Office of Statewide Health Planning and Development

# Healthcare Payments Data Program
# Review Committee Meeting

**June 20, 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; Ted Calvert, Consultant, OSHPD; Chris Krawczyk, Chief Analytics Officer, OSHPD; John Freedman, President, Freedman HealthCare; Jonathan Mathieu, Senior Health Care Data/Policy Consultant, Freedman HealthCare; Bobbie Wunsch, Consultant; OSHPD.

**Others:** Emily Sullivan, Deputy Director, National Association of Health Data Organizations.

**Public Attendance:** 16 members of the public attended.

| Agenda Item | Meeting Minutes |
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| Welcome & Meeting Minutes | The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions.<br><br>The May 16 Review Committee meeting minutes were approved, with some minor edits that Anne Eowan and Emma Hoo provided to the Review Committee Coordinator.<br><br>Bobbie Wunsch went over the ground rules for the meeting. |
| Deputy Director's Report | Scott Christman provided an overview of what was discussed at the May Technical Workgroup. He noted that the group dove more in depth into the elements of the APCD-CDL™ as well as a discussed the current data submission landscape, including the current submission requirements that plans comply with, the frequency of those submissions, and the thresholds for submissions. He also mentioned that in the upcoming Technical Workgroup meeting for June, the workgroup will discuss potential supplementary file formats. For a full summary of the May Technical Workgroup please see: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/HPD-Technical-Workgroup-5.16.2019-Summary-Final.pdf |

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| | As a reminder to the committee, Scott Christman provided an overview of a high-level proposed road map for data collection and data linkage. He explained that upon completion of the legislative report, due July 1, 2020, due to the legislative and regulatory cycle, there would be some time until an official statutory mandate is in place. However, he noted that OSHPD is interested in finding ways to do as much work as possible prior to the official start of the statutory mandate. The road map is available on slides 4-5: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-6.20.2019-Final.pdf<br><br>*Amber Ott, CHA,* inquired why linkage to vital statistics is in Tier 2, as this is something OSHPD already does. Scott Christman discussed that the priority is the development of a Master Patient Index, which is necessary to complete ongoing data linkages. He noted that OSHPD wants to set realistic expectations and core linkages need to be working effectively first, prior to exploring more complex linkage.<br><br>*Anne Eowan, ACLHIC,* asked if dental data is part of the authorizing legislation. Scott Christman noted that Assembly Bill 1810 is not considered authorizing legislation and that the job of the Review Committee is to recommend who should be submitting what data. Anne Eowan noted that we have not yet discussed if other states collect dental data, and since the Review Committee does not have a representative from the dental association, she suggested engaging the California Association of Dental Plans.<br><br>*John Kabateck, NFIB,* asked what California Open Data is. Scott Christman noted that within the California Health and Human Services (CHHS) Agency, the Open Data Portal is a platform where CHHS departments make data available in a machine-readable format. He noted that the Open Data platform has become a rich resource for public data and represents a commitment to data transparency.<br><br>*Cheryl Damberg, RAND*, asked if claims data collection includes pharmacy claims and workers compensation. Scott Christman confirmed that pharmacy claims are included however, workers compensation is not, which is something that can be discussed further down the road. John Freedman noted workers compensation claims are usually paid through the health plans then reimbursed through subrogation or coordination of benefits by the workers compensation carrier. He noted that the workers compensation payments however, are out of scope for state APCDs. Cheryl Damberg followed up, asking if the medical side of workers compensation will be captured. John Freedman confirmed that to the extent to which the workers compensation claims are paid through the commercial carrier they would be included.<br><br>*Ken Stuart, California Health Care Coalition,* asked a question regarding coordination of benefits and if these reimbursements are included in the total cost of care measure. John Freedman confirmed these reimbursements would have to be accounted for to capture the actual Total Cost of Care.<br><br>*Joan Allen, SEIU-UHW,* asked if the HPD system would capture patients' share of costs. John Freedman noted that it depends on the use case. He noted that some states are interested in the allowed amount and what the patient's out of pocket cost is. Scott Christman commented that the fields which capture this information are included in the APCD-CDL™, and all information that is available will be collected and reported. Joan Allen also followed up inquiring where the self-paid and uninsured data would be captured. Scott Christman noted that the topic of self-insured and uninsured will be covered under the data submitters, not |

