Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Review Committee Meeting

September 19, 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); Ken Stuart, California Health Care Coalition; Joan Allen, Service Employees International Union- United Healthcare Workers West (SEIU-UHW); Cheryl Damberg, RAND Corporation; Anthony Wright, Health Access California; William Barcellona, America's Physician Groups.

Attending by Phone: No members attended by phone.

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

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

Others: Amy Costello, Project Director, Institute for Health Policy and Practice- UNH; Emily Sullivan, Deputy Director, NAHDO; Linda Green, Vice President - Programs, Freedman Healthcare

Public Attendance: 10 members of the public attended.

Agenda Item	Meeting Minutes
Welcome and Meeting Minutes	The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions. The August 15 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 some updates in his Deputy Director's report on the following topics: • Duals/PACE question from August Meeting • Question regarding stakeholder input on data quality • Technical Workgroup *Duals/PACE* At the August meeting Charles Bacchi asked where duals are captured in the enrollment reports

Agenda Item	Meeting Minutes
	from DMHC and CDI? Scott commented that it is not completely clear. According to DMHC and matching various data sources the team concluded that duals enrollment usually shows up as Medi-Cal but sometimes is counted as Medicare. He noted that that the HPD team has worked to identify the main sources of duals coverage and is continuing to work on whether and how HPD will be able to obtain those data. He noted that there will be exceptions and timing issues, but this data most likely will be included through the sources we've already discussed and recognized that DHCS will be an important partner in collecting this data, which is a significant value-add for the HPD. He also commented that there are about 1.4 million duals eligible in California and about 9,000 duals obtain coverage through the Program of All-Inclusive Care for the Elderly (PACE). *Stakeholder Input on Data Quality:* Scott Christman noted that at the August meeting there was discussion and concern regarding data quality, public reporting and stakeholder input on what is quality data. He noted that OSHPD recognizes the points made about the limitations of public reporting on individual physician quality as there are many factors to consider. He also noted that this will be a topic that will be discussed more in depth in governance. Lastly, he reminded the committee that through this current process OSHPD is seeking high level legislative language in recommendations while additional details will be worked out through regulations and a multi-stakeholder process during implementation. *Technical Workgroup* Scott Christman provided a summary of the Technical Workgroup discussion from August. He noted that the group discussed the Medical Claims File of the APCD-CDL™. There was conversation about the onboarding process, and Scott Christman noted that the OSHPD team confirmed there will be an onboarding process where OSHPD would meet with submitters to determine their thresholds for data elements. He commented that there was a suggestion to do an itemized variance report to identify which plans will not have which data elements, and then building in this process into the data quality checks. He also commented that OSHPD assigned a homework assignment to the data submitters to fill out a "Data Feeds Survey" to submit data on the number of feeds each data submitter would expect to be submitting and the number of covered lives in each of those feeds. It was noted by health plans that flexibility is appreciated as data processes might be different for smaller regional carriers. Finally, he mentioned that it was noted that there is a ne 42 CFR proposed rule amendment that is currently being worked on that may ease restrictions on collecting 42 CFR data. The Technical Workgroup will be discussing elements of the Pharmacy Claims file at the September Technical Workgroup meeting. Cheryl Damberg, RAND, inquired about the discussions at the Technical Workgroup regarding the elements of the APCD-CDL™ and if the committee would have an opportunity to weigh in on these discussion Ted Calvert noted that currently the team is mostly listening. The team plans to use the APCD council process to provide suggested edits to the APCD-CDL™ that come out of these discussions, but right now we are just gathering information. Bobbie Wunsch commented that at the November meeting, there could be a possibility to present what OSHPD has learned from the Technical Workgroup and get feedback from the experts.

