

Office of Statewide Health Planning and Development

**Healthcare Payments Data Program
Review Committee Meeting**

April 18, 2019

Draft Meeting Minutes

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

Attending by Phone: No members attended by phone.

Not Attending: All members were present

Presenters: Scott Christman, Chief Information Officer, OSHPD; John Freedman, President, Freedman HealthCare; Jonathan Matthieu, Senior Health Care Data/Policy Consultant, Freedman HealthCare Michael Valle, Chief Strategy Office, OSHPD; Jill Yegian, Consultant, OSHPD; Bobbie Wunsch, Consultant; OSHPD.

Others: Denise Love, Executive Director, National Association of Health Data Organizations;

Public Attendance: 14 members of the public attended.

Agenda Item	Meeting Minutes
Welcome & Meeting Minutes	The Review Committee Chair, Ken Stuart, brought the meeting to order and introduced Robert P. David, OSHPD Director. The Director administered the Oath of Office to the Review Committee members who were not present at the March meeting - MJ Diaz (Health Access), Bill Barcellona (America's Physician Group), and John Kabateck (National Federation of Independent Businesses).
Deputy Director's Report	Scott Christman provided follow up to questions Review Committee members had from the March 21 Review Committee Meeting: Question 1: At the March 21 Meeting, Charles Bacchi, CAHP, had a question regarding Section 127674 of the legislation that states that the database will not be implemented if there is a determination, after consultation with the Review Committee, that the Office is unable to obtain necessary, reliable, and relevant data. OSHPD Response: Scott noted that, based on the recommendations of the Review Committee which will be included in the legislative report, the Administration will make the

determination on whether there is reliable and relevant data. Additionally, as there are existing voluntary efforts that collect this type of information in California already, OSHPD does not foresee this being an issue.

Question 2: Charles Bacchi, CAHP, asked what the role of the Review Committee was in the editing and approval of the Legislative Report. Scott noted that he will clarify with the OSHPD legal team regarding the statutory requirements of the Review Committee in terms of reviewing and approving the Legislative Report.

OSHPD Response: Scott responded that the Review Committee will make recommendations which will be incorporated into the Legislative Report. OSHPD will also provide a summary of the recommendations back to the Review Committee for review. After the report is completed it will go through an internal review process, prior to being submitted to the legislature. Charles clarified that there will not be a formal vote of the Review Committee to approve the report, but that the recommendations will be memorialized in the report; Scott confirmed.

Question 3: Amber Ott, CHA, asked a question regarding section 12672(b), which states that providers and payers shall submit data.

OSHPD Response: Scott noted that the legislation states that the legislative report will provide recommendations on who the mandatory data submitters will be. Based on the recommendations of the Review Committee it will be determined whether or not providers will submit data directly or through health plans. As we have seen in other states it is customary for the payers to be primary data submitters to an APCD, while providers submit data to the payers.

Scott also provided an update on the upcoming Request for Information (RFI) that OSHPD will be releasing in the next month. The RFI is specifically designed for market research on what capabilities vendors have when it comes to collection of data, data management, protection and security of the data and data integration. It will also be used as a part of the State's Project Approval Lifecycle (PAL) for technology projects. This RFI is non-binding and is informational in nature. The result of the RFI may inform future recommendations and what is included in the legislative report. OSHPD is looking to release the RFI in May, collect the responses in June and plan to report back to the Review Committee the results of the RFI at the October Review Committee meeting, which is focused on Technology Alternatives.

Cheryl Damberg, RAND, inquired if the Review Committee will have an opportunity to review the RFI. Scott noted that it is solely focused on the technical aspects of the APCD, but OSHPD will consider that recommendation.

Scott additionally made mention of the Technical Workgroup, which consists of health plans, the traditional data submitters to an APCD. The Technical Workgroup will meet on the afternoons of the Review Committee to accommodate any health plan representatives that are traveling from out of town to attend the meeting. The technical workgroup will focus on some of the more technical elements of the APCD including data collection, data linkage, data submitters, and technology alternatives. A summary of the discussions at the Technical Workgroup will be provided to Review Committee members at the subsequent meeting.

