Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Review Committee Meeting

August 15, 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); EAmber 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); 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: Cheryl Damberg, RAND Corporation.

Presenters: Scott Christman, Chief Information Officer, OSHPD; Jill Yegian, Consultant, OSHPD; Linda Green, Vice President – Programs, Freedman HealthCare; Anthony Tapney, Manager, OSHPD; Jonathan Mathieu, Senior Health Care Data/Policy Consultant, 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.

Public Attendance: 18 members of the public attended.

Agenda Item	Meeting Minutes

Welcome & Meeting Minutes	The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions.
	
	The July 18 Review Committee meeting minutes were approved, with some minor edits summarized below:
	
	• *Ken Stuart, California Health Care Coalition,* noted that on page 6 the word "is" should be removed and on page 12 to add "this" before "motion".
	  ○ *Ken Stuart, California Health Care Coalition, noted that with the proposed legislative changes that VEBA ~~is~~ 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.*
	  ○ *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.*
	
	• *Terry Hill, CMA,* commented that in his comment on page 6 regarding long term care

	insurance, the insurance context got lost. He suggested replacing the word "this" with Long Term Care Insurance and out of pocket costs. ○ *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 Long Term Care insurance and out of pocket cost ~~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* • *Amber Ott, CHA*, noted that on page 12 there was an "and" missing between Federal and California ○ *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….* *Bill Barcellona, America's Physician Group,* made a motion to accept the minutes as amended. *Terry Hill, CMA,* seconded Bill Barcellona's motion. The minutes were approved 10-0. *Ken Stuart, California Health Care Coalition,* also mentioned to the Committee that there is a federal bill that is being worked on that could reverse the Gobeille decision. He inquired with the committee if there is a change on the federal level, does it become reasonable to assume that ERISA payers would become mandatory. *Charles Bacchi, CAHP,* noted that it is a relevant topic to discuss as a committee and that it will depend on the terms of the bill. *Ken Stuart, California Health Care Coalition,* also commented that the recommendation the Review Committee approved in July regarding mandatory submitters, included a note that mandatory submitters will be defined in compliance with both federal and state laws. Bobbie Wunsch went over the ground rules for the meeting.
Deputy Director's Report	Scott Christman discussed the issue of Third-Party Administrators (TPAs) that was brought up at the July Review Committee meeting. He noted that the team has compiled some additional information regarding TPAs available at the end of the deck. Slides 72-77 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Reivew-Committee-Master-PowerPoint_08.15.2019.pdf) He also commented that the team is still continuing to gather information, including through meetings with both the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI). At present, the sense is that Recommendation 1, regarding mandatory submitters, reflects best thinking. The team will return to the Review Committee for reconsideration if the process of gathering additional information results in any substantive shifts in thinking. Lastly, he added that OSHPD is committed to providing relevant information in a timely manner to Review Committee members to ensure they are fully prepared to discuss all topics that are being considered.

	Scott Christman also noted proposed changes to the Review Committee schedule which include: • Extending the schedule out by two meetings and adding a January and February meeting. • Making November an "overflow month" in order to finish any topics left over from prior months as well as providing an opportunity to address any topics that have not fit into the schedule thus far, such as, Risk Bearing Organizations (RBOs), Ambulatory Surgery Centers (ASCs) and uninsured. • Shift the Governance topic to December and Sustainability to January. *Charles Bacchi, CAHP,* inquired when the report is due, and Scott Christman confirmed it is due July 2020. *Ken Stuart, California Health Care Coalition,* inquired what the report review process entails. Scott Christman noted that there is first an internal review through directorate at OSHPD. Once approved at OSHPD it is sent to the California Health and Human Services Agency, which also has several steps of approval, prior to sending it to the Governor's Office for review. The Governor's Office would represent the report to the legislature for delivery. Scott Christman also provided an overview of what was discussed at the July Technical Workgroup. He also mentioned that in the upcoming Technical Workgroup meeting for August, the workgroup will be doing an analysis of the APCD-CDL™ Medical Claims File. For a full summary of the July Technical Workgroup please see: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/HPD-Technical-Workgroup-7.18.2019-Summary-Final.pdf *MJ Diaz, Health Access,* commented that Health Access has a concern that race, and ethnicity data was identified as a data element that might not be collected and submitted to the HPD by all plans. She noted that Health Access' understanding is that plans have been required to collect race/ethnicity data, therefore it should be included in the HPD. She commented that race and ethnicity data is important to collect for improvements in health quality and reduction of disparities. She also mentioned that it is important to keep in mind the difference between language access data and race and ethnicity data. *Anne Eowan, ACLHIC,* responded that based on regulations, health insurers are not allowed to ask for race and ethnicity information. She noted that the language access requirement is different, as it is a survey to see what languages need to be supported by health insurers. She commented that health insurers are not allowed to ask for information on race and ethnicity as it is prohibited to discriminate on the basis of race. *Ken Stuart, California Health Care Coalition*, inquired if information regarding race/ethnicity is part of the 837 files that a service provider would be submitting. Anne Eowan noted that she is not sure about that but in terms of the data that insurers have this information is not on the claims form nor on the enrollment form. *Denise Love, NAHDO,* mentioned that the 837 does have an Office of Management and Budget (OMB) standard for collecting race and ethnicity, as does the 834 (enrollment). Anne Eowan noted that she is happy to share what insurers are allowed to collect based on regulations.