Agenda Item	Meeting Minutes
Follow Up from August 15 Meeting	Jonathan Mathieu continued a presentation on data quality and reminded the committee that data quality is done at each of point across the data life cycle. Jonathan reviewed the 3 recommendations discussed and approved in August – summarized below – and noted that this discussion is focused on recommendation 4 which was tabled at the last meeting. Recommendations: 1. Establish HPD Data Quality and Improvement Process: The HPD Program develop transparent data quality and improvement processes. In developing the program, OSHPD shall review and leverage known and effective data improvement processes and experiences. *August Action: Approved 10-0* 2. Multi-Phase Data Quality and Improvement Process: Data quality processes should be applied to each major phase of the HPD data life-cycle, including: a. Source data intake b. Data conversion and processing c. Data analysis, reporting, and release *August Action: Approved 10-0* 3. Resubmission Requirements: The Review Committee recommends that the HPD Program have authority to require resubmissions if data fail to meet established data quality standards. *August action: Withdrawn – Review Committee agreed this was sufficiently reflected in a revised Recommendation #1.* 4. Stakeholder Data Quality Information: The Review Committee recommends that the HPD Program provide stakeholders with accessible information on data quality, including: a. Descriptions of processes and methodologies b. Periodic updates on known issues and their implications. *August action: Postponed discussion and vote due to time constraints* Terry Hill, CMA, noted that he had some confusion about this recommendation as it got grouped under release. He commented that he was clearer now that this is about data quality within the OSHPD data base and the usual data quality checks that OSHPD runs, rather than about public reporting. Terry Hill made a motion to approve the recommendation as written. Charles Bacchi seconded Terry Hill's motion. Public Comment: None Cheryl Damberg, RAND, made a comment reminding the committee that despite everyone's best efforts to get it right, the ultimate check is when people start using the data. She inquired if OSHPD will have a mechanism to get end user data. Scott Christman noted that OSHPD has regular data users of current OSHPD data sets such as the Healthcare Analytics Branch and Data Operations people, who are already doing this. He also noted that OSHPD has launched a formal outreach and engagement program, and there is a desire to be very intentional about this process. He noted that

Agenda Item	Meeting Minutes
	through outreach and engagement there is an opportunity to gather information from end users, as well as lessons learned. Charles Bacchi, CAHP, provided a reminder on recommendation 2, noting that he believed that 2c captures what Cheryl is concerned about. Jonathan Mathieu noted that a number of APCDs have created data user groups – researchers, and analysts – who provide feedback on what issues they see and potential solutions. The committee voted 10 to 0 to approve the recommendation as written. Final Recommendation as approved by the committee: The Review Committee recommends that the HPD Program provide stakeholders with accessible information on data quality, including: c. Descriptions of processes and methodologies d. Periodic updates on known issues and their implications.
OSHPD Current Data Privacy and Governance Practices	Scott Christman gave a short presentation on current OSHPD privacy and security practices and how OSHPD governs data access under state laws including the Information Practices Act. For a full presentation please see slides 11-16 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint_9.19.2019_Final.pdf) Charles Bacchi, CAHP, inquired as to who sits on the Committee for the Protection of Human Subjects (CPHS), also referred to as the CHHS Agency IRB. Scott Christman noted that most, if not all, members are public servants that are on the board. He also noted that they all have deep credentials in research and their primary work is on research involving human subjects. The committee does two things 1) under their federal law they evaluate research projects looking at the protection of human subjects; 2) under the Information Practices Act (IPA), they review any data requests that fall under the IPA. Beth Herse, OSHPD attorney, also added that CPHS membership is defined by the federal government. Cheryl Damberg, RAND, noted that researchers have to submit IRBs to their home institutions as well. She also noted that anyone who is touching the data has to take the training class offered by the federal government. Scott Christman also added that in addition to CHHS IRB and the institutional IRB, each department that has the data also reviews the data request, a total of 4 levels of research checks. Emma Hoo, PBGH, inquired if there are circumstances where an application that is designated as quality improvement is reclassified as a research request, based on the requirements. Beth Herse noted that she is not sure how often this has occurred, but in general the CPHS has the authority to determine whether a project constitutes research. Anthony Wright, Health Access, inquired about the aforementioned 4 levels of research checks. Scott Christman noted that there is the CHHS IRB (also known as the CPHS), OSHPD, CDPH and the home institution IRB. He noted that OSHPD works to make sure these processes are consistent across departments, and OSHPD typically looks for approval from CPHS as a part of the OSHPD release

