Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Review Committee Meeting

October 17, 2019

Meeting Minutes

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

Attending by Phone: No members attended by phone.

Not Attending: Anthony Wright, Health Access California; William Barcellona, America's Physician Groups.

Presenters: Scott Christman, Chief Information Officer, OSHPD; Phil Smith, OSHPD Consultant: Jonathan Mathieu, Senior Health Care Data/Policy Consultant, Freedman HealthCare; Ted Calvert, OSHPD Consultant; Bobbie Wunsch, Consultant, OSHPD.

Others: Denise Love, Executive Director, NAHDO; Emily Sullivan, Deputy Director, NAHDO; John Freedman, President, Freedman Healthcare

Public Attendance: 8 members of the public attended.

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Welcome and Meeting Minutes	The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions. The September 19 Review Committee meeting minutes were approved, with some minor edits submitted by committee members to the Review Committee Coordinator. Bobbie Wunsch went over the ground rules for the meeting.
Deputy Director's Report	Scott Christman provided a summary of the September Technical Workgroup Meeting. He noted that the topic for the APCD-CDL™ discussion was on the pharmacy file. The full summary is available at https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-

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	Meetings/Documents/HPD/HPD-Technical-Workgroup-9.19.2019-Summary.pdf. Scott reminded the committee that the expectation is that all fields are required, though some are situational. If a health plan does not have a piece of information that the APCD-CDL™ is requesting, they will not be required to submit it and there will be an exemption process to identify those fields. Scott also noted that the workgroup discussed that there are multiple ways of mapping to the provider file, which is why there is more than one field requesting similar information on providers. It was noted that tracking physicians in an APCD has proven to be challenging, which is the reasoning behind having multiple identifying fields. The workgroup also discussed future updates to the APCD-CDL™ via the Data Maintenance Process. Through this process of the Technical Workgroup reviewing the file formats, OSHPD can compile a list of all of the comments and changes proposed, review those back with the Technical Workgroup, and then submit to the APCD-CDL™ data maintenance process. Additionally, Scott provided a recap of the data feeds per submitter survey that was completed. • Five plans responded • The number of feeds varied from 2 to 16 feeds per plan • The number of covered lives per file varied from 750 to several million • Files were organized differently across plans. Some organized by lines or business, others pulled out subsidiary companies, or had separate feeds for dental or behavioral plans • One plan lumped the entire eligibility file together, but had multiple feeds for different claims and provider files There was a discussion on opportunities to consolidate the feeds prior to submission. Plans noted that it may be challenging to consolidate the feeds. Health plans are HIPAA covered entities and have all of the privacy standards that apply to them. Each of the subsidiaries owns their own data and will be their own separate submission. There is no mechanism to bridge all of this data. Additionally, when there is feedback on the data, it will need to go back to the data owners in their organization anyway, so combining the data may make it harder to troubleshoot issues and respond to questions. Lastly, Scott provided a preview for the upcoming months of the Technical Workgroup noting that in October the group will be discussing the Provider File, November will be the Dental File and December will be when the proposed summary of changes that will go to the APCD Council will be discussed.
Follow Up from September 19 Meeting	Scott Christman followed up on Amber Ott's question from the September Review Committee meeting. Question: Is there a reason OSHPD does not disclose more granular levels of patient level charge data? Response: Scott Christman noted that OSHPD collects both facility level and patient level