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| | under collected data element.<br><br>*Emma Hoo, PBGH,* inquired if the standard would be that plans are submitting net adjudicated files or is there also change transactions that get housed within the OSHPD database as adjustments and updates over time. John Freedman noted that both would be captured, and that an important part of the process will be versioning of the claims to ensure we have final count of who paid what.<br><br>*Charles Bacchi, CAHP,* noted that trying to track subrogation is very challenging, and that it is important to set realistic expectations. He also followed up on the pharmacy rebates question inquiring what data would be received and from whom. He noted his skepticism in Medi-Cal or Pharmacy Benefit Managers (PBMs) sharing their rebates. He also noted that having third party submitters, such as PBMs, can add complexity. Lastly, he noted that timeliness of the data is also an issue when it comes to collecting rebate data. Scott Christman was appreciative of the point and noted that OSHPD's focus is on what is possible to do.<br><br>*Terry Hill, CMA,* followed up on the discussion regarding pharmacy rebates noting that some of the most basic HEDIS measures rely on knowing if a patient is on a drug.<br><br>*Charles Bacchi, CAHP,* clarified that pharmacy data is important, however, pharmacy rebates may be challenging to collect.<br><br>*Ken Stuart, California Health Care Coalition,* also noted that data on pharmacy rebates is also important as it gets us closer to the true total cost of care.<br><br>Lastly, Scott Christman provided an update on the $50 million reversion that the Senate had proposed to the $60 million originally allocated for the HPD System. Scott noted that the reversion was not passed and that there was support from both the Assembly and the Administration to keep the full amount of the originally allocated funding, demonstrating their strong support for this project to be successful. |
| Follow-Up from May 16 Meeting | Ken Stuart reviewed the five data collection recommendations that the committee approved at the last meeting regarding. He then introduced Ted Calvert, OSHPD Consultant, to present one of the two tabled recommendations from the May meeting, regarding supplemental files.<br><br>At the May meeting the committee had tabled the following recommendation regarding supplemental files, citing that the draft recommendation was not specific enough on the type of data that would be collected. Ted Calvert introduced a revised version of the supplemental file recommendation, for the committee's consideration. He provided some background information noting that the goal of this recommendation is to capture all the payments made by health plans toward the cost of care.<br><br><u>Original as Presented in May:</u><br>6. **Supplemental files**: The HPD should collect non-claims-based payments through required supplemental files to support total cost of care analyses in California's heavily capitated environment.<br><br><u>Revised</u>:<br>6. **Non-Claims-Based Payments**: The HPD should collect non-claims-based payments, such as APM payments and pharmacy rebates, in order to capture the total cost of care. Since these payments are not included in the APCD-CDL™, OSHPD will work |