	Scott Christman also commented that the program will be in regular communication with submitters to ensure that OSHPD understands what the capacities of the submitters are in terms of the data that they are allowed to collect. Anne Eowan agreed that will be important and commented that it isn't that health insurers don't want to collect this data, but they are not legally allowed to collect it as it is considered a discriminatory practice. *Emma Hoo, PBGH,* noted that employers collect race and ethnicity data for Equal Employment Opportunity Commission (EEOC), but that data typically resides on the payroll side and not on the benefit side, and is not provided to the insurance carriers. *Joan Allen, SEIU-UHW,* noted that she appreciates the flag as a current barrier, but commented that the Review Committee could make recommendations to the legislature to support improvements to data access. *Anne Eowan, ACLHIC,* noted that there might be some statutory limitations, and that the discussion around privacy might be a good time to look into what is possible. Public Comment *Bernie Inskeep, United Health Care Group*, noted that the Federal Title 7 Anti-Discrimination Law prohibits providing incentives or penalizations to get the data on race, ethnicity, and language. She noted that health plans are happy to report the data they voluntarily receive, but not any more or less.
Continuation of July 18 Agenda Topic: Mandatory Data Submitters	Jill Yegian and Linda Green continued planned presentations on the thresholds, frequency and population for data submissions. For the full presentation please see slides 8-36 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Reivew-Committee-Master-PowerPoint_08.15.2019.pdf) The committee was reminded that recommendations 1, 2a, 2b, and 2c were approved in July, listed below for reference: 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 federal and existing 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 2. 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: **a. 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 2. 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: **b. Coordination of submission:** The mandatory submitters are responsible for submitting

	complete and accurate data 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. 2. 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: **c. 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 The committee still had to finish presentations and discussion on recommendations 2d, 3a, 3b, and 4 regarding thresholds, frequency, populations and voluntary submitters. *Amber Ott, CHA,* inquired if the "no threshold" for Medi-Cal data includes both Fee for Service (FFS) and Managed Care, which was confirmed to be true. She followed up with a second question inquiring if the data from the Qualified Health Plans (QHPs) would come from Covered California or from the plans, which the team confirmed the initial thinking was that the data would come from the plans to the HPD. *Charles Bacchi, CAHP,* inquired if the Medicare Advantage includes the dual eligible population. Jill Yegian noted that the enrollment data presented is from the California Health Care Foundation document and does not provide that level of detail, but that the team can provide an update into the duals break down. *Anne Eowan, ACLHIC,* noted that the data must come from the data owners, which can be subsidiaries to a parent plan. Because of HIPAA and other considerations this data is sometimes not submitted to the parent plan, therefore small subsidiaries that are below 1000 covered lives could be required to submit to the HPD if the parent plan is above the designated threshold. She noted that this would be very burdensome for these small subsidiary plans and asked if OSHPD was considering an exception process for these small organizations. Jill Yegian commented that the exceptions process will be a part of the onboarding conversation with each plan. She also noted if this is something that needs to be in a recommendation that can be added, or this could be developed down the road as part of the implementation. Jill Yegian also mentioned that there is sometimes a delicate balance between what actually has to be as a part of a recommendation versus what will be a part of an adopted process. Anne Eowan followed up that she is concerned about being too specific in a recommendation that ties OSHPDs hands, and she recognizes that there will be adjustments that will happen and that there is an understanding that there will be exceptions to reduce undue burden. *Ken Stuart, California Health Care Coalition,* inquired if there is any statistical significance to the difference between capturing 97.5% of all covered lives at a threshold of 50,000 to capturing 99.5% of covered lives with a threshold at 25,000, adding that he feels that the HPD would be no less actionable at 97% then at 99%. Jill Yegian noted that there was not a statistical analysis completed, however she does agree that the small percentage difference between 97% and 99% would not make the HPD any less actionable. Emma Hoo also followed up that the issue is regarding regional plans. Ken Stuart agreed that we should make

sure we do not leave out any geographic areas just because they are small, however the 50,000 threshold seems to cover the majority without putting a huge impact on smaller submitters. Jill Yegian agreed and noted this is a tough tradeoff and the committee was given the full list of carriers so that they can make that determination for themselves. She also noted that many of the significant regional players fall above the 50,000 covered lives threshold, except for some Medi-Cal plans.

Terry Hill, CMA, commented that he believes that CMS exempts PACE programs from some of their requirements of reporting Medicare Advantage. He inquired if the team has contemplated including PACE as it is an important consideration. Jill Yegian commented that PACE is important and that this line of research fits in well with Charles Bacchi's point on duals made earlier today.

Discussion of Recommendation 2d

Recommendation as presented to the Review Committee:
2. 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:
d. Plan Size:

1. Exemption for plans below a threshold to be defined, between 10,000 and 50,000 covered lives for:
    a. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
    b. Dental
2. Given that DHCS will be submitting Medi-Cal data, there is no plan size threshold for Medi-Cal.
3. All Qualified Health Plans (plans participating in Covered California) are required to submit.

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

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

There was no public comment on this recommendation.