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	data. The facility level data have quite a bit of accounting detail including cost to charge ratio at a facility level. The patient level data includes a total charge associated with the visit. The follow up is to clarify that these two data sets are not related to each other and the total charge in the patient level is very particular in terms of the bundled services and varies based on the primary and secondary services performed. He noted that those charges do not have any additional underlying detail that could be reported. He also noted that it is good to point out that with these different data sets we are not able to use this data together and these are separate data collections.
Technology Alternatives	Phil Smith, Jonathan Mathieu and Ted Calvert presented on the options for the technical build of the HPD System including approaches taken by other states, learnings from OSHPD's Request for Information (RFI) process, and a review of analytic enhancements available in APCD solutions. The discussion also included a vote on recommendations regarding system implementation, data collection processes, and data management. For the full presentation see slides 5-38 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Program-Master-PowerPoint-10.17.2019.pdf) Emma Hoo, PBHG, inquired if the presentation could tease out what is technology versus analytic, as some of the goals on slide 7 can be both technology or analytics. Phil Smith noted that he would do that and show throughout the discussion where human analytics can enhance technical abilities and vice versa. Denise Love, NAHDO, inquired if interoperability is subsumed in the standardized portion of the "goals." Phil Smith noted that interoperability can be a bit of loaded term, and that a fundamental purpose of the HPD is to collect data from both sophisticated and not sophisticated submitters and to perform data exchanges. Interoperability is the ability for computers to communicate with one another, therefore whatever that is most pragmatic to be done is best. Cheryl Damberg, RAND, inquired if data documentation falls into technical solution or somewhere else. Phil Smith noted that the technical solution would be a means to apply those non-functional requirements to the technology, while the documentation is more about what to supply to data submitters to describe how to do it or what the expectations are, for example data submission guidelines. Cheryl clarified that her question was regarding data documentation that allows an end user to know what codes are for each field. Jonathan Mathieu noted that data documentation and communication to the end users is part of the data quality discussion and is available at each part of the data quality life cycle. Phil Smith also noted that Ted Calvert will go into some of the enhancements that are available that provider greater clarity of the meaning behind fields. Ken Stuart, California Health Care Coalition, inquired if the appropriated $60 million is encompassed in the budgeted amount allocated for the technical build. Scott Christman noted that OSHPD is using 5-10% of the allocated amount on planning, leaving a generous sum for implementation. He also noted that the market research has confirmed that full

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	implementation will be covered by the $60 million. Emma Hoo, PBGH, asked if we have data from other states around their APCD implementation costs as a comparison for what the OSHPD RFI process revealed. Ted Calvert noted that costs provided in the RFI were just for the commercial vendor portion and there are other IT costs that will be involved. Ted also noted that later in the presentation there will be an estimate of proposed on-going costs for the HPD. He also noted that in terms of comparing to other states, there are several other states that have public contracting processes, though unfortunately many of them are smaller and do not provide everything that California would need, so it was not very comparable due to California's size and nuanced needs. Charles Bacchi, CAHP, inquired if based on the RFI process, did the team feel there is strong interest in the California APCD and that there will be competition during the RFP process, which would hopefully help to keep the costs competitive, which the team confirmed to be true. Charles Bacchi also noted that the Request for Proposal (RFP) process will be very important to not only assess the costs, but the capabilities of the vendors. He noted that it could be possible to do this project "low-cost" and end up with a low- performing product. He commented that it is really important that RFP process be informed by the data submitters and stakeholders. Phil Smith noted that the RFI process was more of an open range and did not go as into specifics as the RFP process will in terms of assessing the range of costs. John Kabateck, NFIB, inquired if the RFI respondents were able to perform all the tasks required by an APCD, or were they experts in certain elements. Phil Smith noted that the system capacities were broken down into three groups: Data Collection, Data Management and Data Access. Within each of these three areas, there are specific functionalities or modules that apply to each area, and each of the respondents identified which areas they could support. Some were able to support more, others only specialized in a specific area. Anne Eowan, ACLHIC, inquired if any of the respondents to the RFI are an all-in-one solution. Ted Calvert noted that there was a subset of companies that completed all of the required modules, while some only did certain ones. Ken Stuart, California Health Care Coalition, inquired if the vendors that were contacted all had experience with APCDs in other states. Ted Calvert noted that not all vendors had experience with APCDs specifically, but vendors have other specializations for elements needed to run a successful APCD. Ken followed up inquiring if there has been any information collected on whether states had issues with any of their specific APCD vendors. Ted noted that through second hand sources of FHC and NAHDO, OSHPD has received some feedback, however, a part of the issues that states may have encountered could do with the team the state is working with and not the company itself. John Freedman also noted that there are only about half a dozen vendors who have done work on APCDs specifically, but there are a lot of vendors who have other specializations, and California is an attractive market. He also noted that there is no perfect vendor, all of them do some