Agenda Item	Meeting Minutes
	Cheryl Damberg, RAND, also noted that penalties for any kind of data breach are severe.
Data Privacy and Security	Karen Boruff and Jonathan Mathieu provided a presentation on the background on both the national and California legal environment related to APCDs and privacy laws, and a discussion, and vote on recommendations regarding guiding privacy principles, access to HPD data, the authority of OSHPD to collect personal information, and relevant information security standards. For a full presentation please see slides 17-53 (https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint_9.19.2019_Final.pdf) The committee had a discussion regarding 42 CFR part 2, which limits the sharing of substance use disorder data. Karen Boruff noted that the Utah APCD found an interesting way to meet the research exception for 42 CFR part 2 by making a research project to analyze the value of having 42 CFR data as a part of an APCD, which was approved and makes Utah a lawful holder of the data. It was also noted that there is a proposed rule currently at the federal level, that would provide for disclosure for research exception to allow data to go from covered entity to non-covered entity. Charles Bacchi, CAHP, also noted that 42 CFR part 2 data is an issue for Medi-Cal and the data that will be received from DHCS. Ken Stuart, California Health Care Coalition, inquired as to what it means for the California HPD and the recommendations that are being currently brought forth, should there be subsequent changes federally. Jonathan Mathieu noted that the authorizing legislation for APCD should be written in a way to provide flexibility and allow for faster changes at the state level. Amy Costello also noted that it is important for the state to retain some control rather than completely aligning with the Federal government, which may lead to additional federal requirements and greater costs. Ken Stuart added that it is important to give OSHPD the authority to be flexible regarding updates when it comes to federal law changes. Charles Bacchi, CAHP, inquired what Karen Boruff had meant in her presentation when she said that “in the absence” of authorizing legislation, the HPD would be subject to the IPA. Karen Boruff noted that there are specific groups in the IPA that are allowed to receive the data, so if there is no change to that other groups would not have access to the data. She noted that the statement seeks to provide a pathway for other groups to have access to the data Joan Allen, SEIU-UHW, noted that as a member of one of the organizations that does not fall under the IPA, she appreciates the expansion past the already defined groups. Cheryl Damberg, RAND, noted that organizations are required to have a data safeguarding processes and they themselves are very aware of dealing with PHI. Scott Christman also added that beyond the IPA, hospitals that request data not under the research exceptions, there exists a Data Use Agreement, that is operated under HIPAA requirements. Anne Eowan, ACLHIC, commented her thank you on the addition Insurance Information and Privacy Act. She noted that health insurers and dental insurers are not subject to the Confidentiality of Medical Information Act (CMIA). She also commented her thanks to the presenters for doing the research to assess that there is also a “as required by law” exception to submit data under the Insurance Information and Privacy Act. Emma Hoo, PBGH, inquired if there are any implications for researchers who want to link identifiable data with social determinants of health data. Cheryl Damberg noted that at RAND, CMS requires

