Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

December 19, 2019

Meeting Summary

Attending: Bernie Inskeep, United HealthCare; Christina Wu, CAHP; Denise Love, NAHDO; Dolores Yanagihara, IHA; Jill Yegian, OSHPD Consultant; Jonathan Mathieu, Freedman HealthCare; Linda Green, Freedman HealthCare; Michael Valle, OSHPD; Norm Thurston, NAHDO; Phil Smith, OSHPD Consultant; Scott Christman, OSHPD; Starla Ledbetter, OSHPD; Tara Zimonjic, OSHPD; Ted Calvert, OSHPD Consultant; Wade Iuele, OSHPD Consultant.

Attending by Phone: Amy Costello, APCD Council; Claire DeCastro; CalPERS; Dave Falla, Kaiser; Eric Lee, SCAN Health Plan; Gina Gonzales, CalPERS; Matt Nakao; CalPERS.

Welcome & Roll Call

Tara Zimonjic facilitated a welcome and introductions and provided an overview of the agenda.

APCD-CDL™ Data Maintenance Request

Ted Calvert led a discussion on the proposed APCD-CDL™ Data Maintenance Request (DMR) that California will be submitting to the APCD Council. Ted reminded the group that over the last few Technical Workgroup meetings the group has gone file by file discussing the elements of the APCD-CDL™. The feedback that was gathered during these sessions is what has informed the development of this DMR, in addition to feedback received through the Review Committee and the consulting team's review of the file layout. Ted noted that the team is hoping to finalize the DMR by the end of January, so if there is any additional feedback it can be sent to the OSHPD team through the end of January.

Suggested Changes:

- Add services location street address as a new data element on the medical file

  Comments: Reasoning was to allow for analyses of access (e.g., travel time) require the location of where the service was provided. The current

specifications include Rendering Provider City, State, and Zip Code, but not street address.

Clarified that this information is present in the provider file, but not on the medical file, and that this change would only add the street address. It was confirmed that this data element is present in the 837.

Noted that for entities that lease networks this data point would be unavailable.

- Use Standard Unit of Measure

  Comments: Reasoning being that referencing national standards (such as the PACDR) will help ensure consistent use and interpretation. This is an example where there is no reference to the national standard.

  There is currently no PACDR reference for units of measure. It was noted that in anesthesiology its either units or minutes. However, it was noted that currently this is challenging to capture as there is a very long list of types of units (i.e. minutes, pints, mL, etc.)

  If the plans are required to manipulate non-standard units into the standard from to data will actually be "dirtier." It was recommended that whatever unit of measure is on the claim is what should be submitted to the APCD-CDL™ and then the analysts on the back end can manipulate into standard units of measure if that makes sense to do so.

  It was determined that this field was intentionally made free-form so that plans are not required to reinterpret the data from how they receive it from providers.

  It was determined to remove this recommendation from the DMR.

- Clarify what is expected for no – pay encounters

  Comments: In California there will be a number of services covered by capitation, and there needs to be guidance as to what financial information the plans are supposed to input. The current description indicates "If there is not an allowed amount, leave blank," and doesn't provide much guidance for no-pay encounters.

  A sample description could be: "The Allowed Amount for the claim. For no-pay encounters (when payment arrangement type in CDLMC132 is equal to 01 for capitated services), report an FFS equivalent, such as the

amount the member is responsible for under a high deductible health plan."

Commentary that this would help to clarify as the current description is not very clear.

It is important to acknowledge with caution that some claims systems will have an FFS equivalent and some will not, therefore the data will be regularly irregular.

There was a discussion about what would a plan input if it is a no-pay encounter, but their claims system does not create an FFS equivalent and if it makes sense to put in a zero or null, since the data is not available. The plans noted that in fact the payment sometimes is zero and not null. It was also discussed that what may be helpful is to define what a zero entry means, such as it meaning "no allowed amount" as currently defined in the CDL. The plans also noted that they will only be able to report what is available in their system and may not have a definition from their system as to what the zero represents. The plans feel that they should be reporting what their system says, rather than interpreting. It was noted that this will differ by payer. Some payers maybe coded null and zero, while other payers just use zero, and rather than having plans interpret the data, the plans should submit what they have on their claims, and the researcher can adjust it on the back end.

The OSHPD team commented that the DMR should maybe include some clarification about what to input if an FFS equivalent does not exist in a plan's system.

- Use NDC codes rather than drug names:

  Comments: NDC codes are more standard than drug names, and often the drug names are longer than what is allowed in the 80-character element limit. Using space between drug names doesn't work because some drugs have multiple words in the name.

  It was asked if this is the NDC 9 or NDC 11. The team decided there should be maybe some more description about which NDC version to use, but this was seen as a good suggested change.

- Add references to the HIPAA transaction elements.

Comments: Currently in the APCD-CDL™ there are references to the PACDR, and some people at the plans might be more familiar with HIPAA transaction elements.