Finally, Scott introduced Freedman HealthCare as part of the OSHPD consulting team. Freedman has provided support to a number of states as they setup their APCDs and is providing some of the lessons learned from other states. Additionally, he noted that we

	<p>continue to be appreciative of Denise Love and her team at NAHDO and they really serve an advisory role in this work.</p> <p>Lastly Scott reminded committee members that the Form 700s are due to OSHPD by April 19, 2019.</p>
<p>Follow-Up from March 21 Meeting</p>	<p>Ken Stuart reviewed with the group the updates OSHPD has made to the Review Committee topics timeline, based on feedback heard from Review Committee members at the March meeting:</p> <ul style="list-style-type: none"> • The Data Collection topic was moved up from June to May • The Enhancing Database Analytics topic was moved up from December to June • The Data Governance and Privacy topic was moved down from May to September • The Sustainability topic was moved down from October to December. <p>Ken also made mention that upon completion of the Doodle Poll the committee determined that the third Thursday of the month was still the best time to meet. The rest of the dates for the Review Committee have been finalized to reflect that decision.</p>
<p>Data Types</p>	<p>John Freedman and Jonathan Mathieu from Freedman HealthCare provided a comprehensive presentation on what kind of data come in to an APCD, what are the differences between claims and encounters, and how to handle the non-claims based payments. For the full presentation please see slides 7-34: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-4.18.2019-Final.pdf</p> <p>The presentation and the discussion were intertwined with committee members providing thoughts and questions intermittently throughout the presentation.</p> <p>Discussion around slide 12: Claims and Encounter Data from Health Payers</p> <p><i>Cheryl Damberg</i>, RAND posed a question asking if any of the states have gone after the Federal databases (FEHB, Tricare, the VA, and Indian Health Service). John explained that thought there has been interest, especially in states like Hawaii, which has a lot of federal employees, states have not yet started collecting this data. A part of the issue is that these data submissions cannot be included in a state mandate but there is work being done to address this.</p> <p><i>John Kabateck</i>, NFIB asked why small commercial plans are part of the not typically included subset. John Freedman explained that these small plans would have a relatively small data submission and would have high costs associated with the data submission. Different states set different thresholds for how small is too small, depending on the burden of submission that would fall on these small plans.</p> <p><i>Bill Barcellona</i>, America's Physician Group, asked which states have found good incentives to get ERISA plans to submit their data into an APCD. John Freedman explained that there is no perfect plan to encourage submission. Part of the issue of the Gobeille case was that administratively it was very difficult to submit data to multiple states since each state had different collection formats. Rhode Island and New Hampshire, put certain requirements on their TPAs that they must inform their clients that they have an opportunity to voluntarily submit and there is an opt out process. Lastly, he mentioned that there are large employers that are interested in participating that can be leveraged.</p>

Ken Stuart, California Health Care Coalition, following up to Bill's question inquired do those states require health plans that do ASO administration to also reach out to their clients for approval? John Freedman noted that since they are licensed with the State, states can compel them to share the information with the client however, they are not able to compel them to turn over the data. Ken clarified that means that we could potentially get everyone to submit the data, and John confirmed that is true though no state has gotten to that point quite yet. It is critical that the business community is at the table.

Emma Hoo, PBGH, spoke on the PBGH and IHA experience in California and there are processes in place for large employers to opt in and authorize the use of data, however in California the variation that exists is more at the payer level and changes will need to be implemented at the contractual level. But it is critical to note that we can leverage infrastructure that already exists in California.

Discussion around slide 13: Four Core Data Files

Cheryl Damberg, RAND mentioned that there is a lot to unpack with the last bullet point about provider file. One of the big elements is the specificity around address whether it is the billing address rather than the service address. Cheryl also wondered when do we talk about the specifics of what is in the file. John explained that the goal of the provider file is to provide data on who the doctor is and which medical group they work for. He noted that this data is always a challenge because there are changes that occur, and that Cheryl is correct in that this group will need to go into some technical detail about what is collected.

Joan Allen, SEIU-UHW, inquired about how much variation is there in the provider file from state to state and are there some states that California should look to as exemplars. John noted that the data elements contained in most of these files is fairly standardized. He notes that the APCD-CDL™ was created by looking at the data collection standards that exist and picking what do they have in common them, so overall state to state it is fairly similar.

Ken Stuart, California Health Care Coalition, followed up asking if it is possible to disaggregate the specific providers when their medical group bill under the same tax ID number? John Freedman responded that you will not if that is how they bill. This becomes an issue of data quality; some states require this additional data to be collected, many states require info for billing, and rendering providers, but it requires a lot of diligence to get payers to submit the information accurately. It is also an issues of data technology to appropriately match providers with a provider master index. Ken followed up noting that the information is only as good as in the information we get, so how can we better ensure the correct information is provided? John noted that none of the states have developed regulations around this, but it is more of a reminder that HIPPA requires that this field be filled with rendering provider rather than billing provider. He also mentioned that at least at first you are not drilling down to an individual provider level. But rather connect to the medical group, so as long as that information is correct you would not have too many issues, and then could work to improve the data quality as the database matures.

