SEIU- UHW, inquired if TPAs are going to be included should they be held to the same threshold limits across their aggregated contracts.

Bill Barcellona, America's Physician Group, noted that the committee will be specifying the threshold levels in a separate recommendation. He noted that he does not see a problem in including TPAs as mandatory submitters.

Emma Hoo, PBGH, noted that Joan Allen's comment regarding defining thresholds at the aggregate level across all contracts should also apply to self-insured entities.

Terry Hill, CMA, noted that he does not feel that the intent of the recommendation is captured very well in the way the recommendation is written. He suggested not voting on the

recommendation and asking for OSHPD to clarify the language, specifically around the definition of TPAs, and then to bring back at the next meeting. Ken Stuart followed up inquiring if the introductory language to the recommendation did not capture the intent of the recommendation. Terry Hill responded that the recommendation does not define what a TPA is nor does it capture the concept of aggregation that was mentioned earlier. Cheryl Damberg noted that the language can be clarified through amendments, however the thresholds will be covered in a separate recommendation.

Joan Allen, SEIU-UHW, noted that in order to capture the intent that the list of mandatory submitters may increase, she suggested adding the word “initially” before the word “include.”

Anne Eowan, ACLHIC, suggested adding the term “not otherwise preempted by ERISA” next to word “TPA.”

Ken Stuart, California Health Care Coalition, suggested that in order to better define which type of TPAs would be mandatory submitters to the HPD, to add the words “of plans” after the word “Third Party Administrators”

Bill Barcellona, America’s Physician Group, suggested to add the word “federal” between existing and California laws, as federal laws would encompass HIPAA as well.

Bobbie Wunsch summarized the proposed changes to the recommendation:

- After the word “existing” to add the word “FEDERAL”
- Before the word “include” to add the word “INITIALLY”
- In bullet “d” to add after Third Party Administrators to add “OF PLANS” and in parenthesis (NOT OTHERWISE PREEMPTED BY ERISA)

Cheryl Damberg, RAND, made a motion to move the recommendation as amended

Anne Eowan, ACLHIC, seconded Cheryl’s motion.

Public Comment:

Adam Francis, California Academy of Family Physicians, noted that he supports the first two amendments. However, with the term Third Party Administrators, he agrees with Charles Bacchi that the term is too vague to be voted on right now. He recommends that the committee either completely remove the term or table it until more information could be gathered.

Charles Bacchi, CAHP, noted that he would support the recommendations as it encompasses mostly everything that he agrees with. However, from a process perspective, he noted that, introducing a term that has not been fully vetted in the materials prior to the meeting, and asking the committee to vote on said term is not something that he agreed with. He noted that the committee was provided with an entire slide deck that breaks down the decisions that they are making today, therefore it is frustrating to have a term brought up and inserted that has not been fully defined to the committee. He noted that he will be withholding his support for this recommendation not because he disagrees with what it says, but because terminology has been included in it that has not been fully vetted and discussed at the committee level.

MJ Diaz, Health Access, noted her support of the motion as that it captures the intent to

include currently defined mandatory submitters and also leaves open the opportunity to include additional submitters down the line.

Ken Stuart, California Health Care Coalition, asked if Jill Yegian could provide more insight on how the addition of TPAs evolved. Jill Yegian noted that Charles Bacchi's frustration completely resonates with her, and she noted that the team is learning as fast as possible. She noted that there is currently a choice that the recommendation could either leave out TPAs and trust that whoever uses TPAs will include the data or include it to be explicit. She commented that other state APCD legislation says, "health plans, insurers and TPAs." She stated that it was challenging to include information on TPAs as it is hard to get. She also noted that the committee could remove TPAs and then later include them, as the recommendation states that these are the mandatory submitters "initially." Ken Stuart also noted that the committee can adopt this motion without TPAs and then bringing it back once there is more information, or the committee could table the entire recommendation.

Charles Bacchi, CAHP, noted that he is supportive of the committee voting on this recommendation, however he is noting his abstention based on process.

Terry Hill, CMA, noted that he would support tabling this recommendation until there is more information that can be provided. He noted his support for the intent of the recommendation, however he was still not comfortable with the term TPA.

Cheryl Damberg, RAND, inquired if the recommendation was tabled, would the committee actually have more information at a later date to vote on the recommendation. She worried that this would not actually happen and communicated that the combination of the addition of the "Federal law" amendments as well as the exclusions will narrow the definition of who is mandated to submit data. She also noted her support for the amendments that clarified "TPAs of plans (not otherwise preempted by ERISA), and that those amendments seemed to clarify what we are discussing.

