Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

April 18, 2019

Meeting Summary

Attending: Tara Zimonjic, OSHPD, Anne Eowan, ACLHIC, Christina Wu, CAHP, Walter Suarez, Kaiser Permanente, John Freedman, Jonathan Mathieu, Starla Ledbetter, Wade Iuele, Ted Calvert, Scott Christman, Jill Yegian, Michael Valle

Attending by Phone: Randy Smith, San Juaquin Health Plan; April Blaazik, Aetna; Kirk Noe, OSHPD Consultant; Emily Sullivan, NAHDO; Dave Falla, Kaiser Family Foundation; Mary Watanabe, DMHC

Agenda Item	Summary
Welcome, Introductions, & Purpose	Tara Zimonjic facilitated a welcome and introductions and provided an overview of the agenda. Scott Christman provided a brief overview of the legislative intent that was guiding the Healthcare Payments Data (HPD) Program as well as the legislative requirements to convene Review Committee to provide recommendations for a forthcoming legislative report. Scott also noted that the purpose of the technical workgroup is to engage California health plans in the planning process for the HPD. The group will have monthly meetings, aligned with the HPD Review Committee schedule, during which they will drill-down on more "technical" topics of the HPD, including data formats, covered populations, encounter data, data quality, governance, etc. The discussions and input from the technical workgroup will inform OSHPD's work on the Legislative Report and technology planning.
Healthcare Payments Data: Opportunities and Challenges	Tara Zimonjic facilitated a discussion on what the health plans see as opportunities and challenges with the HPD. This exercise followed what was done at the first Review Committee meeting with the Review Committee members. ***Opportunities:*** • California is not the first state doing this and we can rely on experience in other states that have completed deliverables. • Uniqueness in the market in California, especially considering higher use of non-fee-for-service (FFS) payment models • Significance in terms of self-insured • Address gaps in the data with federal data submitters • Address the uninsured and uncompensated care • Help create some standards and definitions, such as defining:

	- Cost - Payment - Charges - Opportunity to look into the appropriate cadence and sequencing - Evaluate periodically achievement of goals – define evaluation parameters of these goals - Reduce costs - Improve quality - Improve access ***Challenges*** - Recognizing the level of significance of capitated plans and alternative payment models (APMs) in California, given Kaiser has such a large presence in California - For example, Kaiser's reporting of a fee-for-service equivalent may not be fully reflective of all costs - Defining the data - Sequencing correctly - Managing expectations - Database has the potential to be very large - Ensuring we have conversations about security and privacy - Sustainability has been a challenge in other states - Demonstrating the value to all the stakeholders - Providers, health plans and employer - Duplicative efforts in what other state agencies are collecting - Challenges could be multiplied for not integrated health systems - Obtaining data from self-Insured plans
"Core" Data Collected by State APCDs	Ted Calvert provided a presentation on the types of data collected by an APCD and facilitated a conversation with the plan representatives regarding data collection formats. He provided a brief recap of some of the materials presented at the March and April Review Committees including claims, encounters, and non-claims-based payments Discussion: Jill Yegian asked about the completeness of Kaiser encounter data. She noted that in some lines of business there are greater requirements for more complete encounter data. She wondered what the differences were across the lines of business. Walter noted that the quality of the encounters is tied to the purpose of the encounters, and some of the elements that are on a claim are not included on a Kaiser encounter, as they are not needed. The information regarding the patient, provider and the encounter itself are there so in that sense they are included. In Kaiser they do not put in a health plan component into their encounters, however all the other information is included. Anne Eowan asked how Kaiser assigned a dollar amount for an encounter. Walter Suarez discussed that Kaiser does find a FFS equivalent in Oregon and Colorado which are the two states that require it. He also noted that the FFS equivalency methodology is created state by state and it will be critical to be thoughtful about how the methodology is developed. Walter Suarez inquired about collecting behavioral health data. Ted Calvert noted that it is included in the medical/pharmacy claims sent to APCDs, but due to 42 C.F.R. Part 2 there