Charles Bacchi, CAHP, reminded the group that there are laws that govern health care networks and it is critical to know what the goal is of the APCD. Is it necessary to know that there is a physician at different locations? He also mentioned that it can be easy to lose sight on the delivery of the promise of the database by getting too stuck in the weeds, and this would also possibly be replication some of the regulatory elements already in place.

Amber Ott, CHA, asked if there was a methodology for developing an FFS- equivalent, and was reassured that that will come in a later part of the presentation.

Cheryl Damberg, RAND, disagreed with the statements proposed that we don't want to know information on the individual physician level. She argued that, in order to look at and implement interventions it is critical to have this data. As a part of this work we will need to be able to map patients to physicians, physicians to one or more health groups, and also examine their relationship to health plans and hospitals. Cheryl inquired if the OSHPD team has worked with IHA? Scott confirmed that OSHPD has had informational interviews with IHA both on their Data Atlas as well as the provider directory. He notes that leveraging what exists today is top of mind and we are hoping that we can leverage those.

Ken Stuart, California Health Care Coalition, noted if we are ultimately going to start looking at quality and appropriateness of care then we would need to look at the individual provider levels.

Terry Hill, CMA, mentioned that in the Review Committee meetings we are not going to get into the granularity of the data but that is it important to address how much noise is there in the data, in order to appropriately level set. Terry reflected on the analysis he did on medical group data and noted that there are a lot of problems with the data and it can be very difficult to do individual measurements. The limitations of the data will need to be delineated. John noted that as with any complex data set, there will be imperfections, therefore we propose a phased approach and as the data base matures to get more and more granular with the data.

Cheryl Damberg, RAND agreed with the tiering strategy but also reminded the committee that California has a pretty rich history of doing work with Tier 1 data sets, so how do we take this existing work and take it to the next level.

Anne Eowan, ACLHIC reiterate the importance of managing the expectations of what we can collect. She requested that the OSHPD team provide written information to RC members of what is collected in each of these data files.

Charles Bacchi, CAHP, reminded the committee that there are no regulations to guide the behavior of providers. If the APCD only asks for health plan data it is important to remember that health plan data is under contracts with groups or providers, and the terms of contract limit the health plan's ability to collect certain data elements. There is data we can get and data that we cannot get, and the issue of the contracts as a limiting factor is critical to address.

MJ Diaz, Health Access, reiterated the importance and benefits of getting provider data, especially as it relates to quality and how different populations are treated differently for different conditions.

Denise Love, NAHDO, mentioned that in Utah there was iterative process with the data collection and as the database matured the quality of the data improved. It took about two years with the vendor. Part of the drive to improve the quality of the data was that the stakeholders themselves were finding issue with how low quality the data is. There can also be Use Cases for the APCD that track the improvement of data quality over time.

Cheryl Damberg, RAND, followed up on Denise's point by asking if there is something that

California can learn from Utah and other states in terms of how they improve their provider directories. Denise explained that part of it is that the data vendors are getting better at mapping to Master Provider Index. John Freedman also mentioned that a robust data quality effort is an important element of all APCDs. Finally, Bobbie Wunsch reminded the group that the committee will have an opportunity at each meeting what we have learned from other states, that way California is not starting from scratch.

Emma Hoo, PBGH, reminded the committee that it is important to look at the currency of the examples that the committee examines, as some of the more current examples will be more relevant to the current landscape rather than looking at examples from five years ago.

Joan Allen, SEIU-UHW, noted that there are a few efforts here in California that the Review Committee should get updates on to ensure that the committee has a common understanding.

John Kabateck, NFIB, inquired if out of any of the Core Files is there one of them that has more discrepancies in the data. John Freedman noted that each of the core files is different and has its own inherent limitations.

Cheryl Damberg, RAND, noted that it seems like there are some changes that would be required to contracts based on learning from other states. It will be critical for stakeholders who have to make these changes will have lead time to make these changes. Scott Christman noted that the Review Committee may also provide guidance which could be conceptualized as recommendations around enabling legislation to ensure these changes are made.

Discussion around Slides 14-16

Joan Allen, SEIU- UHW, inquired if there are there any APCDs where you can see all of the cost elements: charge, insurance discount, allowed amount, copay, coinsurance, deductible, and insurance payment. John confirmed that the data are all in their on the claim.

Amber Ott, CHA, inquired if the cost data that is collected is available on an aggregate basis? John affirmed that all this information is available on a claim level, however it is not made publicly available.