The committee voted 9-2 to approve the recommendation. There were no abstentions.

Final Recommendation as Approved by the Review Committee:

1. The Review Committee recommends that definitions for the types of organizations required to submit data as previously defined to the HPD ("mandatory submitters") should be based on existing **FEDERAL AND** California laws and definitions, and **INITIALLY** include:

- a. Health care service plans and health insurers
- b. The California Department of Health Care Services, for Medi-Cal managed care plan and fee for service data
- c. Self-insured entities not subject to ERISA
- d. Third party administrators **OF PLANS (NOT OTHERWISE PREEMPTED BY ERISA)**
- e. Dental plans and insurers

Recommendation as Presented to Review Committee

2a. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Required lines of business:

1. Commercial: individual, small group, large group, Medicare Advantage
2. Self-insured plans not subject to ERISA

3. Dental
4. Medi-Cal

Bill Barcellona, America's Physician Group, made a motion to move the recommendation as it is written.

MJ Diaz, Health Access, seconded Bill Barcellona's motion.

There was no public comment on this motion

The Review Committee voted 9-0 to approve the recommendation as written. There were no abstentions.

Final Approved Recommendation:

2a. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Required lines of business:

1. Commercial: individual, small group, large group, Medicare Advantage
2. Self-insured plans not subject to ERISA
3. Dental
4. Medi-Cal

Recommendation as presented to the Review Committee:

2b. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Coordination of submission: The mandatory submitters are responsible for ensuring complete and accurate data submissions directly, and facilitating data submissions from appropriate data owners, including data feeds from pharmacy benefit management companies, behavioral health organizations, subsidiaries, and other services carved out to a subcontracting organization.

John Kabateck, NFIB, made a motion to approve the recommendation as written.

Bill Barcellona, America's Physician Group, seconded John Kabateck's motion.

Public Comment

Bernie Inskeep, United HealthCare, commented that where it says, "the mandatory submitters are responsible for ensuring complete and accurate data submissions directly, and facilitating data submissions from appropriate data owners," fails to see that data owners have also have privacy responsibilities under HIPAA, therefore the mandatory submitter that is responsible for the data would have prohibitions from accessing the data.

Charles Bacchi, CAHP, noted that the crux of this recommendation comes back to the word "ensuring" which gets to the fact that a mandatory submitter cannot ensure how a technical data submission is going to happen from the entity that owns the data. This puts a burden on the mandatory submitter, which is ok for the data that they own, but the wording may need to be adjusted to recognize that mandatory submitters cannot access data that they do not own.

Ken Stuart, California Health Care Coalition, suggested removing the term “ensuring.”

Emma Hoo, PBGH, noted that if a mandatory submitter has a contractual agreement with a subsidiary these requirements can be included in their contracts. She also noted that there is ramp up time to include these requirements in the contracts, so that they would be ensuring the submission of that information.

Joan Allen, SEIU-UHW, suggested to instead of saying “ensuring complete and accurate data submissions” it could say “submitting complete and accurate data submission.”

Charles, Bacchi, CAHP, agreed that this would be an amenable suggestion as it captures that the mandatory submitters are doing two things – submitting data and facilitating data.

No public comment on the revised motion.

The Review Committee voted 9-0 to approve the recommendation as amended. There were no abstentions.

Final recommendation approved by the Review Committee:

2b. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Coordination of submission: The mandatory submitters are responsible for ~~ensuring~~ **submitting** complete and accurate data ~~submissions~~ directly and facilitating data submissions from appropriate data owners, including data feeds from pharmacy benefit management companies, behavioral health organizations, subsidiaries, and other services carved out to a subcontracting organization.

Recommendation as presented to the Review Committee:

2c. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Excluded lines of business: all those listed in Insurance Code section 106b as excluded from the definition of health insurance, plus the following:

- Supplemental insurance (including Medicare supplemental)
- Stop-loss plans
- Student health insurance
- Chiropractic-only, discount, and vision-only insurance

Terry Hill, CMA, made a motion to move forward this recommendation as written.

Charles Bacchi, CAHP, seconded Terry Hill’s motion.

MJ Diaz, Health Access, inquired if student health insurance should be excluded, as they are ACA compliant, even if they are temporary coverage for students. Jill Yegian noted that it is up to the committee to determine if student health insurance should be excluded.

Public Comment:

Beth Herse, OSHPD Legal, asked whether the student health insurance issue interacts with the California resident recommendation, given that a significant portion of California students may not be California residents. Linda Green noted that students would have on file a California residency because they are living on campus. Beth Herse commented that in the UC System it may take several years for out of state students to establish California

residency.