Charles Bacchi, CAHP, commented on his knowledge regarding a few specific plans that are between the 10, 000 and 50,000 thresholds:

- SIMSA which has 44,000 covered lives is a cross boarder plan for Mexican nationals and does not necessarily sell coverage to US providers with a few contracted exceptions for Emergency Services.
- CCI, CalOptima, IEHP all could be partial duals
- Valley Health Plan is part of the Exchange
- Ventura Health Plan is for In-Home Supportive Services workers under a small program with one dedicated staff member
- Oscar which has 10,000 covered lives is only in Covered CA and has a very light administrative presence in California.
- LA Care is also only Covered CA lives
- IEHP - he noted his surprise that they have commercial lives.

Charles Bacchi commented that for some of these plans putting a mandatory submission

	guideline on them would be a hardship due to administrative burden. He commented that he is leaning towards less specificity when it comes to assigning recommendations and to instead give OSHPD the authority to do what makes sense. He also mentioned that there could be a more tiered approach where OSHPD first focuses on the larger plans, and then moves to collecting from smaller plans down the road. Charles Bacchi also noted that in order to participate in the exchange, plans have to meet a number of individual steps and the cost is prohibitive. Adding an additional requirement to also become a mandatory submitter to the HPD, could make it harder for plans to want to participate in Covered CA, which goes against the greater public policy goals of expanding access and choice of care. He also noted that there is both pending legislation (Assembly Bill 929) to assess what authority about Covered California has in collecting data from their plans, as well as a regulatory process for Attachment 7, which places massive burden on plans to report data and quality information to Covered California. Once Attachment 7 is complete data will flow from all QHPs to Covered California and the HPD could look to Covered California to provide the QHP data through an Interagency Agreement. *Amber Ott, CHA*, recommended that for the Medi-Cal threshold it would be helpful to specify that it includes both Managed Care and Fee for Service in order to prevent ambiguity down the road. *Emma Hoo, PBGH*, noted that she agrees with Charles Bacchi's earlier comment about maintaining flexibility. She noted that there are broad assumptions being made about what threshold means, noting for example that a 10,000 covered lives Medicare Advantage plan would have a higher claims volume than Oscar, which also has 10,000 covered lives. She noted that it would be helpful to have some determination of claims dollar or claims volume, by per member per month, so that high volume claims plans can be included without necessarily creating huge burdens for all small plans. She also noted that in regard to the Medicare Advantage data that is sent to CMS being in a non-CDL format, CMS has a standard data format therefore it would be a one-time mapping exercise to match to the APCD-CDL™ format. This process would not increase burden for the smaller Medicare Advantage plans, and it would still capture the data. *Anne Eowan, ACLHIC,* commented that she too agrees with the thought of more flexibility, and giving OSHPD broad authority to develop thresholds as statistically relevant without undue burden. She noted that she would like to make this recommendation even broader. *Ken Stuart, California Health Care Coalition,* offered the addition of the phrase "a threshold to be defined and overseen by OSHPD for flexibility." Anne Eowan agreed that would be a helpful amendment however, she noted that item 3 in the recommendation regarding QHPs, should also be more flexible and not as prescriptive. Ken Stuart inquired if this would be different if Covered California were remitting the data. Charles Bacchi reminded the committee that Covered California might not be able to submit this data in day 1, which will need to be considered. Anne Eowan noted that as written she would not support part 3. *MJ Diaz, Health Access,* noted that Health Access would support the recommendation as is written. She noted that Health Access is comfortable with the given range. In regard to item 3 regarding QHPs, Health Access supports the current wording as Covered California is not yet able to access the data required by Attachment 7 on cost, quality and health disparities. She noted that currently the QHPs do not submit enough data to Covered California and Health Access is sponsoring legislation to increase that data feed. She also commented that Health Access and their consumer advocate partners, strongly support all QHP data being brought

	into the HPD but are flexible on whether that data come directly from the QHPs or from Covered California. *Ken Stuart, California Health Care Coalition,* suggested that to item 3 there could be language added to communicate that the data will come either directly from the QHPs to the HPD or indirectly through Covered CA. Suggested Edit: add to the end of item 3 "either directly or through Covered California." *Charles Bacchi, CAHP,* noted that he feels that this amendment gets the committee closer to a point where QHPs would not suffer undue burden and could allow for Covered California to submit the data, if the QHPs will be submitting data to Covered California. Summary of Edits: • On number 1 add "a threshold to be defined and overseen by OSHPD for flexibility" • On number 2 add Fee for Service and Managed Care after Medi-Cal • On number 3 after the word submit: "either directly or through Covered California" *Joan Allen, SEIU-UHW,* expressed her concern about a framing that puts too much emphasis on relieving burden. *Charles Bacchi, CAHP,* noted the importance of the cost benefit analysis that would need to be done by OSHPD and he suggested amending part one to read "Exemption for plans below a threshold to be defined by OSHPD for flexibility with consideration given to cost and value of submitted data." *Joan Allen, SEIU-UHW,* agreed that gets much closer to recognizing the cost benefit analysis and not just framing this as relieving burden. *Anne Eowan, ACLHIC,* noted that the phrase she had in mind to suggest at the end of the first part of the recommendation was "OSHPD retains the flexibility to make exceptions for submitters or data owners based on undue burden or lack of data significance." Scott Christman noted that OSHPD looks at this through the lens of feasibility. He commented that the reality of implementing a program, in the first year of implementation OSHPD will be more focused on getting the very large payers. As OSHPD goes down the path there would be feasibility analyses to determine which additional payers should be included based on a cost benefit analysis. *Emma Hoo, PBGH,* suggested to add the word feasibility instead of flexibility in front of "cost" so it would read "Exemption for plans below a threshold to be defined by OSHPD for ~~flexibility~~ feasibility, cost and value." Bobbie Wunsch provided a summary of the edit: • Exemption for plans below a threshold to be defined by OSHPD with consideration given to feasibility, cost and value of data procurement. *John Kabateck, NFIB*, inquired where the range would be inserted in this sentence. Bobbie Wunsch commented that the range would stay and part 1 of the recommendation would read:

