Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Review Committee Meeting

December 19, 2019

Draft 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; Anthony Wright, Health Access California; Joan Allen, Service Employees International Union- United Healthcare Workers West (SEIU-UHW); Cheryl Damberg, RAND Corporation; William Barcellona, America's Physician Groups.

Attending by Phone: No members attended by phone.

Not Attending: John Kabateck, National Federation of Independent Businesses (NFIB).

Presenters: Scott Christman, Chief Information Officer, OSHPD; Michael Valle, Chief Strategy Officer, OSHPD; Jill Yegian, Consultant, OSHPD; Jonathan Mathieu, Senior Health Care Data/Policy Consultant, Freedman HealthCare; Linda Green, Vice President- Programs, Freedman HealthCare; Bobbie Wunsch, Consultant, OSHPD.

Others: Denise Love, National Association of Health Data Organizations (NAHDO); Norm Thurston, Executive Director, NAHDO.

Public Attendance: 20 members of the public attended.

Welcome and Meeting Minutes

The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions. The November 21 Review Committee meeting minutes were approved with one amendment from Bill Barcellona who clarified that his comment on the term "integration" was regarding the need to clarify the use of the phrase integration between clinical integration versus financial consolidation. Bobbie Wunsch went over the ground rules for the meeting.

Ken Stuart also commented that he has heard positive commentary from industry on the work of this committee. Ken reminded the committee of where we are in the process of the Healthcare Payments Data program implementation, and that the role of the Review Committee is to provide recommendations that will inform the legislation. He commented that there were a number of topics that were

discussed in prior meetings, that were referred to the governance presentation, and while they were all considered in the development of this presentation, decisions on each of them will not be made at this meeting. The goal of this meeting is to provide high level direction to OSHPD, rather than workout every single detail of implementation.

Deputy Director's Report

Scott Christman provided a summary of what was discussed at the November Technical Workgroup. He noted that the group discussed the development of a submitter registration process, as well as previewed some of the governance topics that will be discussed at today's meeting. In addition to those two topics, the Technical Workgroup participants did a walkthrough of the APCD-CDL™ Dental File. The California Association of Dental Plans was able to join the meeting and provided valuable input from the perspective of the dental plans. For a full summary of the November Technical Workgroup please see: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/HPD-Technical-Workgroup-Summary-11.21.2019-Final-ADA.pdf

Scott Christman also commented that as he will be transitioning out of OSHPD at the end of the year, Michael Valle will be stepping in to serve as the acting Chief Information Officer and Deputy Director for OSHPD and will be leading the HPD efforts moving forward. Michael Valle has been working on this project very closely since its inception, and in addition Starla Ledbetter will be staying in her role as the program manager. Fran Mueller, OSHPD's Chief Deputy Director will serve as the sponsor of the project moving forward. The OSHPD Director's Office has made the HPD a priority assignment, and Scott noted that he has full confidence in the team to move this project forward.

State Agency Governance

Michael Valle provided an overview of the role of a state agency in program administration and the value of advisory committees. Michael Valle discussed the unique roll of OSHPD as a state department whose mission is to support effective decision making, rather than as a direct provider of healthcare services. He also commented that there is a benefit to being a part of the CHHS Agency in terms of increased coordination and collaboration with CHHS sister departments. Michael also noted the benefit of utilizing public bodies to maximize the effectiveness of OSHPD's programs. Currently, every OSHPD program has an advisory board or commission, and while OSHPD does have a robust clinical advisory panel for the California CABG Outcomes Reporting Program (CCORP), OSHPD does not have one over health data programs. Lastly, Michael pointed to the effectiveness of the existing Review Committee and Technical Workgroup, as well as the data submitters and data users workgroups that were convened under Senate Bill (SB) 17.

For a full presentation see slides 5-7:
https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint_12.19.2019-ADA.pdf

Governance

Jill Yegian presented on key considerations for the governance of the HPD program including learnings from other states. The discussion also included a vote on recommendations regarding identification of the appropriate entity to operate the database; enforcement; proposed advisory committee structure; and approach to data governance including use, access, and release. For the full presentation please see slides 8-37:
https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint_12.19.2019-ADA.pdf

Advisory Committees:

Ken Stuart, California Health Care Coalition, inquired if the Advisory Committee will be a decision-making entity or an advisory body. Jill Yegian clarified that the Advisory Committee will provide recommendations, and ultimately OSHPD will make the final decisions.

Cheryl Damberg, RAND, noted that in regard to the size of an Advisory Committee, a 25-member committee is too large. She noted that the current size of the Review Committee (11 members) has been effective in hearing various perspectives, while still being manageable. She recommended that for the Advisory Committee, OSHPD should aim to convene 12-15 members, which would provide room for diverse perspective while maintaining flexibility if there are voices missing.