Agenda Item	Meeting Minutes
	justification on how certain data sets will be used. Chris Krawczyk also noted that a current OSHPD practice is to assess what the risk of each request is, and OSHPD can either offer to do the linkage for the requestor or have them come to do the linkage on the OSHPD network. Amy Costello also noted that under the CMS DUA if there is an intention to link data, there needs to be a separate data request for the linkage portion. Cheryl Damberg, RAND, noted that in terms of using the public health exception under HIPAA to receive voluntary data, would voluntary submitters be required to submit all the data or only what is required for public health surveillance. Scott Christman noted that since it will be a voluntary request for submission, OSHPD will have to accept whatever it is the voluntary entities choose to supply. Jonathan Mathieu noted that the approach many states have taken includes drafting legislative language that incorporates all of the HIPAA exceptions (required by law, public health surveillance, and health oversight activities). The biggest issue to overcome is that the compliance entities of these voluntary submitters need to buy in that public health activities or health oversight makes sense. Scott Christman inquired if there has been a case where there is voluntary submission, where they only submit a portion of the PHI. Colorado has not run into that problem, but they have run into resistance to voluntary submission in general. Ken Stuart, California Health Care Coalition, noted that ERISA plans will have the ability to authorize the submission of their data through their health plans, and he does not feel this should not be a significant issue. Charles Bacchi, CAHP, noted that the committee has not yet talked about proprietary cost information. He noted that OSHPD currently collect charges data and inquired if there are there any protections or current rules for that information. Scott Christman noted that these are not paid amounts and there are no limitations to OSHPD sharing that data. However, he did note that what is publicly shared is in terms of aggregate amount (i.e. average charge for a procedure), not at the individual level. Chris Krawczyk also noted that OSHPD does get aggregated facility level reports but that is already public and aggregated, and on the patient side as a part of the inpatient data, OSHPD does receive a “total charge” at the record level, which is non-public data. Beth Herse clarified that it is the personal information that is protected, not the financial information, that makes these data not available at the record level. Anne Eowan, ACLHIC, inquired if OSHPD would have a diagnostic code along with the financial information as long as there is no patient information included. Beth Herse clarified that the data can have up to 24 diagnostic codes on a single record, with only one charge, which is all lumped together, not parsed out. Amber Ott, CHA, noted that from a billing perspective you can’t assign a charge to a procedure. Charges can be bundled for “drugs” or “surgery” not a charge for a “knee replacement.” She noted that what is available in the public reporting is the total billed charges by claim, and the contractual adjustment by payer type, which allows one to figure out what is the cost to charge ratio, for example “third-party traditional payers,” but at the claim level, not at the patient level. This is where the aggregate rolls up and the hospitals are not seeing the actual payment on each claim that comes through – it is rolled up at the aggregate. She noted that this gets back to Charles Bacchi’s original question if there is anything that currently precludes OSHPD from doing that at the patient level today – for example, is there any statutory limitations because when we see the patient level

Agenda Item	Meeting Minutes
	(not the public file, but the one you can get access to) the hospital (for example) cannot see the actual contractual allowance at the patient level they can only see it rolled up in the public files. Chris Krawczyk noted that it comes back to the file type and what is the file that is getting submitted to us and from where. On the patient level side there is a number of procedure codes and diagnosis codes but there is only that one whole amount. He inquired if the question was to get it at procedure level or diagnostic level. Amber Ott noted that is not the question, the question is that at the patient level, the contractual adjustment line in the annual financial disclosure report pivot profile is not included at the patient level of detail in the data set that folks can get access to. Scott Christman noted that is correct – it is not. Amber Ott confirmed that the follow up question is what the rationale behind that is, is it a legal rationale or is it a preferential rationale. Chris Krawczyk suggested deferring the question back to program because those files are facility level aggregated files that get submitted to OSHPD and there is a long history as to how those files came to be and how they have evolved in their content. Scott Christman agreed and noted that program started in the 1980s so the team will go research the rationale and the origin of the definition of the charge and bring it back to the group. Amber added yes, the charge and the contractual adjustment. Ken Stuart, California Health Care Coalition noted that IHA already gets information on the billed, allowed, and paid amounts. He noted that he understands the concern to protect proprietary cost information for plans and providers, but he noted that at some point we will have to allow comparative costs between services. He noted that we see bundled pricing, but without the allowed and paid amounts we cannot make any determinations as to variations in cost. Joan Allen, SEIU-UHW noted that the other element for consideration is patient share cost. Amber Ott reminded the committee that health plans will not have access to what the patient actually paid. Ted Calvert reminded the committee that we are not focusing on business confidentiality issues at this meeting and are specifically focusing on patient privacy. He noted that business confidentiality will be discussed further moving forward. Cheryl Damberg, RAND, encouraged OSHPD to pursue becoming a Qualified Entity to receive Medicare data. Amber Ott, CHA noted that the goal of “reducing health care costs” is challenging as cost is very different depending on stakeholder. She inquired if there have been any attempts to reduce the other drivers of cost of healthcare or have APCDs only looked at the insurance payments and defining that as the cost. Jonathan Mathieu noted that noted that by and large APCDs have looked at claims payments and Non-Claims Based Payments as measures of cost, which is what APCDs collect. Joan Allen also noted that utilization is also a helpful measure. Cheryl Damberg, RAND, noted that there is a desire to unbundle and unpack these specific costs, however usually the data comes rolled up. She also noted that she has seen episode groupers that take claims and piece together that other elements that make up the cost and to see what he cost drivers are. Ken Stuart, California Health Care Coalition, noted that the “holy grail” of cost drivers is the utilization, appropriateness and quality of care, which we will get to closer with APCD data. Emma Hoo, PBGH, noted that California Health Care Foundation (CHCF) has done work around geographic variation, and PBGH had engaged Milliman to run a resource-based analysis in the variation of the types of units and services that contributed to highest costs as well as looking at