	"Exemption for plans below a threshold to be defined, between 10,000 and 50,000 covered lives, AND OVERSEEN BY OSHPD WITH CONSIDERATION GIVEN TO FEASIBLITY, COST, AND VALUE OF DATA PROCUREMENT *Terry Hill, CMA,* inquired if it still made sense to keep the range of 10,000-50,000 covered lives. Charles Bacchi noted that as he reads the recommendation it may seem that the exemption is for plans between 10 and 50 thousand covered lives, and that all plans below 10, 000 would be required to submit. Joan Allen suggested making the "between 10,000 and 50,000 covered lives" a parenthetical. *Ken Stuart, California Health Care Coalition*, suggested to re-word the recommendation to say, "less than 50,000 covered lives." *MJ Diaz, Health Access,* noted that she was ok if the recommendation just said a threshold below 50,000 covered lives. *Joan Allen, SEIU-UHW,* expressed her concern with "below 50, 0000" reminding the committee that las month they discussed lowering the threshold which is why the 10,000 covered lives was added. *Charles Bacchi, CAHP*, agreed with Joan Allen that this was a concern brought up at the last meeting, as Health Access had suggested that a threshold of "below 50,000" would exclude certain populations that Health Access felt were important to include. He asked MJ Diaz if giving OSHPD criteria with which to go below 50,000 covered lives if appropriate, would be ok? MJ Diaz commented that it is fine to remove the 10,000 covered lives and to say, "less than 50,000." *Joan Allen, SEIU-UHW*, noted that "below 50,000" sounds like a floor not a ceiling, and if the committee is signaling that we are OK with 50,000 covered lives, it needs to be clear that 50,000 is the high end not the low end. *Amber Ott, CHA,* commented that if the concern is that 50,000 is the floor not the ceiling, she suggested changing the wording to say "not to exceed 50,000 covered lives" to illustrate its intended to be a ceiling. Joan Allen agreed that would be helpful *Charles Bacchi, CAHP,* commented that on the third part of this recommendation, regarding QHPs, there should be some language that would communicate that there will be a conversation between OSHPD and Covered California. Suggested Edit: "With consultation between OSHPD and Covered CA, all…" *Charles Bacchi, CAHP,* commented that he feels the committee had a good conversation regarding these recommendations, however he is still struggling about the QHP requirement, noting that he wants to make sure that there is not a burden on the small QHPs. *Dolores Yanagihara, IHA,* commented that several of the smaller plans that have been discussed today have approached IHA to submit data to its multi-payer claims database. The committee voted 10-0 to approve the recommendation as amended. Final Recommendation as Approved by Review Committee:

2. 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:

d. Plan Size:

1. Exemption for plans below a threshold NOT TO EXCEED ~~to be defined, between 10,000 and~~ 50,000 covered lives TO BE DEFINED AND OVERSEEN BY OSHPD WITH CONSIDERATION GIVEN TO FEASIBLITY, COST, AND VALUE OF DATA PROCUREMENT for:
    a. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
    b. Dental
2. Given that DHCS will be submitting Medi-Cal data, there is no plan size threshold for Medi-Cal FEE FOR SERVICES OR MANAGED CARE.
3. WITH CONSULTATION BETWEEN OSHPD AND COVERED CALIFORNIA all Qualified Health Plans (plans participating in Covered California) are required to submit EITHER DIRECTLY OR THROUGH COVERED CALIFORNIA.

Discussion of Recommendation 3a

Recommendation as presented to Review Committee:

3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows:

a. Frequency:

- monthly for all core data (claims, encounters, eligibility, and provider files)
- annually for non-claims-payments data files

Anne Eowan, ACLHIC, made a motion to move this recommendation as written with the understanding that comment on flexibility for smaller entities is understood.

MJ Diaz, Health Access, seconded Anne Eowan's recommendation.

There was no public comment on this recommendation.

Charles Bacchi, CAHP, noted that he wanted to follow up on Anne Eowan's comment noting that if bullet point one is written in statute it precludes the ability to add flexibility. He suggested putting in a finer point to communicate that there will be exceptions, because if there is no mention of exceptions in discussion the legislature will do what it will do.

Anne Eowan, ACLHIC, noted that whatever is submitted to the legislature needs to contain a caveat that provides flexibility to what makes sense to do.