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	things well and all of them struggle in some elements, so the RFP process will need to be robust. Scott Christman also noted that OSHPD is working with the Office of Systems Integration (OSI), CHHS' IT project management organization that manages an IT portfolio of $2 billion, which is a huge benefit to this work in making the RFP process as robust as possible. Denise Love also commented that OSHPDs internal capacity is a differentiating factor, which puts California ahead when compared to other states. Anne Eowan, ACLHIC, agreed that there are a lot of vendors that would want to get into the California market, however she noted that it is important to keep in mind that vendors that have worked with health plans in other states can be far more cost efficient to work with rather than a vendor who may be low cost, but who lacks experience working with such a complex data collection effort. Emma Hoo, PBGH, inquired to what extent did the RFI process asses the ability to collect supplemental data sets. Ted Calvert noted that it was one of the questions and was a topic of the interviews. He commented that vendor experience ranged, and no other state has as much APM data as California does, however there are some tools that vendor platforms bring to bear. Phil Smith also noted that DHCS has built a multiplayer claim database and they accept transactions that have all available data that a claim or encounter would have. There are mechanisms in place that have been built that look at future information collection mechanisms and those capabilities. Cheryl Damberg, RAND, inquired if any of the enhancements the vendors provide, talk about linking to other data that would not be collected by an APCD, like census data. Ted noted that it was discussed briefly, and states do this in a variety of ways, usually via a data element or finder file process, however this was not a big focus of the RFI process. Cheryl recommended to include this piece in the RFP process in order to assess vendor capabilities with data linkage. Joan Allen, SEIU-UHW, inquired if the switch from ICD 9 to ICD 10 will be an issue with any longitudinal analyses. Ted Calvert noted that the HPD's 3 years of historical data will all be in ICD 10, so there should not be any issues. However, he did also note that code sets in general change periodically, and these enhancements help to address these changes. Ken Stuart, California Health Care Coalition, inquired if the term analytics also includes the after the fact assessment analytics. Ted Calvert noted that these kinds of groupings would be helpful in both cases, noting that you apply the enhancement to one service, but then you are using that case to analyze across a population. Ken Stuart followed up if on the back side a group wanted to do a specific analysis to compare providers, for example, that is a separate part, but it is included in the overall picture. Ted Calvert noted that yes, those kinds of built in reports and comparisons for making the analysis easier to do would be included.

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	Cheryl Damberg, RAND, noted that there are different approaches to each of these enhancements. Ted Calvert agreed and noted that some vendors have proprietary methodologies, others have licenses and while others let you choose which approach to use. Emma Hoo, PBGH, noted that it would be important to assess which vendors have the ability to show the pre and post update methodologies, as that is very helpful when codes change to in order to look at continuity of measures and the availability of data. Terry Hill, CMA, inquired regarding the built in quality measures, how to think about the fact that with three years of historical data you do not get a full picture of all of the screenings (for example colonoscopy done 6 years ago) that have been completed, so the built in quality metrics won't work, absent attestation, which is very burdensome on providers. Ted Calvert noted that the plan is to start with three years, and build that over time, so there will eventually be 10 years of data running. He noted that some of the quality measures are supported by the administrative data, some are not, so these quality measures should be used more for analytical purposes, and not to replace HEDIS measures that the plans report, which have the benefit of looking at medical records and attestation and other elements. He noted that the user has to keep that in mind. Phil Smith also noted that from a technology perspective, these elements are temporal and change over time. It is possible to apply algorithms that program what is appropriate to be done during that time period, so this is another functionality that could be added. Cheryl Damberg, RAND, followed up on Terry's point noting that it is a valid concern if quality measures are being constructed with this data and there is some documentation that highlights the limitations of the use of the information. Jonathan Mathieu noted that states have created physician reporting groups that allow for review of results and technical assistance, which can be disused further in governance. States have taken a collaborative approach with providers. Ken Stuart, California Health Care Coalition, confirmed that the intent would be to afford users to have general analytics of the database in addition to what they do on their own. Ted Calvert noted that the team has not yet determined what data access could look like, but there will be a set of users who will have access to all of these tools (i.e. OSHPD staff), and in the governance there will be further discussion of who else will have that access such as a research enclave etc. Ken Stuart followed up asking if OSHPD's intent would be that some data be released through OSHPD's website. Scott Christman noted that yes, OSHPD is anticipating producing any number of dashboards and aggregate level summaries, which will be informed by the priorities outlined by the stakeholders through the Use Cases that were submitted earlier. Additionally, there will be other "swim lanes" for data access. For example, under the Information Practices Act, researchers can access the data with IRB approval. Additionally, there will be a process for other stakeholders to access the data as well for informed decision making.