Agenda Item	Meeting Minutes
	inefficiencies. Terry Hill, CMA, inquired if the APCD will define what public versus nonpublic data is. Jonathan Mathieu noted that this is usually a state by state determination. Usually authorizing legislation specifies there is an advisory committee to advise OSHPD on the operations of the APCD on an ongoing basis and help to determine what data will be identified as public versus non -public. He also noted that this usually broadly identified in legislation, which is more fine-tuned in regulations and even finer in policy. Terry Hill noted that it sounds like it is defined specifically to the APCD not necessarily to the department. Cheryl Damberg, RAND, noted that in addition to a focus on utilization and quality, price is also a key consideration about what is driving cost. Scott Christman added to Terry Hill's earlier point that there is statute specific to OSHPDs patient data, which calls out specific groups that can have access to the "non-public" data. He also noted that when it comes to linkage it will be worth considering whether there should be alignment for rules around HPD data and other data that will be linked to the HPD. Terry Hill noted that as a user it would be easy to get confused by how CDPH defines public records versus how OSHPD defines public records. Joan Allen, SEIU-UHW, commented that we should be thinking about broadening IPA instead of aligning HPD to IPA. Charles Bacchi, CAHP, inquired if the Review Committee needs to address the need to protect people's privacy, noting that health care plans are required to do so. Scott Christman noted that access to the data will be part of the governance discussion and the team will bring a proposed approach and look for your feedback. Charles Bacchi noted that he wants to make sure that it is on the agenda, and to also include information on cost and proprietary info. Cheryl Damberg, RAND, commented her appreciation on the presentation on the background and laws regulations and procedures regarding privacy. She noted that these are not workarounds, but rather the core of protecting personal information. There are different procedures in place to ensure that the end user gets what they need and protects the privacy of the individual. She noted that the data users are very attentive to HIPAA regulations and following human subject protections. She also noted that she has not seen data breaches in this space, and there has been a precedent for this work. Anthony Wright, Health Access, noted that he appreciated the conversation on privacy and the importance of having a process to deal with these data, especially considering the analytic value as of identifiable data. He inquired about the Project Angel Heart example that Jonathan Mathieu had provided, inquiring if there was any pushback to providing the requested data, or if Colorado had another example where the idea sounded good but did not meet the standard. Jonathan Mathieu noted that he can describe the process for when there is a request that is "just on the other side of the line." Typically, if a research request does not clearly provide the purpose or if they are asking for more data then they need, then there is work that is done to help the data requestor either clarify or re- do their request to better match what is able to be provided. He noted that the data access committee had diverse representation, and they would always work toward getting to a "yes" by methods explained above, though they did not always get to "yes." He also did provide an example of a for-profit company asking for the data to develop products off of, which was a clear "no."