Anne Eowan, ACLHIC, inquired if the Advisory Committee is a separate committee from the data release committee. She noted that the scope of the Advisory Committee will determine the need for the diversity of representation. If the Advisory Committee will be getting into the specific decisions regarding data access and release, there will need to be greater representation and more expertise, than would be required if this body is making high level policy decisions. Jill Yegian noted that all of the topics do intertwine, however in addition to the Advisory Committee, the plan is to have other committees and workgroups such as data submitters, data users, and a data release committee - which is virtually ubiquitous across all APCDs. She noted that the current thinking is that the only committee that would be under statutory authority would be the Advisory Committee, while the others would be at the authority of OSHPD's Director. Anne Eowan noted that having a data release committee is critical, and the determination of the size of the Advisory Committee will be informed based

on how deep into the subject matter the Advisory Committee goes. Scott Christman noted that he agreed that there is a need for both policy and technical expertise. The more specialized stakeholder group would apply the policy that the Advisory Committee is providing.

Emma Hoo, PBGH, noted that one of the challenges is to balance participation of data contributors. While at the outset the focus is on the health plans as the primary contributors of data, she noted that Covered California would be an important voice to have on the Advisory Committee.

Terry Hill, CMA, noted that he agrees with Cheryl Damberg's earlier comment for the Advisory Committee to have less than 15 members, and noted that an approach to ensuring a small overall Advisory Committee could be to include sub committees which will address more of the hands-on work. He also noted that he would argue for having flexibility in the composition of the Advisory Committee, to avoid the rigidity that currently guides the Coronary Artery Bypass Graft (CABG) program, which was written very restrictively and maybe does not meet the current needs. He also noted that it would be important to bring in dental representatives when appropriate and commented that it was handled well during this process to have the dental plans participate in the Technical Workgroup discussion when necessary.

Anthony Wright, Health Access, agreed with keeping the Advisory Committee at a manageable size while also having diverse representation. He noted that on the consumer side there is a room for broad based consumer representation, but also given the questions that come up with this data and the importance around representation regarding race/equity data, specific underserved consumer groups (such as for people of color, high healthcare utilizers etc.) would be an important perspective to include.

Anthony Wright also followed up with a question regarding the decision process to determine that OSHPD should be the operator of the database. Jill Yegian noted that while the team did not do a deep dive on coming up with robust alternatives, they did think about the issues that were discussed at the Review Committee meetings as well as what other state APCDs have done. She noted that when deciding between a state agency or a vendor as the operator, looking at guidance from other states, a state agency made more sense. In California when assessing which state agency made the most sense, the consensus from team is that it is best to have the operator be a neutral party and not an entity that is responsible for provision of care or a regulatory role (i.e. DHCS or DMHC), CDPH was also considered and noted that they have great data assets, however their mission as a department is not as aligned with the HPD as OSHPD's mission is. As OSHPD is the state agency that is focused on data, has the experience with data, and runs the Committee for the Protection of Human Subjects (CPHS), it seemed like the natural operator of this database.

Cheryl Damberg, RAND, noted that there should be some additional at large seats. She agreed with the prior comment to add Covered California, but also noted it would be important to include safety net providers given that 1/3 of the population is covered by Medi-Cal. She also suggested that including social services agencies as representatives, would be helpful to support integration and linkage of the HPD to social service data. Cheryl also followed up inquiring if this group will be providing input to help OSHPD set priorities for the future. Scott Christman noted that yes, the Advisory Committee would be providing input on priorities. He noted that as an organization OSHPD has begun to focus more on outreach and engagement to data users to help with input, and the Advisory Committee is a more formal way to collect that input.

Ken Stuart, California Health Care Coalition, suggested including large pooled risk groups in the Advisory Committee. He also commented on the importance of versatility in the makeup of the group, to get the most expertise from the fewest number of people.

Joan Allen, SEIU-UHW, noted that if there are more “at large” seats being added, then there should be a “tipping point criteria,” such as no more than half of the Advisory Committee members should be data submitters.

Amber Ott, CHA, noted that she agreed with the prior comment to add safety net providers, and suggested three options including the California Association of Public Hospitals, the UCs or a county such as LA County which is doing unique population health work. She did note that the clinic perspective is missing and is also an important consideration.

Charles Bacchi, CAHP, noted that with all of these suggested additions, the Advisory Committee is almost up to 35 people. He noted that it is important to think through if this current representative body has been effective, and to be thoughtful about how adding a number of additional members could change the dynamic. He noted that this current discussion has gone a bit too far into the weeds and suggested moving on.

Cheryl Damberg, RAND, noted that on possible way to deal with size creep would be for the state to solicit broader input through a “public comment” opportunity to garner input.

Ken Stuart, California Health Care Coalition, commented that there is so much expertise just within the Review Committee as a starting point. It would be best to make the best use of the experience that the Review Committee would bring, and then then supplement as needed.