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	Cheryl Damberg, RAND, noted her support for continuous review and updating based on user feedback. She inquired if there has been any discussion with analysts who have worked in other states or people who have worked with Medicare, noting that there might be some benefit to gather information from them on the front end to inform the RFP process. Ted Calvert noted that the team has interviewed analysts at Covered California and CalPERS about their experience with a multi-payer database, but it is a great idea to have additional informational interviews with researchers and analysts. Terry Hill, CMA, noted that there is more and more overlap between social services being provided through Medi-Cal. He inquired if there is a relationship between the APCD effort and Medi-Cal social service programs, for example In-Home-Supportive-Services or transportation for doctor visits. Ted Calvert noted that the short answer is if Medi-Cal paid for it through their plans or their Fee-for-Service program the data will come into the HPD. However, some of the more recent waiver programs, such as Whole Person Care may not be paid in that way. Phil Smith noted that some of those programs that are housed in other departments, such as Developmental Services or Social Services, but that are administered as part of the Medi-Cal enterprise, get reported to DHCS, and could be part of the data feed that comes to the HPD. Scott Christman also noted that there is work currently being done within the CHHS Agency to link across social services programs, including Medi-Cal and SNAP, TANF, Developmental Service, Child Welfare etc., with the goal of being more informed about program participation through a person-centered lens, recognizing that people participate in more than one program. He also noted that OSHPD is part of the Agency's data sharing environment, allowing for easier linkage from health to human services. Terry Hill followed up that some of the linkage enhancements were built without anticipating including Cal -Fresh data, for example. He inquired if this is something that will be considered for the RFP process. Ted Calvert agreed and noted that in addition to these "off the shelf" tools, analysts will also do manual linkages to include some of this other data. Ted noted that until other states also start to look at these cross health and human services linkages, these elements will probably not be part of the "off the shelf" offering of vendors. Scott Christman agreed and noted that in the RFP OSHPD would specify that as a requirement, there is flexibility to add in other data linkages as well. Charles Bacchi, CAHP, noted that there are a lot of services being provided by Medi-Cal that are not being billed for. He noted that to the extent the state allows plans to bill for these services, they will show up in the data. He also added that the administration plans to carve out pharmaceutical benefits for Medi-Cal, meaning that plans will no longer have that data, so HPD would need to interface with the vendor. In addition, he noted that there are other carve outs, such as county mental health etc., which will not come through the plans, and to access that data the HPD would have to either collect from the providers, or have the state provide the data. Charles also commented that there are many examples of enhancements and methodologies. He inquired if including more of these would tend to increase the cost of the RFP, which the team confirmed would be likely. He followed up noting that he thinks it is important to recognize that there will be a lot of disparate data sources being brought in and that there is some reality of how many enhancements we choose to add in while being cost efficient.

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	Ken Stuart, California Health Care Coalition, inquired if other APCDs include measures that are not captured in this presentation. Ted Calvert noted that there are hundreds of measures that could be added and each APCD does some combination of measures, however no one APCD will have all of them. Denise Love noted that use cases will evolve rapidly, and the database should be flexible to accommodate future new ideas for linkage and analysis. John Freedman commented that in the big picture there are some core functions, and some other functions. These other functions can be done by a vendor or by the OSHPD analytic team. He noted that part of a careful RFP process will weigh to see what needs to be outsourced and what can be done in house. Ken Stuart, California Health Care Coalition, noted that there will need to be a balance of what is needed right now and what will be needed of the future. John Freedman agreed and noted the advantage California has is that there are many models to follow. Cheryl Damberg, RAND, noted that the list of enhancements can be endless and very costly. She suggested that a good framework would be to consider what are the core ingredients that analysts will need to use the data analytically and protect the privacy. She noted that she feels that linking to census data is an important one to consider as it is not a heavy lift and will provide added value particularly to researches who want to look at disparities in care, all the while maintaining patient privacy. She also noted that if researchers are provided with the “raw ingredients” they can create their own risk adjustments for example, so it is more critical that the raw ingredients are there in than every single possible enhancement. Jonathan Mathieu reminded the committee that the Use Cases that were developed back in April will be a great guide to help identify which of the enhancements are most critical for completing the analyses required by those Tier 1 and Tier 2 Use Cases. He also commented that no APCD is static, and it has always been an evolution, and those priorities will change and will evolve, but using the use cases as the starting guide and finding a balance between cost efficiency and usability. Scott Christman noted that it is critical to identify what the priorities are of the stakeholders in order to manage costs going forward. As part of the governance structure there will be an opportunity to develop an agreed-on set of priorities for the best use of the data. OSHPD will plan to actively engage the stakeholder community. Denise Love noted that it is important to carefully craft policies on access up front and need to balance privacy and access and utility. It is also important to try to not outsource everything to a vendor, as there might be a time when legislators will ask the department what is going on, and it will be important for the state be ready to respond.