The APCD Council noted that it was originally done with the HIPAA transactions, but there was a business case brought to bring in the PACDR references. It was noted that there was a hope at one point in time that the PACDR would take over, but it seems like most people are more familiar with the HIPAA transactions. It was recommended not to remove the PACDR references, but to rather add in the HIPAA transaction elements.

- Expand the definition of Service Units/ Quantity to allow for professional services.

  Comments: A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information.

  The description currently only references bed service lines, but this applies to all types of services. It was agreed that the description can be cleared up a bit.

- Clarify when element applies to institutional claims and encounters, professional claims and encounters, or both.

  Comments: A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. Currently some descriptions say which type of claim it comes from, while others do not. There are some data elements that are only going to be found on the institutional claims, while others are only found on the professional claims.

  It was noted that a way to do this is to have a separate column that identifies this rather than including in the description.

- Add the standard refence for claim line type

  Comments: Currently the way that it is written it is not clear for submitters how to distinguish between some of the types such as what is the difference between V-Void and B-Back Out?

  There was a suggestion to specify if Void is preferred or Backout as the two are interchangeable.

One possibility is to use the following standards:

Medical claims: CLM05-3 in the 837P is the Claim Frequency Type Code. The following link provides a list of values: https://www.resdac.org/cms-data/variables/claim-frequency-code-ffs

The NCPDP 4.2 equivalent is Record Status Code (399). Link to values: https://ushik.ahrq.gov/ViewItemDetails?&system=mdr&itemKey=107320000

- Add prescriber specialty to the pharmacy file

  Comment: Although taxonomy is also collected in the provider file, collecting it on the pharmacy claim would be consistent with data collected on Medical file, which does include specialty. It was noted that this information does come in into the NCPDP.

  There was a question about how this field would be populated if the pharmacist is able to prescribe the drug for example. It was noted that the information is an element on the claim, however there is no certainty as to how often that information is populated on the claim. It would be important to know how often this element is filled out prior to deciding whether or not to include this on the APCD-CDL™.

- Clarify which fields are supposed to be fully populated and for which types of services.

  Comment: The team understands that the CDL does not have threshold amounts for each data element, in order to allow states to set those thresholds individually. However, some data elements do have certain expectations around how often they should be filled out (i.e. "paid date should always be filled out")

  Add a new column, something like "Recommended Threshold Expectations," and use the rules that come with the underlying standards. Some of the elements already have this information, but it's combined with the description. Here are some examples:

  - Paid Date
    - Required: report a valid date value for all records
  - Date Prescription Filled
    - Required: report a valid date for all records
  - Social Security Number
    - Situational: report when available

    - Race 1
        - Situational: report when available
    - Admitting Diagnosis
        - Situational: report for all inpatient institutional claims and encounters

    The APCD Council noted that this will be a good suggestion for discussion at the committee, as there might be states that would not want social security number, even situationally.

- Remove ICD-9 / ICD-10 indicator

  Comment: It was noted that ICD-9 cannot be used for dates of service after October 1, 2015.

  Suggested to say "rename" rather than "remove," in order to future proof, and have this field be used for ICD-9, 10 and future 11.

- Clarify description for Total Monthly Premium Amount

  Comment: Suggested changing the definition as follows:

  Change the definition from this:

  "For fully-insured premiums, report the average monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025)"

  To something like this:

  "For fully-insured premiums, report the total monthly premium amount received for health insurance coverage for a given number of members (e.g. individual, individual plus one, family). Report the total monthly premium, including the combined subscriber and employer shares, and prior to any medical loss ratio rebate payments. Report at the Subscriber level only. Do not report on member lines. Report the Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025)"

- Clarify description for Tiered Network

Comment: The Technical Workgroup had discussion around what a tiered network means and what the business case really is for this data element.

The technical workgroup discussed what the potential definition could be, but there was still some confusion. It was decided that it would be helpful to determine what the business case was for having this field in the first place.

- Add income related elements

  Comments: It was noted that this would only be available for Medicaid and Exchange members.

  It was clarified if the Medicaid data elements would come in from the Medicaid agency, which was confirmed. The Department of Health Care Services (DHCS) will also be using the APCD-CDL™ to submit Medicaid data to the HPD.

  There was a comment that when income related data was requested by researchers from the Colorado APCD, there was extreme sensitivity from the Exchange, as well as the state Medicaid agency about sharing anything on the patient level about the Federal Poverty Level (FPL). It was noted that this was mentioned by Covered California that this data would be useful to have.

  It was noted that this data element will have a low threshold, some states will have this data, others will not. There is no expectation that plans would have this data. In California there is some flexibility if the data will come from Covered California or from the plans.