Bill Barcellona, America's Physician Group, noted that if the plans have to submit encounters on a monthly basis and the RBOs are submitting their data up to the plans, that process takes more than 30 days. He inquired what will happen when those encounters are revised down the road. Anne Eowan responded that her understanding is that a complete claim would be submitted and have had all the concerns resolved. Emma Hoo reminded the committee that Denise Love had talked about change files when claims get adjusted. Charles Bacchi commented that Bill Barcellona's point is important because there is a distinction between the data that is received that month to the plans and the data received to OSHPD. He noted that

	the way he was looking at frequency was that once the plans meet their data submission standards that data would flow on a monthly basis to OSHPD. Bill Barcellona noted that this will most likely be a topic of discussion at the Technical Workgroup. Scott Christman noted currently OSHPD collects data quarterly. OSHPD is proposing monthly for this data collection due to the volume expected, however he noted that OSHPD also appreciates the flexibility as well. Linda Green noted that data submitters would submit adjudicated claims and the responsibility of the data management vendor is to clean the data. *Emma Hoo, PBGH,* asked if "capitation," typically monthly data as part of eligibility compared to shared risk which is annual, is included in "core data". Jill Yegian noted that the current thinking is that capitation is considered an alternative payment and it does not come in through the claims and encounters. Jill Yegian did note that the encounters are separate from the capitation payments. Emma Hoo followed up noting that for some plans, like Kaiser, capitation is tied to eligibility and getting the capitation payments on a monthly basis would be very helpful. Jill Yegian agreed that it would be great to get a monthly capitation feed, but noted it may not be feasible *John Kabateck, NFIB,* inquired if there are any other states that have more frequent than annual APM data submission. The team confirmed that there are none that do. The committee voted 10-0 to approve the recommendation as written. <u>Recommendation as approved by Review Committee:</u> 3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows: a. Frequency: • monthly for all core data (claims, encounters, eligibility, and provider files) • annually for non-claims-payments data files <u>Discussion on recommendation 3b</u> Recommendation as presented to the Review Committee: 3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows: b. **<u>Population</u>:** residents of California *Bill Barcellona, America's Physician Group,* made a motion to move this recommendation as written. *Anne Eowan, ACLHIC,* seconded Bill Barcellona's recommendation. There was no public comment. *Charles Bacchi, CAHP,* noted that there might be some noise when plans submit data for their population. Plans will do the best that they can to determine who the residents of CA are, but if a member lives on the east shore of Tahoe, for example but everything else is in CA

	there might be some noise in the data. The committee voted 10-0 to approve the recommendation as written. Recommendation as approved by Review Committee: 3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows: b. **Population:** residents of California
Voluntary Submitters	Jill Yegian and Linda Green led a presentation on the national experience and a discussion and vote on recommendations for California on approaches for encouraging voluntary submissions. To see the full presentation see slides 32-36 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Reivew-Committee-Master-PowerPoint_08.15.2019.pdf) Discussion of Recommendation 4: Recommendation as presented to Review Committee: 4. The Review Committee recommends that: • HPD should be statutorily authorized to receive data from voluntary submitters. • HPD shall develop an appropriate process to encourage voluntary data submission. *Bill Barcellona, America's Physician Group,* made a motion to move the recommendation as written. *Terry Hill, CMA,* seconded Bill Barcellona's motion. There was no public comment *Ken Stuart, California Health Care Coalition,* proposed adding a clause that suggests that upon any changes that happen at the Federal level that would no longer prohibit collecting this data from non-public ERISA self-insured plans, these entities would become subject to the mandatory submitter's requirement. *Anne Eowan, ACLHIC,* inquired if the TPA would be submitting or the employer. Ken Stuart clarified that the plan would be subject to submission whoever their payer might be. Ken Stuart's proposed amendment: "Upon the elimination of ERISA preemption for self-funded plans they will become subject to mandatory submission of data." *Anne Eowan, ACLHIC*, noted that the state could pass the law, but that won't change anything, since this is a federal issue. She noted that it could be helpful to say upon action by Federal government or the courts. *Charles Bacchi, CAHP,* noted that it feels a little awkward to add mandatory requirements to a recommendation regarding voluntary submitters. He suggested adding some sort of preamble

	to recognize that this recommendation is still regarding voluntary submitters such as "OSHPD will seek voluntary submission from ERISA plans, in the event of a change in federal law or ERISA preemption these submitters would become mandatory." *Emma Hoo, PBGH,* wanted to also note that there is a need to tie in the other rules of submission that were discussed in prior recommendations. She noted for example the threshold issue would surface in a lot of cases and would be complicated. *Ken Stuart, California Health Care Coalition,* suggested to withdraw his suggestion, and to just note that in principle the committee agrees that if there are changes on the Federal level regarding ERISA self-insured plans, appropriate adjustments will be made in California. *John Kabateck, NFIB,* asked what kind of input employers would have to develop this voluntary process. Scott Christman noted that it would be significant input. He commented that currently there is already outreach and engagement efforts and OSHPD would work to expand these efforts and to focus on the incentives to show what the value add is to these groups for participating. *Amber Ott, CHA,* inquired if IHA's Atlas collected data from self-insured plans and how their process worked. Dolores Yanagihara noted that yes IHA does have some of the self-funded plans and the process depends on the arrangement between plans. However, Dolores Yanagihara noted that IHA has not looked at the split between public and private self-insured plans. Amber inquired if it would be possible to compel the plans within their contracts for the plans and networks to have to submit data to the HPD. Anne Eowan noted that she believes there could be legal recourse as Gobeille prohibits direct or indirect impact to a plan. *Ken Stuart, California Health Care Coalition,* noted that in the ERISA world there has been issues with health plans because the self-insured entities maintain that it is their data, and that they are able to do what they want. There has been precedence with health plans reaching out to their self-funded plans to request direction with regard to network participation or exclusion, and a similar process could be followed to give the green light to remit their data. *Charles Bacchi, CAHP,* just wanted to note that there are a lot of lawsuits and there have been a great deal of attempts to get to this data and it has not been successful. *Joan Allen, SEIU-UHW,* suggested adding examples from the Washington or Utah examples of what processes they actually used to encourage voluntary submission. The two examples were as follows: • Washington: State may require health plans, TPAs, and other administrators to notify clients that they can opt into the APCD • Utah: State may require health plans, TPAs, and other administrators to notify clients that they can opt into the APCD *Charles Bacchi, CAHP,* inquired if adding this would be interpreted that 100% of the health plans are going to contact their TPAs and ask for data, or is this just an option that OSHPD can employ. *Anne Eowan, ACLHIC,* noted that what she likes about the recommendation the way that it is written, is that there is an opportunity for OSHPD to determine what makes sense. She suggested possibly adding that, in determining the process OSHPD will look at what has been done in other states. She noted that she does not want to box in OSHPD if there is another or