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	Amber Ott, CHA, inquired who will make decisions with what an appropriate cost for this database is. Scott Christman noted that part of the process will be to establish an approach for the technical build, which will be part of the recommendations today. The key will be in how we approach the RFP process. He noted that OSHPD does not want to be a poor steward of public resources. He also added that the recommendations the committee will review today have concepts in them to help manage the costs. Lastly, he added that in parallel to the Review Committee process, OSHPD is working through a Project Approval Lifecycle (PAL) process with the California Department of Technology, which will also frame how the RFP is managed. Charles Bacchi, CAHP, noted that the state procurement process is bit of a black box, so once the RFP is finalized that is the end of the opportunity for anyone to provide input the RFP, which he noted is why it is important to be thoughtful about this process. John Kabateck, NFIB, inquired if the modular structure that is being proposed is consistent across other state APCDs. Phil Smith noted that it depends, some RFI respondents were built as modular systems or could integrate with modular systems and other did not. However, Phil noted that the directions that technology is moving towards is a more modular approach. Joan Allen, SEIU, noted that the presented modules look like a comprehensive set. She inquired if there are any other modules or technical elements that states use in their APCDs that we are missing. Phil Smith noted that this is the best guess that we have right now, however there might be other modules that come up as being necessary to include in the future. Emma Hoo, PBGH, inquired regarding the development of master provider index (MPI) with the medical group organizational structure in California as well as the hospital system structure, and how we capture that as either reporting or cost accountability performance level. Phil Smith noted that the master provider index is for the subject of the provider which can be an individual provider or a facility. The data set that is used to apply the index across the data consistently will be supplied by the index module. Ted Calvert noted that there will be separate provider files from multiple submitters, so the MPI is to support analysts as they link across these different data streams. He noted that to Emma's other point of how to map relationships between individual providers and medical groups or hospitals, it is a challenging undertaking, but with having all of the data together along with the work that IHA is doing with the Symphony provider network gives an exciting opportunity to make some headway in that work. Charles Bacchi, CAHP, inquired if the security module also applies to data management, which was confirmed that it does. Jonathan Mathieu noted that these are high level categories of functions, as was mentioned there are a lot of elements in the MPI for example, and if one were to list all of the details for each of these the Data Processing category would be too large to describe.

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	Cheryl Damberg, RAND, noted that one of the critical enhancements needed is mapping individual providers to organizations. She noted that a lot can be learned by some of the work that she has been involved in that was funded by the Agency for Healthcare Research and Quality, and she would encourage OSHPD to reach out to the teams involved in this work to learn from their experience. She also noted that one of the key learnings is that the Tax ID is an imperfect unit of analysis. She commented that having California organizations move towards applying and getting an organizational NPI would be very helpful and a step in developing a common linking variable. She also noted that there has been discussion of a research enclave, as a way for researchers to come in and manipulate the data in the context of the enclave. Phil Smith noted that that is the general set up of research enclaves, however it does need to be fleshed out. Cheryl Damberg noted that CMS allows users to tunnel in and it keeps them from having to construct very large files. She noted that it would be helpful to talk to analysts about what issues they have run into, such as space constraints. She noted that given the size of the HPD there could be some issues around computing space constraints that are similar to the ones that happen with the Medicare data. Scott Christman agreed that those interviews would be helpful and commented that the CHHS Agency is in the process of developing a research hub, which could inform with feedback from that process and leveraging those efforts. Terry Hill, CMA, noted that Cheryl Damberg has brought up system issues and identification of roll ups which is an interesting challenge, but also at the micro level it is a challenge when you have physicians working in two different practices but are part of the same group, which has caused various analytical challenges. Cheryl Damberg noted that ideally there should be a mapping of the individual NPI to the organizational NPI. She noted that in some of her current work she has run into challenges of mapping with just Tax ID as it ends up being an incomplete mapping. It works very well for the hospital systems, but falls apart with medical groups which are particularly challenging in California as they are under a “foundation model” where under one entity there might be 15 or so medical groups that will not be able to be identified with the Tax ID. John Freedman noted that this is part of what makes creating the indexes so challenging. He noted that some of this is technical and it will never be 100% perfect, but this also starts to push into data quality, which like privacy and security needs to happen across each of the modules. He noted that the schematic on slide 26 is helpful to visualize all of the parts, but in reality, each box is not as siloed as it looks, and many of these elements bleed one into another. Joan Allen, SEIU-UHW, noted that for the data enclave, it will be important to bring varied data sets into the enclave in order to do linkages within the enclave. Phil Smith noted that the current technical solution has specific data marts so there are specific data structures that help to answer specific questions and that get enhanced with some of the additional enhancements that are provided to answer those questions. Joan Allen followed up clarifying that she meant the requestor having the ability to upload other data in the enclave in order to perform linkages. Phil Smith noted that process is the technically feasible, but requirements will need to be defined.