Denise Love, NAHDO, also commented if student health insurance would meet the threshold to be a mandatory submitter. Jill Yegian noted that there are 900,000 covered lives in student health insurance, at a point in time in 2017 and one plan had 600,000 lives.

Emma Hoo, PBGH, inquired if it was primary insurance, since the age limit has been raised to 26. Jill Yegian commented that in many universities you have to prove that you have eligible coverage for the area, in order to waive the required health care coverage mandate. Cheryl Damberg confirmed that is how the UCs work.

Bobbie Wunsch inquired if there was any interest in amending the recommendation to not include student health insurance as an exclusion. There was no comment and the committee took a vote.

The Review Committee voted 9-0 to approve the recommendation as written. There were no abstentions.

Final recommendation as approved by the Review Committee

2c. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Excluded lines of business: all those listed in Insurance Code section 106b as excluded from the definition of health insurance, plus the following:

- Supplemental insurance (including Medicare supplemental)
- Stop-loss plans
- Student health insurance
- Chiropractic-only, discount, and vision-only insurance

Recommendation as presented to the Review Committee:

2d. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

Plan Size: Exemption for plans below a threshold to be defined, between 25,000 and 50,000 covered lives for:

1. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
2. Dental

There is no threshold for Medi-Cal.

John Kabateck, NFIB, made a motion to move the recommendation forward.

Terry Hill, CMA, seconded John Kabateck's motion.

No Public Comment

Cheryl Damberg, RAND, inquired why there was a threshold for Medicare Advantage, as all Medicare Advantage plans already submit this data to CMS. Linda Green noted that the data to CMS has a rather large time lag, while if the Medicare Advantage data came in with the commercial data it would be received sooner and could have the same data quality standards applied to it as with the commercial data.

Emma Hoo, PBGH, noted that CMS is delayed however the, plans are required to submit the

data on a regular basis to CMS. She noted that the suggestion would be to get that same feed coming into the HPD.

MJ Diaz, Health Access, noted that certain Medicare Advantage plans have smaller numbers of covered lives, around the 10,000 range. She commented that part of the reason Health Access and their consumer advocacy partners are recommending a lower threshold is to capture these plans.

Bill Barcellona, America's Physician Group, noted that the Medicare Advantage covered lives should still be used to determine the combined threshold across lines of business, however he noted that a Medicare Advantage only plan should not be excluded if they do not meet the threshold, since they are already submitting this data to CMS.

Joan Allen, SEIU-UHW, noted that there are plans that do not meet the 25,000 covered lives threshold, but that will be submitting Medi-Cal data. She suggested that Medi-Cal covered lives should be added to the threshold to determine mandatory submitters.

Charles Bacchi, CAHP, noted that it is possible to have a large Medi-Cal plan who also has a smaller commercial plan for county employees that would capture a couple hundred covered lives. This would be very burdensome for these small plans. The Medi-Cal data would be submitted to DHCS and that is a different process than developing a submittal process for their covered lives line of business.

Bill Barcellona, America's Physician Group, inquired if Covered California plans would submit data. Jill Yegian noted that Covered California plans are fully insured and if they are below the threshold, they would not be submitting data. If they are above the threshold the plans would submit the data, but the data would not come from Covered California.

MJ Diaz, Health Access, made an amendment that the threshold should be between 10,000 – 50,000 covered lives.

Cheryl Damberg, RAND, emphasized that there should not be a threshold for Medicare Advantage. Jill Yegian noted that there should be some consideration for the tradeoffs. For example, if a Medicare Advantage plan has only 8000 covered lives there is a burden associated with it for both submission and intake. Emma Hoo noted that it is important to keep in mind that the time lag in getting the data from CMS is getting better and better

Cheryl Damberg, RAND, amended the motion to say “there is no threshold for Medicare Advantage”

Bill Barcellona, America's Physician Group, seconded Cheryl's amendment.

John Kabateck, NFIB, moved the amended motion.

Terry Hill, CMA, noted that the amendment was unfriendly and asked for a vote.

Public Comment:

Bernie Inskeep, United HealthCare, noted that from the United HealthCare Group perspective 50,000 covered lives is an appropriate threshold. She also noted that from her prior experience with APCDs normally a threshold is set in regulations not in the statute. She also suggested that another option would be to recommend that there will be an appropriate

threshold defined, and then during the rule making process reach out to health plans and have them register their entities and do a data driven process to determine this threshold.

Charles Bacchi, CAHP, noted that he agrees with Bernie and feels that a range is a good start, but another option could be to also say there can be exemptions and OSHPD will determine the range. How do committee members feel about removing thresholds and just assigning that there should be a threshold?