Terry Hill, CMA, inquired about how does an APCD handle bad debt. John responded that the patient is responsible for paying their share, however the payer does not know if the patient paid. The provider may take action to ensure that they receive that payment, including small claims court, however it is not included in the APCD as the payer does not have access to that data.

Joan Allen, SEIU-UHW, in follow up to Amber's questions Joan wanted to ensure that the committee should not live in the assumptions that claims level data will not be available for research purposes. John clarified that publicly available meant accessible by the general public and that data with appropriate protections would either be aggregated up to protect the privacy of individuals and released publicly or with certain data release protections and considerations be available for release to a research body.

Discussion around Slide 17

Emma Hoo, PBGH, noted that in California there are managed care Medicaid plans that are currently collecting CPT 2 codes that capture clinical outcomes and we should learn from that. John noted that yes that is a great point and that data has improved so much over the years, but it is important to remember that there is an immense amount of information in this data and it has to be taken in proper context.

Charles, Bacchi, CAHP, asking about the spectrum of different data sets – claims, encounter, non-claims –, where would claims data go in terms of how easy and clean it is to collect as compared to encounters or alternative payment methods. John noted that this is a bit of an evasive answer but each source is different and has its own intricacies so in certain ways there are benefits to each, but by their nature if you get full FFS claims you can get more information than from the other sources. Charles followed up asking if claims would have more accurate cost information than the other methods. John noted that about cost, in a pure FFS world yes it would have more accurate information, but a pure FFS world is shrinking and there are many other costs that have to be taken into consideration.

Discussion around Slides 18-21

Emma Hoo, PBGH inquired to what extent do we see encounter dollar amounts in other states. John mentioned that this will be part of the Alternative Payment Methods portion of the presentation.

Charles, Bacchi, CAHP, noted that it might be helpful to talk to DHCS and their efforts to improve encounter data in Medi-Cal and it may be helpful for the Review Committee to know where is the Department and where are the plans in getting quality encounter data. Though Medi-Cal is only 11 million in managed care and 2 million in FFS, it is still helpful to know what some of the complexities in the work are.

John Kabateck, NFIB, inquired about the difference between encounters and claims. John Freedman explained that encounter data is a record of the visit but is not tied to payment information since providers are paid on a capitated basis. Claims are a record of the visit however they include cost information. The claim is what ensures the provider actually gets paid.

Ken Stuart, California Health Care Coalition, asked if there was a methodology for comparability of services in the capitated model versus Fee For Service. John segued into the alternative payment method portion of the presentation to address Ken's questions.

Discussion on Slides 23-27

Ken Stuart, California Health Care Coalition, asked if you can have a large group medical group participate in a health plan, do you just tie those network costs to the encounter data services. John noted that ultimately you need to make the connection, however the question is what kind of method you will use to and it depends on what type of alternative payment it is. The exercise becomes that you must assign a numerical value.

Emma Hoo, PBGH, noted that the slide that says that approximately 70% of commercially insured Californians are covered by health plans that generate encounter data it is important to separate the services that are under capitated payment rather than by percentage of population that is under capitation, as in many cases it may just be primary care so as a portion of the dollars it may be a relatively small amount. Jonathan noted that there are

initiatives in some states to collect information about the percentage of cost that goes to primary care, to see effects on primary care spending for long term health costs and outcomes.

Charles Bacchi, CAHP, requested some insight to other states in terms of their percentage split of encounters versus claims. Jonathan noted that Colorado is very different in terms of their split though they do have a large Kaiser presence. He was not sure on the split in Oregon, but will be able to check on that, however the big take away is that states do vary on their splits, however the California claim/encounter split is larger than in most states. Charles also followed up on the statistical viability of a sample size has 30% claims data with actual paid amounts, 70% data that has been generated by proxy and how valid the data will be if 70% of that data that has been generated by a proxy rather than reality. Jill Yegian noted that the 70% is that 70% of the people are under some form of capitation, not that it is 70% of the core data is not needed. That is more like 15% of the payments that are under capitation, and the team will provide more detail on the types of services that are included in that 15%. Denise also noted that because of this fact, the validity process of the data is very important and having an active feedback loop is critical. She noted that it is important to proceed cautiously in the beginning of what conclusions are drawn. Jonathan also noted that it is critical to not mix apples and oranges and once of the ways to do that can be to segment the data into large discreet chunks to do comparisons across FFS and capitation. He also provided an example of an analysis the Colorado APCD did where they compared average facility payments in simple knee and hip replacements and were able to show price variation across the state. Once people became aware of the discrepancies and they wanted to know if it was warranted and what they could do about, which is priceless for an APCD to generate such conversation.