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| | with industry to specify the format(s) of the supplemental file(s).<br><br>Discussion on Recommendation:<br><br>*Anne Eowan, ACLHIC,* inquired if "work with industry" refers to working within the regulatory process? Ted Calvert responded that in the immediate-term, it means working with the technical workgroup and looking at what other states as well as the Integrated Healthcare Association (IHA) are doing to help determine what the supplemental file format would look like. He also noted that ultimately down the road the supplemental file format would need to be specified in regulation through a formal process. Anne Eowan commented that she thought it was a great idea to get the consensus early on.<br><br>*Ken Stuart, California Health Care Coalition,* also reminded the group that the Committee's recommendations go into the legislative report, however, ultimately it will be up to the Legislature to develop the final statute and formal adoption of these recommendations.<br><br>*Amber Ott, CHA,* suggested that if the technical workgroup will be determining the file format, OSHPD should consider adding providers to the workgroup, noting that providers will be the sources of data for the patient share of cost. Ted Calvert agreed that provider representation on the technical workgroup could be helpful, however, most state APCDs do not capture information directly from providers, and as of now, providers will not be submitting data to the HPD. John Freedman confirmed that no other state APCDs have providers submitting data thus far. Scott Christman agreed that including providers on the Technical Workgroup would be helpful and asked Amber or anyone else who has suggestions for provider representation on the Technical Workgroup to bring them forward.<br><br>*Emma Hoo, PBGH,* suggested that for the recommendation it would be helpful to add an amendment to include the words "and sources" in addition to formats to help note that industry will help to determine what the sources of the data for the supplementary file will be.<br><br>*Charles Bacchi, CAHP,* asked for some clarification on Emma Hoo's comment, inquiring if she meant that having capitated groups report instead of plans was something that should still be on the table for discussion. Emma Hoo clarified she did not mean groups should submit data instead of plans, but in alignment with Amber Ott's comment, she felt it could be helpful to consider all the sources of where this data could come from, which could also include capitated groups.<br><br>*Ken Stuart, California Health Care Coalition,* inquired if it is even possible to come to a determinable amount of what consumers actually pay. John Freedman noted that the patient-paid amount is very difficult to assess which is a reason states have traditionally not chosen to pursue that data element.<br><br>*MJ Diaz, Health Access,* noted that Health Access would be supportive of including providers in the technical workgroup given Health Access' work to better understand risk sharing arrangements that hospitals have with other entities. Additionally, she noted that given that DMHC has finalized regulations that would require those type of risk sharing arrangements to be either licensed fully or limitedly Health Access thinks that having that data to support other state department work around better understanding what those risks are, would be helpful.<br><br>Ted Calvert noted that the intent of the recommendations is to collect this data from payers, which narrows the potential sources to discuss. |

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| | *Cheryl Damberg, RAND,* noted that we should not try to limit the sources of data and that adding the word "sources" into the recommendation would be important as the sources of data need to be considered as a part of this discussion, to which Emma Hoo agreed.<br><br>*Charles Bacchi, CAHP,* reminded the Committee that the next Review Committee meeting is on data submitters and he wondered if adding in language into this recommendation would predetermine that conversation. He noted that right now the committee should just focus on deciding if we want non-claims-based payments, and that down the road there could be a distinct recommendation on sources. He also commented that in the recommendation, currently, there is a list of some specific non-claims-based payments, but not all. He suggested to either list all the non-claims-based payments that would be collected or to not list any of them. He recommended removing the clause "such as APM payments and pharmacy rebates." Ken Stuart followed up suggesting adding "all" in front of non-claims-based payments. Charles Bacchi commented that "all non-claims-based payments" is ambitious.<br><br>*Cheryl Damberg, RAND,* responded that she would like to add in the word "sources", because it is not predetermining the sources but just noting that sources should be considered.<br><br>*Terry Hill, CMA,* noted that there are very few medical groups that could report the data that we are requesting.<br><br>*Cheryl Damberg, RAND,* followed up to note that adding the word "sources" to the recommendation allows for a conversation around which sources exist and what the issues may be, not saying that the sources are determined.<br><br>*Joan Allen, SEIU-UHW,* suggested broadening the word "industry" to instead say "stakeholders."<br><br>*Bill Barcellona, America's Physician Group,* followed up on the earlier conversation regarding patient share of costs and noted that the IHA Atlas does report out of pocket exposure.<br><br>Ken Stuart read out the proposed amended version of the revised supplemental file recommendation: "The HPD should collect non-claims-based payments in order to capture the total cost of care. Since these payments are not included in the APCD-CDL™ OSHPD will work with stakeholders to specify the format(s) and source(s) of the supplemental files.<br><br>*Bill Barcellona, America's Physician Group,* made a motion to accept the recommendation as amended.<br><br>*Joan Allen, SEIU-UHW,* seconded Bill Barcellona's motion.<br><br>The committee voted 11-0 in favor of the amended version of the revised supplemental file recommendation.<br><br>Proposed Recommendation:<br>6. **Non-Claims-Based Payments**: The HPD should collect non-claims-based payments, such as APM payments and pharmacy rebates, in order to capture the total cost of care. Since these payments are not included in the APCD-CDL™, OSHPD will work with industry to specify the format(s) of the supplemental file(s). |