	are some challenges in collecting the data. Some states collect the data without any PHI, while other states don't collect this data and put the responsibility on the data submitters to not send in that information. There was a discussion about the member eligibility file. The eligibility file would show if there is eligibility for a certain benefit. However, specifics about the benefit plan and what it covers would be good to have information to have however no state has accessed that information yet, as there is no standard way to collect that benefit information. Anne Eowan pointed out that, in California, there is a state law that requires individual and small group health insurers to notify both policyholders and the California Department of Insurance (CDI) when they propose to change their rates, and rates are provided by benefit plan level to align with the metal tiers of PPACA health coverage. Question Posed to the Workgroup: What are the plans' experiences with submitting data for similar purposes, such as the frequency, formats, recipients, etc.? Walter Suarez noted that the APCDs that Kaiser is submitting to currently, each state has a different requirement for data submission. About 80% of these data collection formats are similar, but there is tweaking from state to state. Each state publishes a manual of the data. Kaiser is looking forward to having a common standard, however Walter Suarez did express that Kaiser does have concerns about some of the elements of the APCD-CDL™ that are currently not being collected. Anne Eowan noted that from her brief survey of insurance providers, a consensus came out that using the APCD-CDL™ was the most appropriate, as insurers tend to be multi-state. She also noted that, once a format is selected, to reduce the burden on the data submitters, it is important to not constantly keep changing the format. Each format change can require a great deal of IT adjustments. Randy Smith noted that since the Health Plan of San Juaquin is a Medi-Cal only plan they solely submit their data to the California Department of Health Care Services (DHCS), which requires data to be submitted to the state in the 837 formats. John Freedman asked a follow up question if the Health Plan of San Juaquin submits the original 837 or do they regenerate an 837 out of post adjudicated claim. Randy Smith noted that the process is a hybrid in which they start with an original 837 and then enhance it with their additional payment information prior to submitting to DHCS. There was some discussion on the usage of the X12 PACDR format, which is not used in DHCS data submissions. Currently the New York APCD is the only APCD trying to use the X12 standard format. Walter Suarez inquired about what the thinking was in regard to the frequency of data submission that will be required - monthly or quarterly? He noted Kaiser believes it is more advisable to do quarterly submission due to the workload required to maintain regular monthly submission. John Freedman mentioned it is important to note that if you get a quarterly eligibility feed you would need to include additional fields or records to note if members had coverage for each month in the quarter. He also noted that it is important to keep in mind that some plans, or lines of business, can have more volatility than others in terms of member enrollment. Medicaid is one of these examples.

	Ted Calvert also noted that there are two different decisions to be considered. How often data is collected for an APCD and how often the analysis with that data is completed and released. Finally, Wade Iuele also mentioned that one of the big benefits of monthly submission is that you have an opportunity to iterate the product more often and can improve your product faster. Discussion of Alternative Payment Models. Ted Calvert provided some information on the Integrated Health Association's total cost of care model, which provides cost information on a per member per month but not to which provide the capitation was paid out to. Oregon and Massachusetts also have an APM model. For both states the APM information comes in a supplemental file that would be outside of the APCD-CDL™ and is collected annually. There was some discussion that payers that submit to both the Massachusetts APCD and the Oregon APCD prefer the Massachusetts approach to the Oregon approach to APM data. They also noted that there is a preference for the Excel file format over the flat file. Jonathan Mathieu noted that Massachusetts actually provides Excel templates along with examples and instructions for the APMs and Premium Files. Massachusetts has also recently simplified the template to make it even easier. It was noted that while neither Massachusetts or Oregon APM requests align perfectly with current health plan contracts, and the Massachusetts APM model does a better job of aligning with the current contracts. The Health Care Payments Learning & Action Network model, done in Oregon, would require a complete change in contracts. Walter Suarez noted that APM conversations are an important consideration, this will be amplified as the general trend in healthcare is to move towards non-FFS models. Jill Yegian asked about how Kaiser captures alternative payment modes. Walter Suarez noted that one of the elements with the Kaiser model is that there are a number of services that are not captured in an encounter, so it is difficult to calculate the cost. Determining the methodology will be very important. Ted Calvert also noted that it will be important for OSHPD to know what are the categories of APMs that allow OSHPD to collect data quickly, without changing contracts but still collecting meaningful information. Walter Suarez noted that Kaiser does submit currently to the Integrated Healthcare Association in California and that their method for total cost of care makes sense, however it is difficult if a patient has multiple conditions to determined what the cost of care for that patient is. He also noted the FFS equivalent methods provide a dollar amount, but we are not sure how accurate that number is. There maybe is an opportunity to develop a better FFS equivalent methodology. Scott Christman followed up on an earlier point regarding the elements of the APCD-CDL™. He noted that we can provide a phased in approach for the elements of the APCD-CDL™, so that plans have some time to adjust their processes in order to be able to submit all elements required by the CDL. Anne Eowan confirmed that in other states they have exceptions. Walter Suarez offered to provide an analysis of the CDL to determine which fields are available and which ones are not. Christina Wu noted that it is important to keep in mind that many plans are submitting a lot of regulatory information to the Department of Managed Health Care and to be mindful of the other data sets being submitted to other agencies and to find ways to have administrative

	simplification. Anne Eowan confirmed that this is also on true on the Department of Insurance side. Jill Yegian suggested if CAHP and ACLHIC could develop a list of the data that they already have to submit, for reference for the Technical Workgroup and the OSHPD Team.
Next Steps	The next Review Committee meeting is May 16 and the Technical Workgroup will be following that meeting. The topic for the May meetings is Data Collection.