Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

May 16, 2019

Meeting Summary

Attending: Anne Eowan, ACLHIC, Bernie Inskeep, United HealthCare; Christina Wu, CAHP; Deborah Haddad, DMHC; Denise Love, NAHDO; Dolores Yanagihara, Integrated Healthcare Association; Emily Sullivan, NAHDO; Jill Yegian, OSHPD Consultant; John Freedman, Freedman HealthCare; Mary Watanabe, DMHC; Michael Valle, OSHPD; Phil Smith, OSHPD Consultant; Scott Christman, OSHPD; Starla Ledbetter, OSHPD; Steven Sottana, OSHPD; Tara Zimonjic, OSHPD; Ted Calvert, OSHPD Consultant**;** Wade Iuele, OSHPD Consultant.

Attending by Phone: April Blaazik, Aetna; David Falla, Kaiser Family Foundation; Emily Sullivan, NAHDO; Jesse Pannell, Aetna; Kirk Noe, OSHPD Consultant; Randy Smith, San Juaquin Health Plan; Walter Suarez, Kaiser Permanente.

Agenda Item	Meeting Summary
Welcome & Roll Call	Tara Zimonjic facilitated a welcome and introductions and provided an overview of the agenda.
Recap of May 16 Review Committee Meeting	Scott Christman provided a quick review of the May 16 Review Committee discussion. He noted the new process of the committee reviewing and voting on draft recommendations for each topic. For this meeting's topic on data collection, 5 out of the 7 proposed recommendations were moved and approved by the committee, with some edits. Two recommendations were tabled by the committee. One of the recommendations that was tabled was concerning the supplemental file format, which will be a topic of discussion for this group. The meeting also covered learnings from the Integrated Health Association (IHA), the California Healthcare Performance Information (CHPI) and Covered California, with their experience with multi-payer data collection. One of the big elements that came forward was the concerns over detailed provider level reporting. Scott closed by noting that it is critical to learn from what has happened in California to help us move forward as we develop the HPD System.
APCD-CDL™ Elements Breakdown	Emily Sullivan presented a brief overview of the elements of the APCD-CDL™ and the development of it. She noted that so far Virginia has updated their rules to implement the APCD-CDL™ and Hawaii and Delaware are moving towards implementation. She also commented that for states that already have an existing format, moving to the APCD-CDL™ will result in some short-term financial burden. Emily discussed that the transactional standards are referenced within the APCD-CDL™, but the data suppliers have communicated that they like the flat file format. She also noted that

	moving forward any updates to national standards will be noted in the APCD-CDL™. Suppliers have also committed to filling out 100% of the elements required by the APCD-CDL™ when they are available. There are caveats, but in general as the format was developed in partnership with suppliers the elements required are generally aligned to the information suppliers have. She also noted that if an element, for example in the race/ethnicity category is not captured by suppliers, that they do not input "unknown." Phil Smith inquired about why the APCD-CDL™ maps to the PACDR format as the national format, as this format has not been widely embraced by the industry. She noted that the PACDR format is where they get the data from to include in the APCD-CDL™. Bernie Inskeep also noted that New York has adapted the PACDR, which is not a HIPPA transaction format and open to interpretation. So far, they have been able to collect Medicaid FFS, Medicaid essential plans and QHP but not shop. The problem they are experiencing is that, because it is not a HIPPA transaction, and is open to interpretation, they have had to publish multiple companion guides to clarify. She followed up noting that when health plans typically report on a flat file format and then try to modify the flat file to make it back into a transactional file that it started with has proven to be both inefficient and challenging. April Blaazik also noted that the idea is to not have the DSMO standards out of sync with the CDL or have a CDL that is incongruent from the way claims are adjudicated. The idea is to narrow the field, and instead of having 17 different proprietary formats to have the transactional format in the PACDR and the flat file format in the APCD-CDL™. This will also improve communication. Walter Suarez also noted that the PACDR format is very challenging for payers that do not generate claims.
Current Data Submission Landscape	The workgroup moved into a discussion, facilitated by Ted Calvert, on the current data submission landscape. Question 1: Who do plans currently submit APCD-CDL™ like data sets to (DMHC/CDI, Federal, DHCS, CalPERS, Covered CA, IHA)? What is the frequency of these current data submissions? What are the pros and cons of monthly v. quarterly v. annual submissions? Walter Suarez noted that Kaiser does participate in IHA and once the system had been put in place and the data elements requested were made available, the experience has been good. Kaiser also submits data to Medicare for the Medicare Advantage program, which is in an 837-like file. They also have Medicare Pharmacy submissions which utilize the National Council for Prescription Drug Programs (NCPDP) structure. Additionally, they also submit Medicaid data to DHCS also using the 837 and NCPDP formats. When it comes to submitting encounter data the 837 format is very straightforward, however if you create a new file structure that has 837 elements and some 835-type data, there will need to be development time. Moving towards an APCD-CDL™ approach will require some adjustments. Walter noted Kaiser has not yet done the analysis to determine which elements will and will not be able to be provided. He noted that in the other states that Kaiser participates in APCDs they submit data per the format required. Bernie Inskeep noted that United HealthCare (UHC) has dedicated staff that pull data for each respective APCD that they submit to. They also submit 837s for government programs which is separate. For their APCD submissions to states they submit in the format required by the state. She noted that some states require duplicative submissions of Medicaid data (one