Anne Eowan, ACLHIC, inquired in terms of performance payments is more of an accounting functions rather than on the claim level. It is challenging to attribute performance payments to an individual provider but tends to be on the medical group level. Additionally, she noted that Oregon and Massachusetts come out with pretty different data sets, and her understanding is that the Massachusetts data comes out with data is more useful. Massachusetts categories of APM are more highly aggregated and we have heard they are more aligned with the ways that payers are structuring their contracts. The data is aggregated and cannot be attributed to individual providers but can still provide some worthwhile information regarding trends. Massachusetts has used this information to determine total cost of care. This is a separate collection effort and format.

Cheryl Damberg, RAND, inquired if any of these examples flag a personal level file to see if the person is exposed to some type of APM. Yes, on the APCD-CDL™ layout will have a capitation flag and the dollar amount associated with that service, sometimes called a “prepaid” amount. Cheryl wanted to know if we could go a level deeper to see what kind of APM the patient is exposed to (bundled payments, shared savings etc.) Jonathan noted that he was not aware of any state APCD that has gone to that level of specificity, though Oregon and Massachusetts do collect the APM file with that information it is a supplemental data submission file.

Emma Hoo, PBGH, followed up on Cheryl’s question noting that IHA currently is capturing an ACO flag for individuals that are attributed, but we may want to think about multiple levels.

Terry Hill, CMA, noted that there is a long-standing issue around risk adjustment and health outcomes and also costs. It is important to note that poorer outcomes in certain areas are not

necessarily associated with poorer performing providers, because we have to consider social determinants of health. It is critical to think about the appropriate use of risk adjustment and needs to be better than we currently have available.

Discussion on Slides 28-29

Ken Stuart, California Health Care Coalition, asked regarding Pharmacy rebates what if the payer, in this case the Pharmacy Benefit Manager (PBM), does not divulge all of the rebates that they are receiving. John noted that collecting pharmacy rebates information is important because it gets at two areas. First, if the payer says that they have for example \$1 billion in drug spending, but they got \$500,000,000 in rebates than that is not fully accurate spending information. Additionally, if they are not seeing those rebates but the PBMs are pocketing those rebates, than that is another element that is of interest to know. Denise also followed up that Arkansas is requiring PBMs to report but they were having a very hard time identifying the PBMs since they are not licensed with the state.

Discussion on Slides 30-31

Emma Hoo, PBGH, noted that Covered California captures actuarial value as a proxy for benefit design which is also captured by IHA. Do any of these states capture that data as a way of assessing differential benefit values and separate high deductible plans from others? John noted that Massachusetts does collect this actuarial value, though he is not sure if it is collected on all plans. Jonathan noted that Colorado collects for both the metallic level, actuarial value, and grandfathered status, but this is only for plans in the Exchange. Denise noted that benefit design is a nut that has not yet been cracked by state APCDs and it is difficult to capture. Some of the actuaries want to have a use case to know high deductible versus other plans due to the risk associated with high benefit plans. Jonathan also noted that many states do a variable risk basis generally used to differentiate between self-funded and fully insured plans but can be used to differentiate between other benefit types.

Charles Bacchi, CAHP, noted that the California Department of Managed Health Care has a minimum actuarial value for all of the Knox Keene plans, that is not pegged to metal tiers of Covered California, but there is at least some minimum threshold that limits the out of pocket cost, which is also included on the insurer side. Emma noted that this data can be stratified to assist with benefit design.

Public Comment:

Catrina Reyes, CMA, provided comment on the discussion on individual provider data. She wanted to note if the goal of the APCD is to look at total cost of care and population health management, then a lot of that can be accomplished with aggregated data. Presenting individual level provider data may present serious concerns around antitrust and privacy.

John Minot, California Association of Public Hospitals and Health Systems, provided comments on the discussion around fee-for service equivalents in a capitated arrangement. He noted that it will be an issue that will take a lot of care and time as it raises a lot of issues. One of the issues that he highlighted that was not a part of the discussion included that a capitated payment that may cover multiple provider systems without connection to one another once you get into global capitation with hospital services and out of network services. Therefore, in addition to the question of how to apportion to the dollars you have the risk if you are not very careful of the dollars that are captured or overreporting the cost of care if you have the capitated