	better way to encourage voluntary submission. *Joan Allen, SEIU-UHW,* noted that she is comfortable not including the exact language but that she would like somewhere to note that there are requirements that are set on plans and TPAs to pursue voluntary submission. She felt that it was important to note that the committee is encouraging OSHPD to utilize this authority and not just doing voluntary outreach. *Ken Stuart, California Health Care Coalition,* suggested adding language that says HPD shall explore legislation addressing the following: Scott Christman noted that as a state department we do not propose legislation, however, as part of the outreach and program development, OSHPD will certainly look at what other states have done. *Ken Stuart, California Health Care Coalition,* suggested adding "such as" for examples of the types of outreach that can be done. *Emma Hoo, PBGH,* noted that any type of requirement goes against the inherently voluntary nature of this recommendation. She suggested changing the population slide to encompass self-funded and insured or other covered lives. Joan Allen noted that she is more interested in noting that OSHPD can place requirements on plans, TPAs, and other administrators however Emma Hoo noted that is different than it being voluntary. *Anne Eowan, ACLHIC,* inquired if Joan Allen's comment was that OSHPD would be able to develop regulations and impose new requirements on health plans, and she noted that would probably require more statutory language. She noted that the recommendation was ok as written as there will need to be more statutory language needed to add additional requirements. *Joan Allen, SEIU-UHW,* noted that it seems like this would not necessarily be a feasible addition, and agreed that the original language makes sense for now. The committee voted 10-0 to approve the recommendation as written. <u>Recommendation as approved by Review Committee:</u> 4. The Review Committee recommends that: • HPD should be statutorily authorized to receive data from voluntary submitters. • HPD shall develop an appropriate process to encourage voluntary data submission.
OSHPD Patient-Level Data Quality Management	Anthony Tapney, a manager with OSHPD's Patient Data Section (PDS), presented a short presentation on how PDS currently manages the data quality process for patient-level data. To see the full presentation see slides 38-51 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Reivew-Committee-Master-PowerPoint_08.15.2019.pdf) *Amber Ott, CHA,* noted that OSHPD currently collects Ambulatory Surgery Center (ASC), Emergency Department (ED), and Inpatient data, but not outpatient, pharmacy, dental and other areas that HPD will be expected to collect. She inquired if OSHPD ever collected that data, or if there was a conscious decision to not collect that data, and if there are any lessons

	learned. Anthony Tapney noted that OSHPD considers ED and ASC outpatient data as those encounters are less than 24 hours. Starla Ledbetter noted that the hospital ASC data is data that is performed in hospital settings, however straight outpatient data such as radiology is not collected, and never has been. Anthony Tapney also noted that OSHPD does collect data form 36 free standing ASCs, which includes dental offices, plastic surgery offices that are licensed with the Department of Public Health. Scott Christman commented that OSHPD used to collect more ASC data, however due to licensure changes OSHPD no longer receives 90% of the ASC data. Over time the procedures moved to physician licensed centers, and therefore the data was no longer statutorily mandated to be submitted to OSHPD, which has created a significant gap in the outpatient data. *Charles Bacchi, CAHP,* inquired if OSHPD does all of the data quality work in house or is there a vendor that does the work. Anthony Tapney noted that OSHPD does the work in house. Initially there were contractors who built the system but since then it has all been maintained by OSHPD staff. Charles Bacchi also thanked Anthony Tapney for laying out a thoughtful set of slides. He inquired if this level of data quality was developed over time with relationships with data submitters. Anthony Tapney noted that OSHPD is continually reviewing all of the data assets and looking to feedback from facilities which helps improve data quality processes. *Emma Hoo, PBGH,* inquired what the time frame was for having corrections to be resubmitted and what the limiting factors are in terms of managing that cycle time. Anthony Tapney noted that the reporting period opens July 1 and a facilities due date is September 30. Data submitters can submit as many times as they need to, and there is usually 14-day extension. Emma Hoo also followed up inquiring if there have been any economies of scale due to consolidation of hospitals or does each hospital still have their own independent reporting systems. Anthony Tapney noted that OSHPD is informed when a facility consolidates, and the facility has the option to report under the parent facility or they can select to report independently. *Ken Stuart, California Health Care Coalition*, inquired if OSHPD would plan to apply the same level of quality controls to the HPD. Starla Ledbetter commented that OSHPD would learn from what other states have done and would evolve over time. *Amber Ott, CHA,* noted that with hospitals submitting data to OSHPD for 30 years, are there any educational opportunities to improve this statistic that says that 99% of submissions have one error on the first time of submission. Anthony Tapney noted that OSHPD does do extensive outreach and training and will continue to do more of that. Scott Christman also added that this has evolved over 30 years and the current thresholds are very high. This is a highly regarded data set and is of high quality, but he noted that it does take a very long time to get there. *Emma Hoo, PBGH,* noted that PBGH had similar issues in managing the CHPI database, and that sometimes there were repetitive data quality issues. She also added that PBGH is happy to share the edit reports that Milliman did at the time.
Data Quality	Jonathan Mathieu and Linda Green conducted a presentation, discussion, and vote on recommendations for creation of a transparent HPD data quality review and improvement process that includes data quality processes for major phases of the data life-cycle, ability to set standards for acceptable data quality, and stakeholder access to information on data