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| | Final Recommendation as approved by Committee:<br>6. **Non-Claims-Based Payments**: The HPD should collect non-claims-based payments~~,~~ ~~such as APM payments and pharmacy rebates,~~ in order to capture the total cost of care. Since these payments are not included in the APCD-CDL™, OSHPD will work with ~~industry~~ stakeholders to specify the format(s) and source(s) of the supplemental file(s). |
| OSHPD Data Linkage | Chris Krawczyk, Chief Analytics Officer at OSHPD presented on current OSHPD healthcare analytics and data linkages. His presentation covered three sections including a background on current OSHPD data assets, OSHPD data linkages, as well as future strategies and opportunities for improving OSHPDs analytic capacities. For the full presentation please see slides 11-22: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-6.20.2019-Final.pdf<br><br>Discussion on Background of current OSHPD Data Assets (Slides 11- 16):<br><br>*Terry Hill, CMA,* inquired about how OSHPD manages inappropriate use or misuse of data. Chris Krawczyk noted that OSHPD does have a process in place and that there are different considerations depending on the data product, the user, their history with OSHPD, etc. The OSHPD team uses the request process to put together a risk matrix, informed by the level of data requested (record level versus aggregated). The team also assesses what scientific process is being used.<br><br>*Cheryl Damberg, RAND,* noted that on the federal level there is a general assessment of what the data will be used for and what level it will be reported at, however, there is not a deep dive into the specific levels of analysis. Chris Krawczyk also added on that as a part of the services OSHPD provides, depending on the risk level, data requesters are invited to the OSHPD offices to do the data analysis or OSHDP staff will do some of the analysis and develop a finder file for the researcher without having to release any of the PII. Cheryl Damberg also followed up noting that the federal government, depending on data set, does have specific data destruction policies or requirements about accessing the data only at specific locations.<br><br>Scott Christman also added that OSHPD's public affairs team monitors all the media mentions to ensure OSHPD data is being used correctly. There is a strong emphasis around partnerships to ensure the users of the data are accurately representing the findings.<br><br>*Amber Ott, CHA,* inquired about the level of scrutiny the data goes through prior to being made available publicly. Chris Krawczyk noted that it depends on the data set. There are error tolerance levels, along with additional validations that the team addresses. The team also does multi-data set comparisons and with certain programs, like Coronary Artery Bypass Graft (CABG), the team will do medical record audits.<br><br>*MJ Diaz, Health Access,* noted her appreciation on the presentation and commended OSHPD's work on giving reassurance that the data is being used properly. She communicated her hope that OSHPD can share learnings with other state entities.<br><br>*Joan Allen, SEIU-UHW,* inquired about what challenges can OSHPD foresee when it comes to data linkage. Chris Krawczyk responded that one challenge is availability of data. If OSHPD were to have access to data such as address or additional outpatient data, the data |

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| | set would be higher quality and there would be improved opportunities for linkage.<br><br>*Charles Bacchi, CAHP,* inquired if OSHPD ever says "no" to a research request. Chris Krawczyk noted that there have been instances where OSHPD has said "no", but it is a rare occurrence.<br><br><u>Discussion on OSHPD Data Linkages (Slides 17-18)</u><br><br>*Ken Stuart, California Health Care Coalition,* commented that to him it sounds like in order for the HPD process to be successful OSHPD's current data collection would need to be supplemented to include individual and provider level identification data. Chris Krawczyk agreed and noted that there would be different usages of the data with these additional elements; however, without these elements the use, accuracy, and validity of the data would be limited. Scott Christman also noted that each additional data element leads to an incremental improvement. For example, OSHPD currently receives ZIP Code information which provides limited geographic analysis, however if OSHPD were to receive address, then the geographic overlays would greatly improve the analysis of geographic variation and patterns.<br><br>*Cheryl Damberg, RAND*, noted her support for adding more data to the OSHPD database as the greater amount of detail would align with more information which would lead to better quality of care. She also noted that not only would patient address be helpful, but also including provider address, as the data typically includes billing address and not where the provider practices.<br><br>*Charles Bacchi, CAHP,* noted that all the data is important, but it is important to note that 100% of the data will never be collected and it is critical to level set what is possible to collect. Some of the data collection challenges he noted include changes in home addresses, self-reported social security numbers, and others that should be kept in mind.<br><br>*Emma Hoo, PBGH,* noted that when data has a very large time lag it does not have a lot of utility. She commented that there is a balance between data accuracy and timely data, and that it will be important to identify what is a good enough quality of data for each use case.<br><br>*Ken Stuart, California Health Care Coalition,* followed up to Charles Bacchi's comment and reminded the committee that we are only as good as the information that we get. He noted that the task that is to aggregate the data and then try to fine tune as much as possible. Chris Krawczyk also noted that depending on the use case, the accuracy needed to report varies on the granularity of the data.<br><br>*Cheryl Damberg, RAND,* commented that there will always be noise in the data, however RAND gets 100% of Medicare beneficiary address with state and county codes which allows for a lot of data linkage. To help with changing addresses RAND has asked CMS to put start and end time for the housing data elements. She also commented that in the past OSHPD has struggled with timeliness issues, but the machine learning process seems to be speeding up this process. She encouraged OSHPD to continue exploring that process. She also inquired at what point the committee will discuss the required the staffing and resources needed, as this work can be labor intensive and will require staffing to ensure timeliness.<br><br>Public Comment: There was no public comment after this agenda item. |