	<p>payment and the out of network claim, which has in fact been deducted from that capitated payment.</p> <p><i>Adam Francis, California Association of Family Physicians</i>, also commented on the discussion around individual provider level, not necessarily with concern regarding antitrust, but more so with the concern about accuracy of the data which can be very difficult. Additionally, he noted the concern of requiring physicians to check the data, as primary care physicians do not have the additional time to do so.</p> <p>The committee recessed for a 10-minute break.</p>
Use Cases	<p>Jill Yegian and Michael Valle presented a follow up presentation to the March 21 Use Case presentation. The presentation included a framework for considering HPD use cases, including "tiers" for data collection and reporting; topics, the audiences; and criteria for selecting use case examples as well as a review and discussion of specific use case examples. For the full presentation please see slides 36-65: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-4.18.2019-Final.pdf</p> <p>Discussion on Slides 39-46</p> <p><i>Ken Stuart, California Health Care Coalition</i>, asked what is the minimum retrospective data collection to get an accurate baseline for data analysis. Michael noted that three years is the recommendation and what we have seen in other states.</p> <p><i>Emma Hoo, PBGH</i>, asked if there are examples of states that have done retrospective data analysis to shorten the timeline? Denise Love, NAHDO, noted that it depends on the individual state, some states have gone retrospectively, but some have not. John Freedman noted that in most states in the initial submission you get three years of data. Jonathan Mathieu noted that they have heard from submitters that they usually hold three years of data that is able to be actively pulled.</p> <p><i>Charles Bacchi, CAHP</i>, asked regarding the fact that most states collect three years of historical data prior to releasing an APCD, did the health plans have to reformat the file or did they submit whatever was available? John Freedman acknowledged that this historical data is limited to what is available and usually the three years of data just include what is in the "core set": claims, encounters provider file, eligibility file. John Freedman noted that he is not sure if APM data was collected in retrospect.</p> <p><i>Terry Hill, CMA</i>, suggested to move vital stats to Tier 1 as that linkage should be relatively simple. Jill Yegian acknowledged that fact and also reminded everyone that the guidance that the OSHPD team has gotten is to go incrementally and not try to do more than is possible all at once.</p> <p><i>Charles Bacchi, CAHP</i>, affirmed that the tiered approach seems reasonable and looks orderly.</p> <p><i>Anne Eowan, ACLHIC</i>, agreed that keeping the scope small and not requiring new ways to report as well as keeping a consistent format is very important, especially as we move from tier to tier. And Anne noted that the technical workgroup is a great resource to determine the technical issues that come along with the data formats.</p>

Emma Hoo, PBGH, agreed that the tiering approach made sense however she felt that we should not let the tiering be a limiting factor. For example, if a specific data format gets locked in the early stages and then doesn't work for data collection down the road that will be problematic. She also encouraged pilots of Tier 3 while developing Tier 1. She also noted that it would be helpful to add procedural registries such as the joint registry, and maternal data quality effort which is mature in California.

Bill Barcellona, America's Physician Groups, noted that he did not see a lot of mention on behavioral health which is a priority for California.

Cheryl Damberg, RAND, echoed Emma's comments that she agreed that we are not going to do everything out of the gate, however in California we are not starting from square zero. While not every payer is doing what is it in Tier 1, a big chunk of the state is already doing this through the IHA work. She inquired what is it that would allow California to go from Tier 1 to Tier 2 and how do we move to Tier 2 more quickly? What needs to appear in the data file and what the issues are there? She also inquired about the timeline from tier to tier. Jill noted that this has been a topic of discussion on the team and more research needs to take place, but one possible timeframe to meet each tier includes:

- Tier 1 Core: 1-2 years
- Tier 2 Expansion: 3-5 years
- Tier 3 Maturity: 6+ years

However, she noted that if things are moving well we can quickly move from Tier 1 to Tier 2. The decision point for the committee to consider is do we want to move things into Tier 1 or do we want to move through Tier 1 quickly. Cheryl Damberg agreed and followed up that whoever the data suppliers are, they will need to know what is forthcoming in terms of data submission requirements, in order to be ready to provide the required data in the required time frame, and so the team will need to be thinking about Tier 2 and Tier 3 while doing tier 1 to lay the groundwork. Jill Yegian affirmed that these are not sequential tiers but are concurrent, so while APM will not be collected in Tier 1 we do not wait until Tier 2 to start thinking about collecting APM data. Cheryl Damberg also noted that some of what is in the Tier 2 is already being done in California and if we maybe should not be divvying these elements up specifically into tiers but recognizing that there will be a tiered process, but the specific elements might fit in down the road. Jill Yegian agreed that we need to learn from what has been done in California, however she still has a healthy skepticism that despite the work that has been done, this effort is unlikely to be quick and easy.