Agenda Item	Meeting Minutes
	Charles Bacchi, CAHP, noted that it is pretty easy to imagine any big company making a healthcare subsidiary to get this data, with a perfectly acceptable looking data request, and then use the data for other reasons. He also noted that the importance of the data access committee is to ensure that they are willing to pull back the veil and ensure that the data is not getting into the wrong hands. Anthony Wright, Health Access, inquired if there are additional safeguards. Jonathan Mathieu noted that all provisions are very explicit in the DUAs that have been attested to by legal counsel. Amy Costello commented that the New Hampshire DUA requires that every product released needs to be reviewed, not as an attempt to control the message, but just as an additional check. Cheryl Damberg also confirmed that most DUAs are written as a contract and provide the necessary safeguards, such as limiting the usage of the data only to this approved project, and not transferring the data to another project, or providing it to other researchers. Ken Stuart, California Health Care Coalition, inquired if there is any form of indemnification written into these agreements. Jonathan Mathieu confirmed that under both privacy HIPAA and Federal Trade Commission/Department of Justice Statement 6 anti-trust indemnification is written into the DUAs. Recommendation #1 Recommendation as presented to the Review Committee: Privacy Principles: The Review Committee recommends the HPD Program adopt the following principles: a) The HPD shall protect individual privacy in compliance with applicable federal and state laws. b) The HPD is established to learn about the health care system, not about individuals. c) The purpose of the HPD is to serve the intent of the Legislature. Cheryl Damberg, RAND, made a motion to move the recommendation. Terry Hill, CMA, seconded Cheryl Damberg's recommendation. Public Comment: Adam Francis, California Academy of Family Physicians, shared a concern about the vulnerabilities of collecting patient information despite good intentions. He also noted the concern about individual provider information. He commented that aside from just the data inaccuracies at the individual provider level, family physicians provide a full spectrum of reproductive care, and border care, and as such have been scrutinized by various organization, as well as the federal government. Adam Francis made a recommendation to amend 1b to say "the HPD is established to learn about the health care system, not about individuals or individual healthcare professionals" Joan Allen, SEIU-UHW, recommended to amend 1b to better reflect intent by adding "and populations" after healthcare system. Charles Bacchi, CAHP, noted that 1c is worded awkwardly as "intent of legislature" does not really make sense, and it should say "intent of enabling legislation."

Agenda Item	Meeting Minutes
	The committee had a conversation about whether AB 1810 was considered the enabling legislation, but ultimately decided that there will have to be new enabling legislation that will be different from AB 1810. Cheryl Damberg, RAND, made a comment about the public comment regarding individual providers and was curious about the committees' thoughts on that. Charles Bacchi, CAHP, commented that "individuals" should capture both individual providers and individual patients. He noted he was hesitant to include "individual providers" as that could be a slippery slope of calling out specific protected classes. He commented that it is better to be more general. Emma Hoo, PBGH, noted that she disagrees with the public comment, HPD is going to be studying the health care system and drivers of variation as there are methodological ways to address individual identification and volume as a proxy for validation of data, rather than arbitrarily cutting it off at individual providers. Ken Stuart, California Health Care Coalition, noted that from a policy standpoint it is helpful to know where there are providers that are doing things that others are not. Terry Hill, CMA, noted that in the recommendation if we keep "individuals", it would make sense to say individual patients and individual professionals. Terry Hill noted that the term "provider" is very large and can encompass the entire health system, however given some of the experience with measurement systems in California in the past, he commented that it would be important to get some reassurance that the data will not be misused. Joan Allen, SEIU-UHW, noted that OSHPD already identifies individual surgeons in their CABG data. She noted that she would not want to preclude the HPD from going down that route. She also noted that she felt the term "individuals" was too broad and would amend to say, "individual patients." Ken Stuart, California Health Care Coalition, noted that he agrees with Joan Allen's points and that he does not see how the HPD can go away from acknowledging certain professionals. Bobbie Wunsch provided a summary of the amendments: a. To 1b add "patients" after the word "individual" b. To 1b add "and populations" after healthcare system c. In 1c to replace "intent of the legislature" to "intent of the enabling legislation" Anthony Wright, Health Access, noted that Health Access supports the patient focus, and inquired if the addition of the word "populations" is the intent to study the heath of populations or the care of populations. He wanted to confirm that there is an understanding of what population means. Terry Hill, CMA, noted that he is not sure that 1c is meaningful, as the legislature does not need the committee to say we will do what you tell us to do. He also noted that it is true that surgeon data is presented in CABG, however he commented that this process can become a methodological nightmare, and he reminded the committee that this will fall under Governance in December. Scott Chrisman pointed out that CABG is unique in the fact it is a highly prescribed state law and the only program OSHPD has that has this level of reporting.