Amber Ott, CHA, inquired what the governance structure would look like. Jill Yegian noted that idea is that the Advisory Committee would provide the general layout and direction for the HPD, and potentially down the road, overall OSHPD

healthcare programs, while the workgroups would have distinct task and be in parallel to the Advisory Committee, rather than filtering up to Advisory Committee. She also noted that the intention is to create a flexible governance structure that can grow and change with the program.

Charles Bacchi, CAHP, noted that there can be churn in terms of OSHPD staff and within these committees. He commented that a direct hierarchical chain could bring everything to a halt with churn. He agreed on the helpfulness of having sub workgroups to dig into the work, and these workgroups may not even need to be statutorily authorized. To Anne Eowan's earlier point there may be specific committees that would need to be mentioned in the report as mandatory, such as the Data Release Committee.

Norm Thurston noted that the key to keep in mind is the difference between policy committees and operational committees. He also noted that a data submitter group, for example, can have open membership so that all data submitters feel that they can join in and participate in those meetings.

Ken Stuart, California Health Care Coalition, noted that currently the Review Committee is providing guidance to OSHPD and the future governance structure should do much of the same, while retaining flexibility for OSHPD to continue to do what they do.

Public Comment:

Mike McKinney, CoveredCA, noted thanks from Covered California for being included in this process. He noted that moving forward Covered California would like to be included as well, and the organization has learned a lot through their own "mini APCD" process and can provide lessons learned. He also commented on the importance of minimizing duplication efforts.

Adam Francis, California Academy of Family Physicians, noted that these conversations can easily devolve into adding more and more representatives to the committee. He noted that the California Academy of Family Physicians would love to be involved, but also that Covered California is an important voice to have at the table as well as the California Primary Care Association.

Dolores Yanagihara, IHA, reinforced the importance of various stakeholder input, and a having a set process that is trusted. She noted that with a consistent process and varied representations, even if a decision doesn't go the way a certain stakeholder group was hoping it would go, they will still stay committed to the effort.

Charles Bacchi, CAHP, noted that it is helpful to include sister CHHS departments, whether in the Advisory Committee membership or through some other stakeholder process.

Leveraging Enforcement:

Charles Bacchi, CAHP, noted that both the plans and insurers are at the table willing to participate in this effort. He noted that with the implementation of SB 17 it was clear that if there is not a requirement to submit information, it would not be submitted. He inquired what the OSHPD experience was like with enforcement of the SB 17. Scott Christman noted that since drug manufacturers are not licensed with a state department, there was no other entity to rely on for enforcement. He noted that for SB 17 there is a penalty fee if a report is filed late, however, there is no penalty if the drug manufacturers did not report the required data, which has been challenging. Lastly, he added that the enforcement proposal presented for HPD is more consistent with existing programs. Charles Bacchi noted he is not opposed to having a regulatory compliance element, however he noted that health plans have to comply with regulations, which can be very fine driven depending on various factors. He noted that it would be helpful to look at the types of violations that are subject to fines, and that there be some sensitivity with respect to enforcement, as the failure to submit data, for example, might make the data set less accurate, but does not put a patient's health at risk. He suggested that the recommendation should reflect some understanding and recognition that there might be different levels of the ability to comply, so that a regulator does not interpret the recommendation as "if a plan does not submit 100% of the elements they will be fined." Scott Christman noted that the current OSHPD process is to work closely with the hospitals to ensure that they know what to do, and in the rare event of a penalty there is an opportunity to appeal and have a settlement, making it a very reasonable enforcement mechanism, which would be a similar approach that would be followed when working with the health plans.

Amber Ott, CHA, noted that the current process OSHPD has with hospitals works very well for the CHA members. She also inquired when the hospital data submission program started at OSHPD, was there a tiered implementation process or tiered fines, where there could be some more leniency at the start while everyone became comfortable and aware of the process and requirements. Scott Christman noted when implementing SB 17, OSHPD was working with a brand-new audience – drug manufacturers, and in many instances when there was late reporting, OSHPD took that into consideration and provided opportunities for appeals and reduced fines. He noted that again it was a reasonable enforcement mechanism based on the sensitivity that this was a new program and that there would be a learning curve associated with full compliance.

Joan Allen, SEIU-UHW, noted that the plans will only have the data that they are receiving from the providers. She inquired if it was possible to create a regulatory framework that reaches past the plan to a non-compliant provider. Charles Bacchi noted that since plans will be mandatory submitters, they would need to

enforce provider compliance with their contracts, which will take time. Amber Ott also agreed with Charles Bacchi's comments and noted that there is also an incentive to provide the data to the plans in order to get paid. Charles Bacchi also noted that this concern does point to the need for flexibility to not immediately implement fines. Scott Christman commented that OSHPD has already begun building relationships with health plans, which is important in moving this work forward.