	quality. To see the full presentation see slides 53-70 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Reivew-Committee-Master-PowerPoint_08.15.2019.pdf) *Terry Hill, CMA,* noted that Med PAC has been very critical on the quality of encounter data that CMS has. He inquired what the status of quality of encounter data is for California as a whole and what are the implications of this quality for the HPD. *Charles Bacchi, CAHP,* commented that it is critical to level set that the quality between claims, encounters and APM will be varying. There are new initiatives with some fiscal incentives to help improve encounter data, however there is still a long way to go. At the current state of encounter data quality there might be some granular levels of analysis we might not be able to access right now. *Emma Hoo, PBGH*, inquired what the IHA experience with encounter data has been. Dolores Yanagihara noted that the more the data is used the better it will get. She also commented that IHA has seen increasing trends in better quality encounters being submitted. Though, the data is still not as good as claims data, it is trending in the right direction. *Terry Hill, CMA,* noted that it would be interesting to see the MEDPAR encounter quality report, and he wondered if in the future it makes sense to use external data sources to validate the HPD data. Linda Green commented that there are a couple of states that have started to use some external data sources to come to a better understanding of how complete the data are, though it is not a one to one comparison, it can be a helpful tool. *Ken Stuart, California Health Care Coalition,* noted that there are already potential data users who are running medical appropriateness projects exclusively on encounter data. These groups have seen improvements, but they do take time. *John Kabateck, NFIB,* inquired if there is data on how long a data manager stays with APCDs. Jonathan Mathieu commented that states have changed their models and many states have changed their data managers for various reasons. He noted that data quality and improvement is an ongoing process and a necessity, but it tends to be a lot more successful when it is a collaborative process. Denise Love commented that it is important to underscore the use and feedback loop improved process to get feedback. She noted that the data makes more sense to people the more that it is used, and there are improvement opportunities in the process. *Anne Eowan, ACLHIC,* noted that especially in claims data it is important to catch any anomalies as soon as possible as companies don't always keep historical data. <u>Discussion of Recommendation 1</u> Recommendation 1 as presented to the Review Committee: The Review Committee recommends that the HPD Program develop transparent data quality and improvement processes.

	Terry Hill, CMA, made a motion to move this recommendation forward. *Anne Eowan, ACLHIC,* seconded Terry Hill's motion. There was no public comment and no committee discussion. The committee voted 10-0 to approve the recommendation as written. <u>Discussion on Recommendation 2:</u> Recommendation 2 as presented to the committee: 2. The Review Committee recommends that data quality processes should be applied to each major phase of the HPD data life-cycle, including: a) Source data intake b) Data conversion and processing c) Data analysis, reporting, and release *Bill Barcellona, America's Physician Group,* a motion to move this recommendation forward. *Joan Allen, SEIU-UHW*, seconded the motion. There was no public comment and no committee discussion. The committee voted 10-0 to approve the recommendation as written. <u>Discussion of Recommendation 3</u> Recommendation 3 as presented to the Review Committee: 3. The Review Committee recommends that the HPD Program have authority to require resubmissions if data fail to meet established data quality standards. *Anne Eowan, ACLHIC,* made a motion to move this recommendation forward. *Terry Hill, CMA,* seconded Anne Eowan's motion. There was no public comment. *Charles Bacchi, CAHP,* inquired how this recommendation would be implemented if the availability of the data is such that resubmission will not solve the data quality issue. *Emma Hoo, PBGH*, inquired what is OSHPD's authority to require corrective action like missing data fields that are not submitted at the provider level. Scott Christman noted that OSHPD has strategies for resolving these issues, though sometimes it may not be resolvable in the immediate term. *Ken Stuart, California Health Care Association,* inquired if there should be a phrase added at the end of this recommendation that says, "and request corrective action to achieve processable data."