Ken Stuart, California Health Care Coalition, noted that at the first meeting we agreed that there will be sensitivity to fiscal impact to payers who are required to submit data as well as importance of leveraging existing data. He noted that it is important to know all the information that will be needing from the payers and to not continually keep coming back to ask for more elements. Jill Yegian agreed that the tiering slides show the teams recommendation of the data that will be collected in order for everyone to be prepared as to what will be expected.

Denise Love, NAHDO, noted that states that are bringing on the APCDs in recent years are moving faster than those first states that started APCDs. Additionally, she noted that data release policies will also determine the speed and having strong data partnerships with academics or interagency, can take off with use cases which will help move that quickly.

Terry Hill, CMA, noted that he is struggling a bit with the timeline in terms of what is wanted and what is realistic. He noted that if there was a governance process that was continuing would make him more comfortable, but there is a bit of nervousness that our Use Cases will be pie in the sky. He also noted that IHA has a data lag which is important to account for and some of the use cases are not realistic like using the data to change the delivery system, due to the data lags. Jill Yegian agreed that some of the Use Cases that were submitted were realistic but not Tier 1, and there were some that will not be possible.

John Kabateck, NFIB, inquired if there is a possibility for a rough calendar to work from? He also asked if the tiers have fluidity that can move things around or are they set in stone. Jill noted that yes there is definitely fluidity.

Anne Eowan, ACLHIC, noted that when we look at timeline it is important to keep in my that anything that requires a legislative mandate will be about 1 year in addition to any technical changes for the data submitters may take one more year.

Scott Christman, OSHPD, followed up on a couple of notes, one noting that Anne Eowan's point on timeline is very good and that there is a milepost of the database being done "substantially" by 2023, but it is important to determine what does "substantial" mean. Additionally, he noted that in response to Terry Hill's question regarding governance we will look to the committee regarding on going convening of the group so that we are not memorializing in a static leg report something that might change we want to build an approach and then have meaningful governance to adjust with changes in the landscape. Finally, he noted regarding Denise Love's point on data partners, OSHPD has infrastructure in place today that allow for restricted access to data to the research community and that will be part of the conversation moving forward.

Joan Allen, SEIU-UHW, inquired about how we develop the feedback loop, so if the research community finds problems in the data how can we incorporate their feedback as quickly as possible, which requires much more work than just a data use agreement. Denise Love, NAHDO, noted that some states have developed data user groups for power users of the data to provide that feedback.

MJ Diaz, Health Access, noted that she appreciates the context provided with the tiers. She noted that for the consumer groups the use cases submitted are a bit more complex based on who we are representing. Finally, she would like to request the resources on what data and sources already exist in order to quicken the process and so we are aware of what is already here.

Cheryl Damberg, RAND, noted that the research community would be happy to share their experience of working with other state APCDs and can provide a list of issues and concerns if that is of interest. Additionally, she wanted to make a point regarding timing of implementation if the plan is to provide lead time for data submitters to know what is coming down the pipe. Jill Yegian affirmed that is the plan.

Charles Bacchi, CAHP, wanted to second MJ Diaz's recommendation to identify resources that already exist, which will provide helpful context for stakeholders to know what data already exists so that all the requirements are not automatically translated on requirements for health plans.

Joan Allen, SEIU-UHW, wanted to make sure that we do not assume that some of these

elements will not be collected right away, and may be linkages at first but could become data elements moving forward.

Scott Christman, OSHPD, noted that there will be a presentation at the next committee meeting highlighting existing OSHPD data assets.

John Freedman noted that what he is hearing in the discussion is that we want to go quickly and do it well. California has a few great advantages, one is that we are not the first in this space, so we do not need to reinvent the wheel in a lot of these areas. Additionally, national insurers have already done this work in other states. California has robust connections that can be leveraged. However, we are still subject to the laws of physics (data quality issues) and economics (man power needed to do the analysis) that will affect the timeline.

Bobbie Wunsch noted that it sounds like the committee agreed that the tiering concept makes sense however there was some disagreement in the details including:

- What is included in each tier?
- What is the timeline of each tier and is there flexibility?
- What is the impact on payers?

Emma Hoo, PBGH, had a question on if other states phased their releases based on data streams? John noted that most states go with commercial data first. He noted that usually Medicare data takes more time while Medicaid data has additional sensitivities.

Cheryl Damberg, RAND, noted that it will be very important for people to use the data and offered RAND as a resource to test this data.

Discussion on Use Case Example Slides 52-57

Terry Hill, CMA, mentioned that looking at just one disease in a chronic condition use case is not representative of reality, as co-morbidity is a multiplier effect.