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	Cheryl Damberg, RAND, commented that CMS data security requirements do not allow cloud computing. Charles Bacchi, CAHP, inquired if the team was aware which of the implementation alternatives would take the longest from a timing perspective. Phil Smith responded that probably the OSHPD internal solution would take the longest, not due to poor existing resources, just that this approach would be much more complicated. He also noted that he believes the fastest approach would be the hybrid approach. By leveraging the best current resources will get the HPD up and running the quickest. Terry Hill, CMA, noted that it seems to him that in other states there is a master vendor that sub contracts many of these functions. He also inquired about the N/A status on Slide 30 in other public reporting. Jonathan Mathieu commented that some states don't do any public reporting at all. Anne Eowan, ACLHIC, again reminded the committee of the importance of not having a vendor who is brand new to APCD collection. She pointed out that Virginia might be a good example to look at, as they have had a successful onboarding process. Phil Smith noted that the HPD solution that the team is proposing would have a $15 million ongoing operations cost. Providing an ongoing funding estimate is a required component of PAL process and will be reflected in Stage 2 Alternatives Analysis. Public Comment Beth Capell, Health Access, noted that for Health Access it is very important to be able to integrate other databases and especially California-specific quality metrics, such as from Covered California, CalPERS and Medi-Cal. She also noted that an MPI is critical to track people across coverage sources, which has not been possible to do prior. She also commented that the Technical Feasibility report from several years ago, mentioned in the presentation, identified a number of California databases that the HPD should link to. Lastly, Beth Capell noted that she understands the concerns around cost of the database, however she noted that part of the reasons there has been so much money allocated for this project was to do the front-end work well. Discussion of Recommendations Recommendation #1 Recommendation as presented to Review Committee: **Leverage Existing Resources and Expertise:** The Review Committee recommends that OSHPD leverage existing resources and expertise to facilitate a faster time to implement, maximize the early capabilities of the system, and learn from subject matter

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	experts in the all-payer and multi-payer database industry. Charles Bacchi, CAHP, made a motion to approve this recommendation as written. Anne Eowan, ACLHIC, seconded Charles Bacchi's motion. No Public comment: No discussion The committee voted 9-0 to approve the recommendation as written. Final recommendation as approved by committee: **Leverage Existing Resources and Expertise:** The Review Committee recommends that OSHPD leverage existing resources and expertise to facilitate a faster time to implement, maximize the early capabilities of the system, and learn from subject matter experts in the all-payer and multi-payer database industry. Recommendation # 2 Recommendation as presented to Review Committee: **Modular Approach:** The Review Committee recommends the HPD system be implemented with a modular approach, with each module performing a discrete system function. Anne Eowan, ACLHIC, made a motion to approve this recommendation as written. Joan Allen, SEIU-UHW, seconded Anne Eowan's motion. No public comment No discussion The committee voted 9-0 to approve the recommendation as written. Final Recommendation as approved by committee: **Modular Approach:** The Review Committee recommends the HPD system be implemented with a modular approach, with each module performing a discrete system function. Recommendation #3