Terry Hill, CMA, reminded the committee that the current discussion is on whether the recommendation should include a note that there is no threshold for Medicare Advantage. He did not second the amended motion and noted that there needed to be a vote as to whether the unfriendly amendment moves forward. Terry Hill noted that he knows too much about submitting data and that Medicare Advantage having no threshold is a “juice worth the squeeze” conversation.

Joan Allen, SEIU-UHW, noted that another lever the committee has to work with is frequency of submission. She noted that if the threshold is lowered there can be an option for smaller submitters to submit data less frequently.

Emma Hoo, PBGH, noted that another option would be to give OSHPD the authority to set the frequency depending on size, but not who the submitters are.

MJ Diaz, Health Access, noted her support for adding the Medicare Advantage plans having no threshold. She noted that she hears the concern about whether the burden for small plans is worth the data received. However, she did remind the job of the Review Committee is vetting these ideas for the legislature to ultimately decide on the details. Scott Christman noted that he agreed that this is a critical part of engaging the stakeholders and much of this will be sorted out during the rule making process. He commented that OSHPD wants the recommendations to provide an opportunity for the Review Committee to have a voice and that there will be more decision making and stakeholder engagement during the rule making process. The decision of the committee is how much detail do they want to provide in this first go around, understanding that these recommendations are not final and that there will be opportunities down the line to fine tune this language.

Emma Hoo, PBGH, noted her support to include the amendment that there is no threshold for Medicare Advantage noting that CMS has a standard format that would be used so even though there are different Medicare Advantage plans, they would be submitting in one format and it would be a simple mapping exercise.

The committee vote 7 to 2 to add Medicare Advantage to the no threshold category.

The committee had a discussion if Medicare Advantage can plans submit data through CMS. The OSHPD team however reminded the committee that a prior recommendation that was voted on and approved, noted that while Medicare FFS data would come from CMS; Medicare Advantage data would need to come from plans.

Charles Bacchi, CAHP, noted that he supports the recommendation but is uncomfortable with no threshold for Medicare Advantage plans. He notes that the importance of having a threshold is currently outweighing the concern for no threshold for Medicare Advantage plans, however he does note his reservations about that amendment.

	<p><i>Bill Barcellona, America’s Physician Group</i>, noted that he agrees with Charles Bacchi. He notes that his original understanding was that the data would come through the CMS feed and that it would not be a separate reporting requirement for Medicare Advantage plans. However, based on the conversation of the committee he has realized that the feed would not come from CMS and therefore he changed his opinion on the threshold for Medicare Advantage being set to zero.</p> <p><i>Emma Hoo, PBGH</i>, suggested adding that there is no threshold for Medi-Cal and Medicare Advantage except as recommended by OSHPD.</p> <p><i>Charles Bacchi, CAHP</i>, noted that was a helpful change as proposed by Emma.</p> <p><i>Cheryl Damberg, RAND</i>, noted that it is possible to request the data from the Medicare Advantage plans when they submit to CMS. Jill Yegian noted that it is important to remember that the committee had voted on the APCD-CDL™ format being the format used by commercial plans including Medicare Advantage. This is not the format that Medicare Advantage plans are currently submitting data to CMS in. Cheryl Damberg suggested tabling this recommendation for the next meeting.</p> <p><i>Ken Stuart, California Health Care Coalition</i>, suggested an amendment to say, “Any threshold with respect to Medi-Cal and Medicare Advantage will be recommended by OSHPD.”</p> <p><i>Joan Allen, SEIU-UHW</i>, clarified that OSHPD could set a threshold higher than 10,000 covered lives. She also noted again that there is a real interaction with recommendation 3 on frequency that needs to be considered.</p> <p><i>Denise Love, NAHDO</i>, noted that she has concerns if the conversation on thresholds is pushed further down as there will be other difficulties that will come up. She noted that she would feel better with the Review Committee making a statement and putting a stake in the ground, rather than allowing it to be determined down the road.</p> <p><i>Cheryl Damberg, RAND</i>, noted that she would like to table this recommendation and to come back with actual numbers of covered lives in Medicare Advantage plans.</p> <p>The committee decided to table this recommendation for discussion at the August Review Committee meeting.</p> <p>The committee ran out of time to get through recommendations 3a, 3b and 4. Those, along with recommendation 2d, will be discussed and voted on at the August Review Committee meeting.</p>
Public Comment	There was no public comment
Agenda for Upcoming Review Committee Meeting & Adjournment	Ken Stuart thanked the committee and OSHPD Staff. He commented that the next meeting on August 15 will be on data quality.