Agenda Item	Meeting Minutes
	Amber Ott, CHA, pointed out if we are adding the term "patient" to 1b then we should include it 1a to say "The HPD shall protect individual patient privacy…" Ken Stuart, California Health Care Coalition, agreed with Terry Hill's point about the lack of meaning of 1c and suggested removing it. Joan Allen, SEIU- UHW, wanted to clarify that these principles are focusing on privacy. She suggested adding in the overview "the HPD Program adopt the following privacy principles." Public Comment: Bernie Inskeep, United Healthcare, noted that for 1a from the point of view of a health plan perspective there are many physicians that use their SSN in lieu of a tax ID and only protecting the patient could be a data breach. Adam Francis, California Academy of Family Physicians, noted that by specifying "patient" means that the Committee is excluding all others. He urged the committee to not adopt this language. Charles Bacchi, CAHP, commented that he recognizes if the data system contains SSN and Tax ID numbers of providers, it is important to protect them. He commented that this recommendation is related to patient privacy, and to ensure that patient privacy is highlighted in all elements of it. He suggested adding in the overview "…the HPD Program adopt the following patient privacy principles" Anthony Wright, Health Access, agreed with Charles Bacchi's comments, and he commented his appreciation on the comments that were made. He noted that it is very important to be aware of protecting reproductive and immigration services that are being provided, however at the level of a principle he cannot vote on a blanket statement on provider privacy, when the point of the database is to shine some light onto provider activities. While this is an important topic to work out, he did not feel it would be worked out at level of principles, but rather at a level down. Emma Hoo, PBGH, noted that the committee has talked at length about the use cases and those will provide appropriate protections on a macro level. Ken Stuart, California Health Care Coalition, noted that this is payer database and does not see how we get away from provider data, but he also noted that OSHPD will do what is legally required to protect everybody. The committee voted 10-0 to approve the recommendation as has been amended. Recommendation as approved by the Review Committee: Privacy Principles: The Review Committee recommends the HPD Program adopt the following privacy principles: a) The HPD shall protect individual patient privacy in compliance with applicable federal and state laws. b) The HPD is established to learn about the health care system and populations, not about individual~~s~~ patients. ~~c) The purpose of the HPD is to serve the intent of the Legislature.~~