	Anne Eowan, ACLHIC, inquired if possibly the first recommendation is enough to give OSHPD the authority to do what needs to be done to implement an effective data quality check process. She also noted that it would be important to note that it is available data that is being requested. Linda Green agreed with Anne Eowan that the term "available data" is a great addition, as OSHPD cannot hold plans to a standard if the data is not available. She also noted that clean claims law defines a minimum standard for what must be on the claim, and if the claim meets the minimum standard then it must be accepted. She also noted that some states do have an exceptions process that will be discussed in governance. *Ken Stuart, California Health Care Coalition,* inquired if there have been instances where an APCD did not have authority to request resubmissions. Denise Love noted that she thinks that the authority is implied, though there have been a couple of states that have required the authority in regulations. Jonathan Mathieu noted that mistakes do happen, and a resubmission requirement does not have to be in legislation but should be addressed in regulations or data submission policies and procedures. Ken Stuart followed up that if left as a standalone recommendation it could be subject to interpretation and could end up creating problems down the line. *Charles Bacchi, CAHP,* noted that he also agrees with Anne Eowan's earlier comment that recommendation 1 empowers the program to develop these transparent data quality processes, which will include a resubmittal process and methodologies. *Emma Hoo, PBGH*, expressed concern that the committee should not settle for "available" data, and that there should be more efforts to fill those data gaps. She also commented that it is important that known processes are being leveraged. *Anne Eowan, ACLHIC,* agreed with Emma Hoo's comment and suggested to also add the term "leveraging existing processes" to the first recommendations. *Joan Allen, SEIU-UHW,* noted that she feels that recommendations 2 and 3 are derivatives off of recommendation 1, while recommendation 4 stands alone as it is regarding stakeholders. She commented her support subsume recommendations 2 & 3 under recommendation 1. Anne Eowan and Terry Hill, as the original makers of the motion, agreed to withdraw recommendation 3. The committee voted 10-0 to withdraw recommendation 3. The committee also decided to revisit recommendation 1 to ensure the language appropriately captured the intention of recommendation 3. The committee suggested adding the sentence: "In developing the program, OSHPD shall review and leverage known and effective data improvement processes and experiences." *Charles Bacchi, CAHP,* rescinded the action to approve recommendation 1 as had been previously written. *Joan Allen, SEIU-UHW,* seconded Charles Bacchi's recension.

	The committee voted 10-0 to approve the recension. Charles Bacchi made a motion to move forward recommendation 1 as edited: 1. The Review Committee recommends that the HPD Program develop transparent data quality and improvement processes. In developing the program, OSHPD shall review and leverage known and effective data improvement processes and experiences. *MJ Diaz, Health Access*, seconded Charles Bacchi's recommendation. Public Comment: *Adam Francis, California Academy of Family Physicians*, inquired what was meant by the terms "the program" as that language seems a little unclear. The committee voted 10-0 to approve the recommendation as amended. <u>Recommendation 1 as approved by Committee:</u> 1. The Review Committee recommends that the HPD Program develop transparent data quality and improvement processes. In developing the program, OSHPD shall review and leverage known and effective data improvement processes and experiences. Bobbie Wunsch inquired if the committee wanted to look at recommendation #2. The committee decided to keep recommendation #2 as written. Discussion on Recommendation 4: <u>Recommendation 4 as presented to the Review Committee:</u> 4. The Review Committee recommends that the HPD Program provide stakeholders with accessible information on data quality, including: a) Descriptions of processes and methodologies b) Periodic updates on known issues and their implications *MJ Diaz, Health Access,* made a motion to move this recommendation forward. <u>Public Comment</u>: *Adam Francis, California Academy of Family Physicians,* noted that the Data Quality presentation highlighted an opportunity to review and correct data. He noted that he is not sure if this would be an appropriate place to add to allow stakeholders to review and correct data. *Anne Eowan, ACLHIC,* inquired how this recommendation would be operationalized. Scott Christman noted that it would be consistent with OSHPD's current practices, such as publishing data quality reports. Starla Ledbetter also noted that OSHPD currently has a process where an automated summary report is provided. Scott Christman also noted that he would expect this to be sorted out during the regulatory process and would most likely look like OSHPD producing reports on the website that are publicly able to be consumed. Anne Eowan followed up to clarify if this would be raw data being reviewed or data after it has gone through the data quality process. Scott Christman noted that there would be quality reporting

	at each part of the data quality cycle as explained in recommendation 2. Linda Green noted that Oregon has data user guides that explain where there are gaps and limitations in the data. *Ken Stuart, California Healthcare Coalition,* noted that this type of reporting would be informational rather than a deep dive, and that there would be no corrective action on this process. Scott Christman noted that downstream when OSHPD produces analytical reports there will be metadata and quality reporting around those reports. *Anne Eowan, ACLHIC,* noted that there is a lot of noise around the data for quite a while and she wants to ensure that people are not confused, but it sounded to her like OSHPD has an existing process that makes sense. *Terry Hill, CMA,* noted that it has been a really important part of the IHA process to include stakeholders, and he feels that it would be helpful to propose a new recommendation to include submitters. *Charles Bacchi, CAHP,* reminded the committee that the transparent process noted in recommendation number one should cover the stakeholder feedback. He noted that if the committee starts to specify specific stakeholder groups, it will get very complicated. *Emma Hoo, PBGH,* noted that it is important to remember that data has gone through multiple entities and the claims the HPD would be dealing with are closed claims. She agreed that recommendation 1 should cover this topic without getting too into the weeds. *Ken Stuart, California Health Care Coalition,* suggested tabling this recommendation and discussing it next meeting.
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 September19 will be on data governance and privacy. Scott Christman responded to Adam Francis' question regarding the term "program," noting that it is a term OSHPD uses for data programs that are established in statute, defined by rule making and administered by OSHPD. He also reminded the Review Committee that Form 700s will need to be submitted. Lastly he commented that MJ Diaz will be stepping down from the Review Committee representation and thanked her for her service. MJ Diaz commented that Anthony Wright may be taking over for her as the consumer representative. Charles Bacchi noted that it felt like a very productive conversation and he appreciated the problem-solving approach from committee.