Ken Stuart, California Health Care Coalition, noted that when health plans negotiate with hospitals, there are financial considerations that go on to the health plans so there has to be some discretion as to imposition of fines, and a lot of it would go to the intent of the provider to remedy the situation. He noted that this will be an evolution as the program matures, which should be kept in mind when developing an enforcement program.

Anthony Wright, Health Access, inquired if OSHPD has an example of how they currently work with existing licensed entities. Scott Christman noted that OSHPD has not ever had to go down to the level of revoking hospital licensure with CDPH. The penalties are laid out in the Data Act, which is $100 per day for late reporting. In terms of OSHPD's experience, Starla Ledbetter noted that the current set up is that the penalties would expire after 60 days if the facility does not get the data in, although OSHPD does have close to 100% success rate in getting the data to come in. The process is set up so that the hospitals have time to work through the edits, there are extension days prior to the deadline, and usually the penalties are small, and the process allows for settlement discussions to reduce the penalty. Overall there is a lot of back and forth with the facilities to support them throughout the data submission process. Scott Christman noted that the penalties have been much higher for SB 17, as the penalty is $1000 per day, so there have been some penalties as high as $1 or $2 million because the reports were very late.

Bill Barcellona, America's Physician Groups, noted that generally providers submit more data than is used by the plans for reporting purposes, and he did not believe this will be an issue. He also noted that OSHPD does note have a history of levying fines.

Anthony Wright, Health Access, commented that he isn't entirely comfortable differentiating utilizing a regulatory structure when it involves patient care versus when it is regarding reporting, as this entire project deals with reporting and need an enforcement mechanism. He noted that he appreciates the spirit of finding an appropriate line with how to implement regulatory authority with the existing regulatory agencies.

Anne Eowan, ACLHIC, noted that in the other examples provided OSHPD is levying fines, versus other entities levying penalties. She inquired if the plan is to include this enforcement mechanism within regulations so that plans and insurers

are aware of what the penalty structure will be in advance. She also noted that it is important to include discretionary authority so that specific situations can be considered, such as PPOs that have no contract and no authority to mandate providers to submitting data. Scott Christman noted that the details would go into the rulemaking and the policies and procedures. He noted that broadly there would need to be a hook in the statute of where the authority to enforce comes from, and the recommendation as written places that authority as a part of existing regulatory frameworks, rather than building a new structure. Ultimately the details have to be worked out and documented with stakeholders.

Ken Stuart, California Health Care Coalition, noted that he agreed with Bill Barcellona that there is more information coming in on the 837 forms, and ultimately the health plan data will only be as good as what they receive. He noted that data will be coming in from various sources, so it should not be a huge issue, however he noted that it will be an evolutionary process and the health plans will need to update their contracts in order to support the providers in ensuring they submit the data in a timely manner.

Denise Love noted that this also gets at the art of public reporting. She noted that another objective of the regulatory capacity is to assure fairness and level playing field, so that all reporters are reporting to their best ability.

Public Comment:

Bernie Inskeep, United Healthcare, noted that there is always a regulatory capacity to leverage fines against payers with APCDs, and in other states it is very judiciously used and focuses on egregious noncompliance and when there is no intention to comply. She commented that when there are issues sometimes, but there is an opportunity to develop a workplan and the HPD can always be made whole. It may be at a point in time later than initially hoped for, but ultimately not submitting data does not harm a patient's health. She also noted that if a plan has leased networks the data will be sparse, which is not a data quality issue but rather a business issue.

Dolores Yanagihara, IHA, noted that under data submission requirements, the non-claims payment information, she recommended to make it more flexible to say "at least" annually, rather than just annual. She also noted its helpful to parse out the member specific data, like capitation from other kinds of non-claims-based payments. If there is no flexibility, the HPD might get locked into only receiving the data on an annual basis, and only being able to analyze it on an annual basis.

Data Access:

Amber Ott, CHA, inquired when the term "aggregate" will be defined. Scott Christman noted that it is defined by the CHHS data deidentification guidelines

that are applied to any aggregate publicly reported data, which OSHPD can share with the committee. Amber followed up with a second question inquiring what does potentially identifiable data mean. Jill Yegian noted that the term is intended to refer to the patient level and intended to refer to the data elements that could be used to identify a person, as opposed to the aggregated public reporting data.

Norm Thurston noted that this is a separate discussion, but it may be helpful to have a conversation about providers who are acting as individual providers who use Social Security Number.

Joan Allen, SEIU-UHW, inquired if deidentified would still identify the name of a hospital, or does the aggregated data mask the name of a hospital. Amber Ott noted that the group has tabled this discussion at past meetings, but it would be important to understand if the aggregate level data would show the cost of a knee replacement at Cedar Sinai or cost of a knee replacement in Los Angeles, which are two different consideration.