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| Data Linkage Concepts and Methods | John Freedman and Jonathan Mathieu from Freedman HealthCare provided a presentation on data linkage concepts and methods, with examples from two state APCDs — Massachusetts and Colorado. Both states collect Personally Identifiable Information (PII) and perform linkage with data within and external to their APCDs. Both states also have different processes to ensure that PII is collected and stored through a secure process. For the full presentation please see slides 24-34: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-6.20.2019-Final.pdf<br><br>Discussion on Massachusetts Data Linkage:<br><br>*Cheryl Damberg, RAND,* inquired what happens if the same person has two different health plans attributed to them. John Freedman responded that each plan uses the same hashing process, so the same unique identifier is associated with the same person at each health plan.<br><br>*Amber Ott, CHA,* inquired if the hashing methodology that Massachusetts employs is also used across government payers. John Freedman noted that he presumed it does but will follow up at the next meeting.<br><br>*Ken Stuart, California Health Care Coalition,* inquired if Massachusetts ever pursued requiring more specific provider information from the service providers when they bill their charges. John Freedman noted that as far as he knows there has not been a concerted effort, however, existing standards state that the information is supposed to be submitted, but in practice it does not always happen.<br><br>*Cheryl Damberg, RAND,* clarified if the hashing process applies to the address, which John Freedman confirmed. She followed up by inquiring how Massachusetts is mapping in social determinants of health. John Freedman noted that Massachusetts keeps the five-digit ZIP code and has only done social determinants at that level.<br><br>*Anne Eowan, ACLHIC*, inquired if the Massachusetts model is helpful in protecting the linkage of providers to their payments and keeping provider payments proprietary. John Freedman noted that the hashing methodology has not been used in that way. He noted that in fact Massachusetts has shared, not from the APCD but from other sources, payment data by provider.<br><br>*Charles Bacchi, CAHP,* inquired if the Massachusetts decision to not link directly to 42 CFR data was forced upon by federal law or if it was a policy decision. John Freedman noted that under 42 CFR a plan could not share this data to the state unless it were to be fully deidentified. The Massachusetts model has not been tested in the courts, but Massachusetts has historically been collecting 42 CFR data, therefore they did not want to lose that data stream, so they enlisted a health expert who ensured their data hashing meet the HIPAA requirements.<br><br>*Cheryl Damberg, RAND,* noted that there was a point in the presentation that said that Massachusetts “rarely allow researchers to link data,” which concerned her. John Freedman noted that other than the Center for Health Information Analysis (CHIA) there are other agencies in Massachusetts that use the linked data such as the Attorney General’s office. However, the data does tend to stay with state agencies. Massachusetts has been very cautious about releasing data for linkages due to fear of risk with the reidentification. |