Agenda Item	Meeting Minutes
	Recommendation 2 as presented to the Review Committee: Authority to Collect: The Review Committee recommends that legislation clearly authorize data submitters to send, and OSHPD to receive, personal information to meet the legislative intent of the HPD. To support the submission of data by voluntary submitters, legislation should clearly specify public health as one of the intended uses of the HPD. Terry Hill, CMA, made a motion to approve the recommendation. Bill Barcellona, America's Physician Group, seconded Terry Hill's motion. There was no public comment Emma Hoo, PBGH inquired if the legislative intent piece in this recommendation is a repeat of the issues of 1c from the first one. And the second clause is different than the first. She noted that she does not feel very strongly about it. Stephen Pollitt, OSHPD Acting Privacy Officer, clarified a question regarding the term "personal information" clarifying that in state law the IPA identifies these data as personal information because OSHPD is not a HIPAA covered entity. The committee voted 10-0 to approve the recommendation as has been written. Recommendation 2 as approved to the Review Committee: Authority to Collect: The Review Committee recommends that legislation clearly authorize data submitters to send, and OSHPD to receive, personal information to meet the legislative intent of the HPD. To support the submission of data by voluntary submitters, legislation should clearly specify public health as one of the intended uses of the HPD. Recommendation 3 as presented to the Review Committee: Access to HPD Data: The Review Committee recommends that only aggregate de-identified information will be publicly accessible. OSHPD should develop a program governing access to non-public HPD data, including a data request process overseen by a data access committee. Charles Bacchi, CAHP, made a motion to approve the recommendation. Amber Ott, CHA, seconded Charles Bacchi's motion. Public Comment: Adam Francis, California Academy of Family Physicians, noted that his concern might be a topic for governance, but he wanted to point out that as much as the Review Committee may want to include individual information on professionals, this data does not exist in an accurate way. That level of measurement does not exist in any source of data, and this would hurt individual professionals and lead to more inaccurate data.

Agenda Item	Meeting Minutes
	Anne Eowan, ACLHIC, commented her support of the data access committee, noting that it makes a lot of sense. She noted that this might be a topic for governance, but she noted her support for an external advisory committee, rather than just internal OSHPD committee. She noted that this has been very successful in other states engaging external stakeholders. Scott Christman noted that is the current thinking but will be discuss further in governance. The committee voted 10-0 to approve the recommendation as has been written. Recommendation 3 as approved by the Review Committee: Access to HPD Data: The Review Committee recommends that only aggregate de-identified information will be publicly accessible. OSHPD should develop a program governing access to non-public HPD data, including a data request process overseen by a data access committee. Recommendation 4 as presented to the Review Committee: Information Security: The Review Committee recommends the HPD program develop an information security program that uses existing state standards and complies with applicable federal and state laws. Bill Barcellona, America's Physician Group, made a motion to approve the recommendation Charles Bacchi, CAHP, seconded Bill Barcellona's motion. Joan Allen, SEIU-UHW, noted that she felt the term "uses" is a little prescriptive and instead recommended the term "informed by." She commented that under existing standards SEIU cannot access data, so staying with those same policies is not helpful There was a conversation that this recommendation is regarding IT technical practices to securely encrypt the data, that would be consistent with state and federal laws. Anthony Wright, Health Access, clarified that this recommendation is for the database, and is intended as a technical element for how the database is intended. The other recommendations are regarding privacy considerations. Terry Hill, CMA, suggested to include the headings with the recommendations. Charles Bacchi, CAHP, noted that when the final report is issued, it will be very important to map back the recommendations to the topic of the day. He also noted that he assumes that the Review Committee has an opportunity to discuss DUAs in December. Scott Christman agreed and noted that there are privacy and security requirements at federal and state levels and the DUAs are based on those requirements. Charles Bacchi noted that he will be interested into sanctions specifically and is looking forward to the governance discussion. The committee voted 10-0 to approve the recommendation as has been written. Recommendation 4 as approved by the Review Committee: Information Security: The Review Committee recommends the HPD program develop an

Agenda Item	Meeting Minutes
	information security program that uses existing state standards and complies with applicable federal and state laws.
Public Comment	There was no public comment
Agenda for Upcoming Review Committee Meeting & Adjournment	Ken Stuart thanked the committee and OSHPD Staff. He commented that the next meeting on October 17th will be on technology alternatives.