Cheryl Damberg, RAND, noted that when researches access the data, they want to know the name of the entity so they can link to other data, but they don't release the individual entity data. Amber Ott noted that her perspective is that from a public space, it should be aggregated geographically. Otherwise there is an ability to back into what health plans might be paying to specific hospitals, which is where the anti-trust and anti-competitive concerns arise.

Terry Hill, CMA, noted that the data release committee will have a robust discussion about what is released to a requestor, and what is made available publicly.

Joan Allen, SEIU-UHW, noted that from a use case standpoint there are some use cases where identified providers are necessary, but other times when that data would not be of value. She noted that OSHPD regularly releases data that includes a provider name, where it is not getting to the level of sensitive data but includes information that is of policy value.

Ken Stuart, California Health Care Coalition, noted that from a purchaser standpoint one of the most beneficial uses of this database is identifying which providers are rendering the most high-quality care with optimal outcomes. The data needs to be granular to that level to allow purchasers to steer their participants to providers that are going to give them the best outcome at the best cost. He noted that he understands the concerns about proprietary rates, however there is a public need-to-know regarding which provider are providing what services in what price range, so that purchasers can make informed decisions about how they structure their networks and plan design.

Emma Hoo, PBGH, noted that she agrees with Ken Stuart's comments, and

noted that it goes beyond a consumer need to know to a right know, with the growing out of pocket costs for health care. She also noted that there are commercial vendors that are putting out information that is not accurate, and there is a major public service that can be performed to ensure there is accurate data being put out in a consumer-friendly way.

Cheryl Damberg, RAND, noted that she would encourage, as a requirement for data access, for researchers to provide the end results of their studies to OSHPD. She also noted that generally researchers have an internal IRB that provides oversight, and OSHPD may want to consider end users use an IRB. Additionally, she commented that CMS includes a penalty for data breaches they feel could have been prevented, which would cut off an entire organization access to the data. She noted it could be helpful to see if there is a need for a similar type of enforcement requirement to ensure people comply with the data use agreement.

Anne Eowan, ACLHIC, noted that she would suggest including different kinds of health plans on the data release committee as they would have different expertise. For example, including different plans by market segment such as PPO, HMO and a Medicare only health plan. She also suggested having diversity across the different data submission groups.

Amber Ott, CHA, inquired what the process will be to delegate membership. Michael Valle noted that there are tradeoffs with how that occurs, one option is that the Advisory Committee could help determine the process.

Ken Stuart, California Health Care Coalition, inquired if the experts appointed to the Data Release Committee would have to go through the same financial disclosure requirements that the Review Committee members had to go through, as that may have a bearing in who decides to be on the Data Release Committee. Michael Valle noted that that is a tradeoff about having a public body such as the Review Committee under Bagley-Keene Act requirements and the advantages of having an OSHPD established committee that would not be subject to the same open meeting requirements. Jill Yegian also noted that it is important to note that part of the flexibility discussed today relates to how these groups are both authorized and convened. If any Advisory Committee is specified in statute it is automatically subject to Bagley Keene, as is any sub-committee of said committee. By contrast there is also the opportunity to create committees and workgroups that are not specified in statute, which are more flexible in their compositions are not subject to the same open meeting laws.

Charles Bacchi, CAHP, inquired if recommending the creation of a committee in the legislative report would automatically trigger it being put into legislation and subject to Bagley Keene, Public Records Act (PRA) and Conflict of Interest. Beth Herse noted that any group that is established pursuant to statue is subject to Bagley Keene. She also noted that OSHPD, at any time, can informally request a

group of people to come and provide feedback which would not be subject to Bagley Keene. She noted that everything is subject to the PRA and the only thing that is currently exempt from the PRA is patient data.

Emma Hoo, PBGH, noted that experts may have their own biases depending on their cliental or the products that they may represent, and similar to this forum it may be a better option to have experts as advisors as opposed to official committee members.

Bill Barcellona, America's Physician Group, noted that statutory requirements that trigger Bagley Keene and conflict of interest standards are separate issues. He also noted members of a data use committee should be subject to conflict of interest standards since the composition of the data use committee could influence the disclosure of sensitive information. Beth Herse added that conflict of interest requirements is defined by OSHPD code which must define what groups are reporters and non-reporters and it may be difficult to include conflict of interest decisions without the committee being officially defined in statute.

Joan Allen, SEIU-UHW, inquired if applications from data users would be subject to public records request, which was confirmed to be true. Joan Allen noted that she could see that being a sensitive issue from a trade secret issue or researchers, which she flagged as something that would need to be addressed.