  There was a question if this will be capturing what someone's actual income is or what they write down on the enrollment form that their income is. It was discussed that ultimately the APCD will get whatever is on the enrollment form. In California it will be whatever is in CalHEERS from when the member signed up for healthcare, and whatever DHCS has in their data from the counties.

- Add language (also only available for Medicaid and Exchange members)

  Comment: It was noted that the reason this was removed was that the data element is so poorly populated, that it was more frustrating for researchers. It was noted that if DHCS has good enough data on language for 1/3 of the state's population it could be helpful to add.

- Clarify if the withhold amount is an amount paid to the provider or an amount withheld.

  Comments: The description and/or element name should be changed to better align. Is this an amount that has been withheld from the claim payment (as the field name seems to indicate) or an amount that was previously withheld and is now being paid (as the description seems to indicate)?

  It was agreed that this should be clarified. The plans noted that this is more of an aspirational element, and that most plans do not have this data element.

- Add the standard reference for Attending Provider ID and Attending Provider NPI

  Comment: Referencing the national standards will help ensure consistent use and interpretation.

  No additional comments.

- Claim adjustment reason code applies only to denied claims

  Comment: claim adjustment reason codes generally apply to more than just denied claims, and the suggestion is to clarify what the plans should be inputting here.

  No additional comments.

- Clarify how to handle leased networks

  Comment: This is a complex issue which the APCD Council may not be able to resolve. The plans noted that what has been done with entities that have leased networks is had to have sit down conversations to clarify how to handle leased networks.

- Clarify COB/ TPS amounts versus other insurance amounts

  Comment: It was not clear if these amounts have already been paid or are expected to be paid by a secondary carrier.

  It was noted that for the most part use cases will be looking at primary claims, rather than secondary claims. In most cases the primary does not know how much the secondary owes. It was agreed there are a great deal of complications and nuances, and that the current description is not perfectly clear as to what is being requested.

- Add the standard reference for Drug Unit of Measure

  Comment: It was noted that this similar to the prior discussion on unit of measures, and maybe should ultimately be left broad so that plans can submit whatever they have rather than manipulate the data.

  Amy Costello reminded the group of the APCD-CDL™ maintenance process and noted that the intention is to release a new version of the CDL in January 2021. There are ways to make corrections between now and then in a subsequent version, but the larger changes that have been suggested will need to go through the council discussion process and would be incorporated, if approved, in January 2021.

Recap of December Review Committee Meeting

Scott Christman noted that the Review Committee discussed governance and successfully moved 5 recommendations around authority to administer the HPD program; enforcement; proposed advisory committee structure; and approach to data governance including use, access, and release. There was a robust discussion around a Data Release Committee, and it was determined that the committee will have a more in-depth conversation at the January meeting, reflecting the importance of the Data Release Committee. Additionally, at the January meeting the committee will be discussing sustainability and funding. To see the full slides from the December Review Committee meeting please visit: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Program-Review-Committee-Master-PowerPoint-11.21.19_ADA.pdf

There was a question if the discussion of the Technical Workgroup would be incorporated into the legislative report. Jill Yegian noted that much of it weaves in through the report and is integrated. The APCD-CDL™ portion is at a more detailed level that will most likely not end up in the legislative report but will be more useful when it comes time to the operations.

Additionally, it was asked if the stakeholders will have an opportunity to provide comment on the report or will it be directly sent to the legislature. Scott Christman noted, as was discussed at the start of the Review Committee, that the entire list of recommendations will be reviewed with the Review Committee and stakeholders broadly. The content of the report is anchored in those recommendations, but OSHPD does not expect that entirety to be up for review by stakeholders. The report will be reviewed by the CHHS Agency and the Governor's Office prior to going to the legislature.

Open Forum

There was a question if, absent any legislative authority for the HPD, is there a thought of continuing these conversations with the technical experts moving forward. It was noted that there are a number of stakeholders that are hoping to see this project come off the ground sooner rather than later, and it could be helpful to have the technical input while the legislation is getting developed. Scott Christman noted that OSHPD believes there is enough intent in AB 1810 in that statute to move forward with the work, and continue to engage with stakeholders, while the legislature deliberates on how the additional legislation is going to look. Michael Valle also noted that there are opportunities to both engage as a group as well as with one on one interviews with data submitters to better learn about some of the greater technical nuances.

Additional topics suggested by Technical Workgroup members that need to be discussed in January:

- It was noted it would be helpful to have a more detailed timeline about what the next steps are and how much time plans will have to implement all of the changes that are needed to submit data to the HPD.
- There was also a comment that it would be helpful to hear more about if there will be a need for data use agreements with health plans in order to submit the data to the HPD, as all plans have different corporate structures and privacy rules.

These two topics will be covered at the January Technical Workgroup meeting.

Next Steps & Closing

The January meeting will be the close out meeting of the Technical Workgroup under its current set up, and there will be a discussion about what the next steps will look like to continue to keep stakeholders engaged.