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	Recommendation as presented to committee: **Data Collection Vendor:** The Review Committee recommends that commercial healthcare data be initially collected by a vendor with established submitter management and data quality processes. Anne Eowan, ACLHIC, suggested an alternative motion to add into the recommendation "with a preference for APCD prior experience." Denise Love suggested adding the word "state" in front of APCD experience Cheryl Damberg, RAND, noted that what is more important is that a vendor have experience aggregating claims from multiple entities, this does not necessarily mean APCD specific experience. Broadening this requirement would lead to a more robust pool. Anne Eowan, ACLHIC, noted that the issue is the process of getting the data from the health plans specifically, rather than just having experiences aggregating claims. Ted Calvert suggested adding "multi payer or all payer experience." Cheryl Damberg, RAND, noted that she understands the concern, but there have been other efforts outside of the context of APCDs, and she wants to capture that experience as well rather than just APCD entities. Denise Love noted that she believes there is some uniqueness with the public process that vendors who have not been required to do this may not be familiar. Cheryl Damberg noted that maybe separate experience of working in public environments also be added. Denise Love noted that some vendors are not used to working in a public setting where everything cannot be proprietary, which can be a tricky balance. Ken Stuart, California Health Care Coalition, suggested that after the words "quality process" we can add "that is experienced in aggregating commercial claims data." Cheryl Damberg suggested broadening it to say "aggregating/ synthesizing/ standardizing." Anne Eowan, ACLHIC, commented that she would like a note for preference for a vendor that has worked with health plans and associated legislation and regulations. She suggested adding "with a preference for state APCD experiences." The goal would be that experience gets weighted in the future RFP process. Ken Stuart, California Health Care Coalition, suggested adding "it is recommended that the vendor have experience with state APCDs." There was a suggestion to say public multi-payer systems instead of state APCD, however Charles Bacchi disagreed and noted that if the recommendation just states multi-payer experience then it is getting tilted back towards experience working with multiple payer sources, also as it is referenced in the prior sentence of the recommendation. He noted that it is important to be balanced in the recommendation and note APCD experience specifically as well.

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	Cheryl Damberg, RAND, suggested changing the word “recommended” to “preferred” and then saying “state APCD programs.” The last sentence would read: “It is preferred that the vendor have experience with state APCD programs.” Cheryl noted that her concern is that with this language OSHPD is limited to a smaller pool of vendors. Ted Calvert agreed that if the pool is only limited to vendors that have worked with state APCDs that is a small list of vendors, but he felt that experience should be given more weight and consideration, without precluding any other vendors with multi-payer experience. Emma Hoo, PBGH, inquired if the technical solution where Medicare and Medi-Cal are collected separately from Commercial, if we might lose sight of the global specifications around mapping sources and there might be some data gaps. Phil Smith clarified that the focus of the left-hand column is just the data collection process. Then all of the data will go into the system where it will be analyzed to answer specific use case questions. Emma Hoo followed up inquiring where does a Medicare Advantage fit which is provided by a commercial plan. Ted Calver confirmed that Medicare Advantage would come through the health plans. Joan Allen, SEIU-UHW, suggested adding an “and’ after the word “processes.” The first sentence would read: “The Review Committee recommends that commercial healthcare data be initially collected by a vendor with established submitter management and data quality processes, **and** that is experienced in aggregating/synthesizing/standardizing commercial claims data files from multiple payer sources.” Anne Eowan, ACLHIC, made a motion to move the recommendation as amended. Charles Bacchi, CAHP, seconded Anne Eowan’s motion. <u>Public Comment:</u> Beth Cappell, Health Access, noted that given the nature of the California market that is dominated by California domicile health plans, experience in other states experience is not as helpful as experience in California, particularly with Kaiser. Bernie Inskeep, United Healthcare, gave a practical example of what can happen with working with an entity that has experience aggregating /synthesizing / standardizing commercial data from multi-payers, but not with APCD. The entity came to payers, both local and national payers and said, “OK here is your data, this is how we always collect data, want the data in two weeks and submit the data how you submit it today.” This did not go along with the statute/legislation which mandated a 6-month timeline for plans to prepare. Additionally, the intake and feedback process were ineffective and manual that after two years most if not all payers were still testing. There is a good argument for giving preference to vendors that have worked with state APCDs as the regulators and statutory requirements are real, and that experience does make a difference.