Charles Bacchi, CAHP, suggested that the team come back to the Review Committee with a Data Release Committee recommendation. He also noted that it would be helpful to have more background information on Bagley Keene implications and public records act requests. And for the committee to be able to determine how public or not public that process should be.

Payment Data Release:

Ken Stuart, California Health Care Coalition, inquired what impact do high deductible plans have for distorting rates and how they impact the average prices. Jonathan Mathieu noted that the patient paid amount will be higher on a high deductible plan and this will impact the average prices. States have taken different approaches to parsing this out. For example, in Colorado fully insured commercial plans, self-funded commercial plans are broken out into separate buckets, and high deductible plans can be a separate bucket. He noted that this is one of the important methodological issues that will have to be discussed by the Advisory Committee down the road.

Cheryl Damberg, RAND, inquired when a median price is generated, is that on a deidentified basis or is that a median price for a hip replacement that X hospital is getting paid. Additionally, she inquired, if it is possible to also provide the range in addition to the median. Jonathan Mathieu noted that states have taken different approaches. Some states report median prices by geography within a state or by

county, such Colorado. States like Massachusetts and New Hampshire provide median or average payments by named hospital on publicly available websites. States through their Advisory Committees and Data Release Committees need to determine what they are comfortable with. He noted that early on being more cautious to ensure the data is complete and accurate and supports accurate measures is helpful.

Emma Hoo, PBGH, commented on the importance of having the variation information available from both a research perspective and utility of consumers and purchasers. She also noted that one of the key issues to consider is the geographic definition given the spread and density that California has in certain communities, that may not be physically very large but have sufficient density. Lastly, she added that a challenge of having the median price is that in some counties you may have one carrier with 80% of the market share, or in some areas only having 2 carriers, which is then not reflecting much of a mix and would not be particularly deidentified.

Bill Barcellona, America's Physician Groups, noted that in the Colorado database not only is the median published but the entire range for prices is published but deidentified. Jonathan Mathieu noted that it depends on the report. In some cases, there is a minimum and maximum value reported other times they report by the 25th and 75th percentile, which is generally a more meaningful measure. However, something that is intended for broad consumer usage should not be too dense, but generally giving some sense of the range in addition to the median is customary.

Terry Hill, CMA, noted that it is important to maintain flexibility, and allow the Advisory Committee to establish guidance and priorities on this project. The details that have just been discussed will be key topics Data Release Committee. He noted that it will be difficult to foresee all of the issues that may come up, and the power to determine what makes sense needs to be in the hands of the committees not in the in statue or regulation.

Consumer Facing Product:

Cheryl Damberg, RAND, noted that she understands that the current reality is not having a consumer facing website, however she encouraged OSHPD to remain open to making this type of information available to consumers in the future. Scott Christman agreed, and he also commented on the positive relationship OSHPD has with the Office of the Patient Advocate (OPA) which is a great source for consumer facing data. He noted that OSHPD looks forward toward more work with OPA in that realm.

Cheryl Damberg also noted that there will need to be different ways in which end users can access the data. She noted data enclaves can work for more limited types of analyses, however when a researcher wants to look at data

longitudinally or across different APCDs, they may require the ability to pull out information out of the enclave. She also noted that that when considering a research enclave there needs to be thought given to computing capacity, as it is possible to run out of space. Scott Christman noted that OSHPD will set an informational interview with the RAND team to learn more from their experience working with research enclaves. He also noted that in addition to the OSHPD market research, CHHS is currently in the process of building an Agency wide research enclave that would be expected to expand to researchers down the road. OSHPD will continue to learn and bring those learnings to the Advisory Committee to see how to best address the different use cases that may come up.

Recommendations

Recommendation 1 as presented to the committee:

Entity to Operate the Healthcare Payments Database: The Review Committee recommends that OSHPD should operate the Healthcare Payments Database.

Charles Bacchi, CAHP made a motion to move the recommendation as written.

Cheryl Damberg, RAND, seconded Charles Bacchi's motion.

There was no public comment

No discussion

The committee voted to approve the recommendation as written 10-0.

Recommendation 2 as presented to the committee

Healthcare Data Policy Advisory Committee: The Review Committee recommends that OSHPD should be authorized to convene a Healthcare Data Policy Advisory Committee of stakeholders with expertise to provide guidance on the Healthcare Payments Data Program. Over time, OSHPD may expand the scope of the Advisory Committee to obtain guidance on other data assets in the OSHPD portfolio.

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

Terry Hill, CMA seconded Bill Barcellona's motion.

No public comment

Charles Bacchi, CAHP, noted that this Advisory Committee would be written into

statute and would therefore be subject to Bagley-Keene and subject to the PRA unless exempted. He noted that he is fine with this just wanted to ensure everyone on the committee was aware as well.

Joan Allen, SEIU-UHW, inquired if the term of OSHPD being "authorized" to convene the Advisory Committee is strong enough, and if it should instead say "required to." Beth Herse noted that in order to convene a committee there needs to be a statutory authorization which is why "authorized" was used.