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| | *MJ Diaz, Health Access,* inquired how can the existing limitations to collect race/ethnicity data be overcome. John Freedman noted that one idea is to use the race/ethnicity probabilistic matching identifiers as a part of the pre-processing and then rehashing the names. He also noted that this is not the method currently used, and this would be an additional potential identifier to consider, but it is an option.<br><br>*Emily Sullivan, NAHDO,* inquired if Massachusetts also hashes their discharged data which contains race and ethnicity data. John Freedman noted that they don't hash that data, which could be a source of race and ethnicity data for inpatient data. However, there is also some discussion on how accurate that data is.<br><br>*MJ Diaz, Health Access,* inquired about how difficult the probabilistic race/ethnicity methodology is. John Freedman noted that it requires name and ZIP code. Cheryl Damberg followed up noting that while there is some amount of mismatching, the probabilistic algorithm preforms better than the Medi-Cal race and ethnicity field. She also noted that if you are analyzing data at an aggregate level it is not that important to have the exact matching, however, the more granular the data analysis gets the more problematic any noise in the data becomes.<br><br><u>Discussion on Colorado Data Linkage</u><br><br>*Amber Ott, CHA,* inquired about what it means that Colorado has a high tolerance for risk. Jonathan Mathieu noted that states have different methodologies for handling PII, and some state APCDs don't collect PII, which would be considered low tolerance for risk. The Massachusetts model, that requires hashing of PII, would be considered middle of the road risk. The Colorado model is relatively high tolerance for risk because Colorado collects PII and has put into place processes to protect it. Scott Christman added in that the state of California has a high regard for privacy and that OSHPD, specifically, has considerable experience protecting patient privacy. He also noted that OSHPD is looking closely at opportunities to conform to HIPAA as it is a set of rules that providers and payers are familiar with.<br><br>*Ken Stuart, California Health Care Coalition,* confirmed with Emily Sullivan that throughout the country most programs adhere to HIPAA, which she confirmed. He followed up asking if adhering to HIPAA would put the HPD at a low tolerance category. John Freedman noted that most APCDs operate at the level where Colorado is while some are more stringent. Ken Stuart followed up asking where OSHPD falls. Scott Christman noted that OSHPD has stringent safeguards with PII and release processes. Currently, OSHPD must adhere to a patchwork of privacy laws, and there is a preference for aligning to national standards such as HIPAA. Emily Sullivan noted that traditionally state laws are made more stringent than HIPAA, and that APCDs have thus far not experienced any data breaches.<br><br>*Cheryl Damberg, RAND,* noted that there are different approaches to mitigating the risk. She mentioned that Colorado is like RAND with one specific difference that RAND moves the data into a cold room, with no internet access, to complete the de-encryption and assign IDs. She noted that research entities are always working hard to ensure the protection of PII.<br><br>*Anne Eowan, ACLHIC,* noted that in September the Review Committee will be looking at the California Privacy landscape, but she reminded the committee that as of the latest consumer protection legislation that passed, health plans and health insurers are only exempt to the |