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	Suggested Amendments: • Add "and that is experienced in aggregating/synthesizing/standardizing commercial claims data files from multiple payer sources" after processes • Add last sentence to say, "It is preferred that the vendor have experience with state APCD programs." The committee voted 9-0 to approve the recommendation as amended. Final Recommendation as approved by Committee: **Data Collection Vendor**: The Review Committee recommends that commercial healthcare data be initially collected by a vendor with established submitter management and data quality processes, and that is experienced in aggregating/synthesizing/standardizing commercial claims data files from multiple payer sources. It is preferred that the vendor have experience with state APCD programs.
November Agenda Setting	The Review Committee discussed and set topics for November "overflow" meeting. Bobbie Wunsch facilitated the conversation. There were two topics that had been previously agreed on: 1. Relatively deeper discussion about the Technical Workgroup including a summary of the changes that have been requested to be made to the APCD-CDL™. 2. Presentation from end users to inform the Review Committee and OSHPD about what they are hoping they will be able to do with HPD data. The committee members also presented ideas on topics that they would either cover themselves or find a designee for: Terry Hill, CMA, noted that he would like to present on the limitations of claims data for distinguishing physician performance. John Kabateck, NFIB, noted that it would be great to have a presentation on what this data could mean for the business community and small businesses. Charles Bacchi, CAHP, noted that currently Health Net and DMHC are working with Manatt on encounter data improvement project. He noted that the effort has just started and there might not be a great deal to present on, but it would be important for committee to understand that there is another effort under way. Anne Eowan, ACLHIC, commented that she will sadly not be at the Review Committee meeting in November and deferred to Charles. Amber Ott, CHA, noted that in today's discussion when looking at the other states table, there were some states that did not do public reporting on the HPD. She noted that she

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	would like to learn more about why some of those decisions were made in advance of governance discussion. Joan Allen, SEIU-UHW, commented that it would be helpful to hear about how we close the feedback loop for researchers and other users of the data to inform quality control of the data. She also noted that there is a struggle of not having good data on race, and how can we as California lead on improving that data element. Cheryl Damberg, RAND, commented that she would be happy to share how RAND has linked data, particularly census data and how they have assigned race/ethnicity data. She also discussed that she could share health systems work and what that looks like. Additionally, she noted that RAND is currently crafting an article on lessons learned from APCDs in other states, and that could be shared if the team is ready to share the data. RAND also has a contract with Millbank to conduct interviews on how entities capture and are able to report information on alternative payments that is of interest to the Review Committee. This work is most likely not going to be ready for the November meeting, but happy to come back and share at some point. Ken Stuart, California Health Care Coalition, suggested a speaker from California Schools Voluntary Employee Benefit Association (VEBA) to speak as a potential user of the data. He also mentioned that VEBA is currently working on a building a medical appropriateness project that could be interesting to hear about. Emma Hoo, PBGH, noted that she would like a review the entire set of recommendations in the aggregate, in order to assess if the committee missed anything and identify areas for future exploration, as a lot of the focus has been on the current claims-based state, so thinking about what some of the future measures might be helpful. She also noted that it would be interesting to discuss prioritization of and supplemental data and linkages of data. Ken Stuart, California Health Care Coalition, followed up on Emma Hoo's point and noted that it would make sense for the board members to go over the list of the recommendations that we have and submit comments in advance of the meeting. Bobbie Wunsch agreed and noted that whether it is done at the November meeting or a future meeting, the committee will need to review all of the recommendations in full and have a discussion. Bobbie Wunsch noted that we will follow up with Bill Barcellona and Anthony Wright for their input on potential topics. Bobbie Wunsch confirmed that the committee was still interested in hearing from the Technical Workgroup. Emma Hoo, PBGH, also commented that relative to Technical Workgroup update expected at the November meeting, it would be helpful to hear about the decision areas or problem areas of the APCD- CDL™ and what some of the issues are. Ken Stuart, California Health Care Coalition, inquired to Scott Christman if there are any areas that he would want to review with the committee as the legislative report is coming

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	together. Scott Christman noted that it is coming together nicely based on the recommendations that have been put together. Ken clarified if we are finding any holes as the report has been developed, Scott noted that he will think about it and get back to the committee. Public Comment: Beth Capell, Health Access, commented that disparities issues, which rests in part on race and ethnicity and part on other factors, are important to consider. California law has required health plans to collect this data since 2003, and for Medi-Cal managed care since the early 90s. She noted that it is disappointing that the data collection is so low. She noted that discussions on disparities are important as we look at quality and this issue will be important to address. Charles Bacchi, CAHP, inquired if there has been any discussion about the CURES data base at the Department of Justice (DOJ). Scott Christman noted DHCS is working with the DOJ and it is not on the current HPD list of datasets. Scott also mentioned the CHHS Agency has a data sharing agreement, in order for departments across agency to share data, and he noted that there might be greater interest across government to develop more data sharing capacities.
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.