Emma Hoo, PBGH, suggested instead of saying "experts and stakeholders" she would recommend rewording to say, "stakeholders with expertise."

Terry Hill, CMA, noted that amendment does raise a question of the level of expertise, however he noted that he is comfortable with the amendment as long as there is discretion given to OSHPD to select the level of expertise appropriate for the committee.

The committee voted to approve the recommendation as amended 10-0

Final Recommendation approved by the committee:

Healthcare Data Policy Advisory Committee: The Review Committee recommends that OSHPD should be authorized to convene a Healthcare Data Policy Advisory Committee of ~~experts and~~ stakeholders with expertise to provide guidance on the Healthcare Payments Data Program. Over time, OSHPD may expand the scope of the Advisory Committee to obtain guidance on other data assets in the OSHPD portfolio.

Recommendation 3 as presented to the committee:

Committees to Support Effective Governance: The Review Committee recommends that OSHPD should create other committees or workgroups to support effective governance as needed, at the discretion of the Director, either as standing bodies or as time-limited ad hoc workgroups.

Charles Bacchi, CAHP made a motion to move the recommendation as written.

Joan Allen, SEIU-UHW, seconded Charles Bacchi's motion.

Anne Eowan, ACLHIC, inquired if adding language that says that OSHPD is strongly encouraged to create a data release committee would subject the Data Release Committee to Bagley Keene. It was confirmed that if it is in statute the committee would be subject to Bagley Keene. If the committee recommends to OSHPD to convene a Data Release Committee voluntarily then it does not end up in statute and will not be subject to Bagley Keene. It was also noted that not every single recommendation will go into statute necessarily, some will be in

regulations, or implemented as a part of the program development. The group was also reminded that it was decided earlier that the Review Committee will talk at more length at the next meeting to determine whether or not the Data Release Committee should be in statute or not.

Bobbie Wunsch noted that the group could add language to this recommendation as suggested by Anne Eowan, or the group could wait to have the more in-depth discussion at the next meeting, and possibly revise the recommendation down the road. It was confirmed that procedurally if this current recommendation is adopted as written, the committee will have an opportunity at a later date to revise the recommendation if necessary.

The committee voted to approve the recommendation as written 10-0.

Recommendation 4 as presented to the committee:

Leverage Regulatory Structures for Enforcement: The Review Committee recommends that OSHPD existing regulatory structures should be leveraged to enforce data submission requirements. Statutory authority should be provided to establish specific processes.

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

Anthony Wright, Health Access, seconded Bill Barcellona's motion.

Charles Bacchi, CAHP, noted that he had two issues. One with the word "enforce" and the other with "data submission requirements." He noted that as written the recommendation does not capture the earlier conversation the committee had about their being a process around enforcement rather than just fines being levied.

Anne Eowan, ACLHIC, suggested saying the Review Committee recommends that OSHPD establish processes to enforce data submission requirements utilizing existing regulatory structures. Anne noted that she wanted to capture that this level of enforcement would be a different standard then claims violations that would have different penalties.

Beth Herse noted that as a state agency unless we have some authority in statute to call upon another agency to do the enforcement, we cannot do so. There has to be authority for both agencies to implement the enforcement process.

Ken Stuart, California Health Care Coalition, inquired if the concern was regarding there being an enforcement mechanism or about the fines.

Anne Eowan, ACLHIC, explained that the conversation that was had earlier went through a whole process that is not captured in the recommendation. Scott Christman noted that what the recommendation is trying to describe is the relationship between OSHPD and the submitters.

Ken Stuart, California Health Care Coalition, inquired how much in fines has been levied by the state of Colorado for their APCD enforcement. Jonathan Mathieu noted that in Colorado there are dollar amounts defined in legislation and rules, however CIVIHC has not ever levied penalties.

Terry Hill, CMA, inquired if adding "should that level of escalation be required" at the end of the first sentence, to recognize the previous conversation that was had.

Charles Bacchi, CAHP, suggested saying "the Review Committee recommends that OSHPD establish a process for data submission, leveraging existing regulatory structures…" and deleting "existing regulatory structures should be leveraged to enforce data submission requirements."

Anthony Wright, Health Access, inquired what was different about the proposed rewrite than what was originally provided. Charles Bacchi responded that the original recommendation read as OSHPD being empowered to leverage existing regulatory structures which concerned him that it could be interpreted, either by the regulator or future OSHPD leadership, as 100% compliance with the data submission requirement, and if a health plan does not meet 100% compliance there is a penalty. By rewording this recommendation to focus on the process for the enforcement of data submission, it gets to the same place, without creating an opportunity for an attorney at a department to incorrectly interpret. Scott Christman noted that the processes that OSHPD established would include, for example, a letter that could be sent out, before turning to the regulators. Anthony Wright noted that he will go along with the amendment but noted that the second sentence is very important because DMHC and CDI will need statutory authority to implement OSHPD's enforcement, which needs to be very clear.