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| | extent they meet the HIPAA requirements. It is important to keep in mind that even though OSHPD is not a HIPAA covered entity the health plans and health insurers are. She noted that it will be an interesting exercise to look at these privacy requirements in September and identify what would need to be done to share these data.<br><br>*John Kabateck, NFIB,* asked what a privacy board was. Jonathan Mathieu noted that under HIPAA data releases require Institutional Review Board (IRB) approval. A privacy board is helpful when data requestors do not have access to an IRB, and the privacy board can approve a waiver of patient authorization request. In Colorado it was only used twice.<br><br>*Charles Bacchi, CAHP,* inquired about a use case where a payer would be able to identify high cost patients and track that person's costs. Jonathan Mathieu noted that the Colorado APCD has not supported those kinds of use cases. The enabling statute and rules specify that the data is available for HIPAA allowable purposes and in Colorado you must satisfy HIPAA, as well as show that there is a benefit to the state of Colorado. He also noted that he does not feel that type of use case would be approved by that data release committee.<br><br>*Terry Hill, CMA,* noted that during Chris Krawczyk's presentation he discussed achieving a 98.5% matching accuracy without the use of SSNs but in Massachusetts, there is only a 95% accuracy, which is a large difference. Jonathan Mathieu noted that the matching is only going to be as good as the underlying data. Claims data is particularly messy in some respects, and matching claims data to other data is always challenging. Chris Krawczyk clarified that the OSHPD linkage does use SSN and the 98.5% referred to the percentage of records successfully linked using machine learning alone. In the remaining 1.5%, missing or inaccurate SSNs were a primary reason that machine learning did not produce a match and it is documented that these issues with SSN are becoming more common. Scott Christman added that OSHPD does not necessarily expect to stay at 98.5 % with the addition of claims data, due to the increase in volume, and new data that will not be as highly curated as the current OSHPD data set is.<br><br>*Bill Barcellona, America's Physician Group,* noted that when he worked in Colorado with CIVIHC the physician groups had a hard time identifying useful use cases. He also noted that it is difficult to engage providers and find useful data sources that they would want to pull or pilots they would want to participate in. He added that this is something the Review Committee should think about.<br><br>*Amber Ott, CHA,* inquired how provider and payer master directories should be defined to be most useful and accurate. John Freedman noted that Massachusetts is in the process of developing a more robust process. He noted that for payers it's more of a manual process, where each payer is identified and assigned an identifier. Jonathan Mathieu also noted that with respect to provider management, data vendors usually have their own solutions or use IBM. Scott Christman added that the current market research the OSHPD team is conducting includes a question regarding the current solutions that vendors provide for developing master provider and payer indexes.<br><br>*Ken Stuart, California Health Care Coalition,* noted that from the payer's standpoint even third-party remote payers are tied to a health plan, making payer data fairly consistent. He followed up that getting the proper provider information is the challenge.<br><br>*Cheryl Damberg, RAND,* concurred with Amber Ott that provider and payer matching is a problem in general. She offered to participate in these conversations and to share what |

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| | RAND has experienced on the Medicare side. She also noted that Massachusetts has put a lot of resources into policy analysis while other states may have not. John Freedman noted that Massachusetts rather widely shares its APCD with researchers even though they do have a lot of internal data analytics. He noted that the caution that came up earlier regarding limiting data to researchers is regarding identified data for linking. In Massachusetts, researchers can take data that has already been linked but cannot link to new data. He also commented that there is difference across what states do allow in terms of access to data and some states, such as Minnesota and Tennessee (now defunct), have been very restrictive with data access and usage. He communicated his hope for California to be able to share data with outside entities and to do a lot of robust work based on the existing infrastructure and talent currently in California.<br><br>*Joan Allen, SEIU-UHW,* asked Charles Bacchi and Anne Eowan if they know how much consistency there is with members on how facility is reported. Anne Eowan noted that she assumes this information would come in on the claim and be based on the contract. Charles Bacchi noted that on the Knox-Keene side it is a bit more challenging to track. Keeping accurate records is a challenge for plans and there is a lot of noise in the data.<br><br>*Terry Hill, CMA,* commented that he has looked at six different versions of what a hospital is called, which are submitted as a text field to providers. Amber Ott noted that Tax ID works as a good consistent field to use, and that there are various identifiers that can be used but it is important to identify which one we want to use.<br><br><u>Recommendation Discussion:</u><br><br>**Proposed Recommendation 1: Ensure broad authority for OSHPD to securely collect personally identifiable Information**. Legislation should ensure authority for OSHPD to collect detailed patient identifiers such as first and last name, date of birth, sex, street address, and SSN. These identifiers are necessary in order to use methodologies, such as a master patient index, to support analyses of the same individuals over time and the impacts from social determinants of health. The Legislative Report will include detailed descriptions of methods and processes to manage and protect such information.<br><br>*Anne Eowan, ACLHIC,* noted that the data submitters must have the authority to provide the information within the context of federal and state laws.<br><br>*Charles Bacchi, CAHP,* inquired if the reference to “broad authority” is from the context of a regulator to compel or broad authority to collect. Scott Christman noted that the intention is the authority to collect.<br><br>*Cheryl Damberg, RAND,* made a motion to move forward the recommendation as written.<br><br>*Terry Hill, CMA,* seconded Cheryl Damberg’s recommendation.<br><br>*Anne Eowan, ACLHIC,* suggested an amendment to say after SSN “to the extent submitters are permitted by state and federal law.”<br><br>*Charles Bacchi, CAHP*, inquired what would happen if the PII data that is requested is not available.<br><br>*Cheryl Damberg, RAND,* noted that currently there may be many data elements that are not |