John Kabateck, NFIB, had a question on if we can drill down to cities or counties who would want to cost, or trend compare. Jill Yegian noted that the granularity that is possible with the data depends on a few issues and noted that we want to drill down as much as possible without violating privacy issues.

Emma Hoo, PBGH, commented that diabetes as an example is one that has been very well documented. To add value the APCD should address population health issues that have not been well examined to illuminate areas that we can act on where there isn't a lot of work. Jill agreed however mentioned that depending on who the audience is, an issue may or may not be well documented. Jill Yegian noted that is an important point and we want to hear from the Review Committee what their general importance issues are, however it is important to note that value depends on who the audience is.

Charles Bacchi, CAHP, when assessing the Chronic Conditions Use Case, was considering whether or not providers belong in the secondary audience bucket.

Ken Stuart, California Health Care Coalition, inquired as to what is the challenge of doing a robust behavioral health use case. Jill Yegian mentioned that with behavioral health data there are a variety of restrictions and limitations, particularly 42CFR regarding substance use

	<p>disorder data. She notes that we certainly could build a Use Case around behavioral health, but it would need to address these various data limitations. Ken Stuart followed up to note that more and more health plans are excluding out of network coverage due to the out of network substance use disorder facilities, which is a growing plan design concern.</p> <p><i>Amber Ott, CHA</i>, suggested for the team to consider doing a pilot APCD with existing OSHPD data sets to see what is possible. Chris Krawzyck, OSHPD, noted that we can definitely do that however there will be gaps due to the availability of data currently. Scott Christman noted that this is a good point and it is important to note that there may be existing assets that can be augmented to assist in this data that may not directly come from the health plans. One example is ambulatory surgery center data, so keeping this in mind as the group further develops recommendations.</p> <p><i>Cheryl Damberg, RAND</i>, had a process question related to prioritization of use cases, and if we are indeed prioritizing then she would be interested in knowing exactly what data is needed. Jill Yegian noted that we are not prioritizing the use cases as there are a limitless number of use cases that can be used, but rather looking at them through the tiers. Jill noted that we looked at the Use Cases through the lens of the tiers, and some crossed tiers, some will never be feasible and others maybe in the future. The team is thinking to look at the buckets of data, linkage and reporting and then fit the use cases into those tiers, rather than dissect each use case based on which data will be required to do it. The use cases helped to identify high priority use cases and also illuminate areas where there are limitations when it comes to what an APCD can do.</p> <p><i>Charles Bacchi, CAHP</i>, noted that he found it helpful that we can do something with these use cases and builds support from stakeholders, however, as a committee we can argue over use case scenarios and their relative value, but we are running out of time, and he did not know if that is the best use of our time.</p>
Public Comment	<p>Adam Francis, California Academy of Family Physicians, commented on the importance of studying primary care spending as so many other states have already done this such as Oregon, Rhode Island and Colorado and we can learn from what they have done. He notes that primary care spending is definitely a national trend as many states are working to gather this information. Especially at a time when we are concerned by costs and we know the cost containment effects of primary care.</p> <p><i>Doug McKeever, Covered California</i>, thanked the group for accepting the Covered California Use Cases that were submitted a bit late. The document provides foundational and critical data categories, and others that we consider aspirational. He inquired if the Use Cases will be shared and publicly available, which Scott said yes but they might be anonymized. Doug McKeever also noted that the terms of leveraging and alignment has come up, which Covered California definitely supports, and suggests to the team that it may be helpful to bring in IHA or others that are doing this work to share with the committee. Lastly, he notes that there has been discussion around timing and he encourages the committee to work to implement this at a more rapid timeline than 5 years.</p> <p><i>Denise Chapel, representing the public and allied health</i>, commented that she supports the tiers, but that we do have a lot here in California that we can use to support this effort to do the business case for the best cost in support of the triple aim.</p>
Agenda for Upcoming Review	<p>Ken Stuart adjourned the meeting and thanked the committee members and OSHPD staff. He offered to Scott to provide some follow up items. Scott noted the following items that will be built into future agendas:</p>

<p>Committee Meeting & Adjournment</p>	<ul style="list-style-type: none">• Considerations of examples from DHCS• Existing assets at OSHPD <p>He also noted that the OSHPD team can prepare the submitted Use Cases for public sharing.</p> <p>Ken had some closing thoughts that there is a consensus that we want to build a comprehensive database that was done yesterday and leaves the committee to think on the quote “Build it and they will come” in terms of developing this database. He closed with noting that the topic for May will be data collection, which will include discussion on format options, streams of data, and data collection with California capitated system.</p>
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