Cheryl Damberg, RAND, noted that she was with Anthony Wright in not fully understanding what the difference was between the prior version of the recommendation and the amended version. She wanted to confirm that the second sentence regarding the statutory authority will map out how the enforcement would occur. Charles Bacchi noted that he is not trying to avoid the enforcement, but just to clarify that there will be a process that is developed.

The committee voted to approve the recommendation as amended 10-0

Final Recommendation approved by the committee:

The Review Committee recommends that OSHPD establish processes for the

enforcement of data submission, leveraging existing regulatory structures. ~~existing regulatory structures should be leveraged to enforce data submission requirements.~~ Statutory authority should be provided to establish specific processes.

Recommendation 5 as presented to the committee:

The Review Committee recommends that OSHPD should have statutory authority to implement a comprehensive program for data use, access, and release. This program will emphasize both the creation of publicly available information and controlling secure access to confidential information. The HPD should be exempt from the disclosure requirements of the Public Records Act.

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

Joan Allen, SEIU-UHW, seconded Bill Barcellona's motion.

Public Comment

Cathy Donnason formerly chief of the health plan administration division at CalPERS, noted that it is not possible to totally exempt the HPD from the PRA. There is information that will need to be disclosed unless it violates the evidence code or HIPPA.

Beth Herse noted that the issue brought up in the public comment could be related to the way that it is worded, but in general it is true that without the exemption there is much information that would be subject to PRA disclosure. However, if there is a statutory exemption from the PRA, then it does not apply. One of the concerns might have been about the extent of the exemption. Beth noted that a program is not exempt from the PRA, but the wording of HPD is intended to imply that just the data in the database would be exempt, not the entire program.

Anthony Wright, Health Access, suggested a clarifying amendment to say "the data in the HPD should be exempt…" instead of the "the HPD should be exempt…" Beth Herse noted that the difficulty with trying to craft such precise wording in this context is that by identifying the "data" specifically being exempted, there are a number of questions that come up such as – is the data exempt in transit, or only when its collected etc. She noted that the intent is to exempt the database rather than the program or OSHPD itself.

Ken Stuart, California Health Care Coalition, inquired if it would be helpful to add to the end of the sentence "to the extent permitted by law." Beth Herse clarified that the only way we can do this is to create a law that permits the exemption, this is not allowed in law as currently written.

Anthony Wright, Health Access, noted that he does not think the intent is to exempt the program, the processes, the deliberations around the database from the PRA, therefore the recommendation should make that distinction. He noted that it is important to be narrower and more specific when it comes to an exemption from the PRA, as it is an important element of democratic structure.

Bill Barcellona, APG, noted that the policy that is stated here is clear, and it will be the job of the legislative counsel to come up with language in the statute that meets the intent. If it does not stakeholders will be able to clarify it during the legislative process.

Beth Herse noted that the recommendation can say "the intent of the committee is that the contents of the database be exempt from PRA."

Terry Hill, CMA, suggested instead of HPD to spell out "healthcare payments database", which would clarify that it is not the program that is exempt but the database itself.

Charles Bacchi, CAHP, agreed with Terry Hill's suggestion to replace HPD with healthcare payments database.

Joan Allen, SEIU-UHW, noted that the word "controlling" sets up a very restrictive dynamic, would propose changing controlling to "ensuring appropriate secure access."

Charles Bacchi, CAHP, inquired if with this amendment it could be read that everyone would have access to confidential information. Joan Allen also suggested adding the word "only" in front of appropriate to address that issue.

The committee voted to approve the recommendation as amended 10-0

Final Recommendation approved by the committee:

The Review Committee recommends that OSHPD should have statutory authority to implement a comprehensive program for data use, access, and release. This program will emphasize both the creation of publicly available information and ~~controlling~~ ensuring only appropriate, secure access to confidential information. The ~~HPD~~ healthcare payments database should be exempt from the disclosure requirements of the Public Records Act.

Bobbie Wunsch summarized the points that will need to be discussed during the Data Release Committee discussion at the January Meeting:

- Advantages and disadvantages of it being in statute
- Relationship of being in statue and conflict of interest
- Whether data requests are subject to PRA

- Are the decisions of the data release committee subject to the PRA
- Issue around space constrictions of research enclave
- Making public any reports that users generate
- Protecting researcher's proprietary information

Public Comment

There was no public comment at this time.

Agenda for Upcoming Review Committee Meeting & Adjournment

Ken Stuart thanked the committee and OSHPD Staff. She commented that the upcoming meeting in December will be focused on governance.