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| | collected, but what could be collected in the future.<br><br>*Charles Bacchi, CAHP,* noted that the issue around the availability of data will be something that the Committee will run up against at each meeting. He cited the current debate that is occurring regarding availability of gender identity data.<br><br>*Amber Ott, CHA,* suggested that the committee consider just making a motion to move forward the part of the recommendation written in bold. She noted that there might be nuances that can be figured out later, but if the committee agrees that it wants OSHPD to be able to collect the data, that recommendation should be moved forward<br><br>*Ken Stuart, California Health Care Coalition,* inquired isn't it generally understood that the data will be collected under state and federal laws.<br><br>*MJ Diaz, Health Access,* noted her support for the current motion to move all the parts bold and non-bold. She noted that she understands that health plans may not have access to data advocacy groups want, but that conversation can be had down the line about what data is or isn't available and if there is a proxy that can be used to determine this data.<br><br>*Joan Allen, SEIU-UHW,* noted that it could be valuable to call out the state and federal law comment, but would add it as its own sentence at the end with OSHPD as the actor. Joan Allen suggested amending the current recommendation to add a sentence stating "OSHPD will work with data submitters to ensure data pursued is in compliance with state and federal law."<br><br>*Anne Eowan, ACLHIC,* noted that since we are "ensuring authority for OSHPD to collect," there is data that may be permitted to be collected, that the plans unfortunately do not have. She commented on wanting to ensure that it is understood that the data must be available to be collected.<br><br>*Ken Stuart, California Health Care Coalition,* suggested an amendment to the current recommendation to add the word "available" before "personally identifiable information". He also supported the addition of what Joan Allen had suggested at the end of the recommendation regarding state and federal law compliance.<br><br>*Joan Allen, SEIU-UHW,* expressed that she is slightly concerned with the word available because we want to push for more data available in the future.<br><br>*Charles Bacchi, CAHP,* commented that the word available is not preventing data from becoming available in the future.<br><br>The committee voted 11-0 to approve the recommendation as amended.<br><br>**Recommendation as approved by Review Committee*:* Ensure broad authority for OSHPD to securely collect available personally identifiable Information**. Legislation should ensure authority for OSHPD to collect detailed patient identifiers such as first and last name, date of birth, sex, street address, and SSN. These identifiers are necessary in order to use methodologies, such as a master patient index, to support analyses of the same individuals over time and the impacts from social determinants of health. The Legislative Report will include detailed descriptions of methods and processes to manage and protect such information. OSHPD will ensure data collected is in compliance with California and |

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| | federal law.<br><br>**Proposed Recommendation 2: The HPD Program should use robust methodologies to match patients, providers, and payers across datasets.** OSHPD should build and maintain a master person index, master provider index, and master payer index as part of the HPD System implementation. These indexes should be supplemented with data from other sources (e.g., vital statistics, state-wide provider directory information when available, and OSHPD facility data) to improve matching success and the analytic value of the HPD.<br><br>*Anne Eowan, ACLHIC,* made a motion to accept this recommendation as written.<br><br>*Cheryl Damberg, RAND,* seconded Anne Eowan's motion.<br><br>The committee voted 11-0 to approve the recommendation as written.<br><br>*Charles Bacchi, CAHP,* had a clarifying question regarding Master Provider, Patient and Payer index and if the data would be collected from outside sources to match or if the data will come into the HPD program and be linked internally. Scott Christman commented that the MPI is designed to support internal data management processes.<br><br>Bobbie Wunsch commented that moving forward we will be very clear about what is the recommendation and what is not. Charles Bacchi agreed and noted that less words is better. |
| Public Comment | Public Comment:<br><br>*Paulette Cha, Public Policy Institute of California,* commented on the data reconciliation project that OSHPD data are being linked to safety net programs across CHHS family, such as Medi-Cal and Cal-Fresh, mentioned in Chris Krawczyk's presentation. She commented that those data should be in consideration for linkage with the APCD. |
| Agenda for Upcoming Review Committee Meeting & Adjournment | Ken Stuart thanked the committee and OSHPD Staff. He commented that the next meeting on July 18 will be on data submitters. |