	for the APCD and one through the Medicaid agency), which can be onerous. Her recommendation is to have the payers submit Medicaid data to the Medicaid agency and then have the state agencies transfer the Medicaid feed for the APCD. Additionally, for Medicare Advantage she noted that there are two separate files that are sent, one for APCDs in the format required and a separate one to CMS. She mentioned that UHC supports the usage of the APCD-CDL™ which would reduce some of the duplicative burden. In terms of frequency she noted that due to how large of a state California is they would prefer either monthly or quarterly data submissions and are leaning more towards monthly due to size of California. She noted that using the APCD-CDL™ for CalPERS data submissions would give CalPERS more data as their current submission files have fewer fields than the CDL. Lastly, she mentioned that if California is interested in getting ERISA and self-funded plans to participate, using the CDL is one way to do that as it would reduce the burden on plans. Jesse Pannell, Aetna, noted that Aetna is structured like UHC and has a separate team for APCD data. They currently submit to 17 different state APCDs and having 17 different formats is a challenge. Aetna is also advocating for the CDL format. Question 3: What are the thresholds for these data submission? How are populations for data submission defined? (i.e. state residents, policy sold in states, employed in state, state employed and retirees regardless of place of residence) Walter Suarez noted for Kaiser in regions like mid-Atlantic (MD, DC, VA), there is a lot of mobility across states, which is an important element in terms of selection of the population that is included. Kaiser tends to not have issues across thresholds as they have enough of a population. The issue is about being careful about the state's scope, and they generally define populations for data submission based on the residence of the covered person regardless of where they get care. Bernie Inskeep noted that UHC cares a lot about thresholds because of administrative burden and data variability with very small submitters. She noted a couple of things she has seen across states. Sometimes the states require plans to submit three years of historical data to try to set thresholds. Sometimes states have payers submit and keep submitting data and then the state establishes the thresholds based on both the historical data and the current data. Other times data submitters know their data so well and decide to set their own threshold variances prior to submitting the data, which is not something she recommends. Jill Yegian wanted to clarify the different types of thresholds she heard discussed. One is by the number of people in a payer, and if there are less people than a certain threshold you do not need to submit data at all. The other is the threshold for the field in the APCD-CDL™ which differs from state to state. The last is by population. Bernie Inskeep concluded that typically, what we see is 1000 people as a threshold, but it will depend on what you do with the data. April Blaazik, Aetna, noted that there are exemptions by submitter ID that exist in terms of thresholds. When considering thresholds, it is important to keep in mind the administrative burden on the payers. She noted that some states require submitters to keep submitting even if it's below the threshold after the submitter ID has been discontinued. Lastly, the threshold amounts differ state to state. Ted Calvert followed up clarifying that the APCD-CDL™ doesn't specify if a field is "situational" but those are determined by the state and communicated through data

	submission guidelines. Dolores Yanagihara, IHA, also added that annual data submissions would result in a very large data file. She recommends doing either quarterly or monthly submissions, which is supported by the plans. Wade Iuele asked if it is it possible to do it daily, however that was determined to be far too burdensome. Jesse Pannell from Aetna commented that due to the sheer size of California monthly submission may make the most sense. He also recommended to give carriers more than 30 days, and closer to 45 days to submit data for each data submission cycle, to consider for the size of the state and for national carriers that may be submitting data to multiple APCDs. Phil Smith followed up inquiring if having a "window" of time to submit the data would be helpful, which was agreed would be helpful also considering other data submissions that plans are required to meet. Anne Eowan inquired about situs and what is the easiest way to handle it. Bernie Inskeep noted that UHC is used to doing state residents for APCDs. Some states do state residents and situs plans. It's important to know what you are doing with the data and the state residents are usually the starting point. She also noted that it is usually only states that are trying to recreate filings that do the situs, but it has been burdensome for the states and there have been issues with data quality. The group also had a conversation about college students who are attending school outside of the residence of their state. Bernie Inskeep noted that if they are still residents of that state they are counted as a resident. There was also a conversation regarding collecting data from student health plans. In California it is a large enough of a population to consider the data collection, but it may be very burdensome. Bernie Inskeep noted that the data collection is not super difficult, but the data is not very satisfying to receive. The student health plans are very limited and the population that they are covering tends to be relatively healthy and has very limited usage. Another specific plan collection consideration is Medicare supplemental plans. However, the group discussed that those plans typically only have about half of the APCD-CDL™ data fields. Ultimately, plans will put whatever you want into the data collection however it is up to the state to decide what is the use case. Scott Christman confirmed that what the health plans are recommending regarding frequency is quarterly is ok, but monthly is preferable due to California's size, and to also have a 45-day window to submit data. Emily Sullivan followed up inquiring if it makes sense for small California-only plans to submit monthly or is that too frequent. Bernie Inskeep noted that data submission can be done in a way to accommodate both the large national plans that have a large amount of data and the smaller plans for whom monthly submission would be burdensome. She gave an example where in Washington there is quarterly submission, but some plans submit 3 monthly files each quarter rather than one large quarter file. Question 4: Who do plans currently submit alternative payment model and other non-claims-based payments data to? What formats are used to collect this data? What is the frequency of these current data submissions?

	Walter Suarez noted that Kaiser submits alternative payments to Colorado, Washington and Oregon, for which they submit price information (Fee-For-Service equivalents). It does vary however from state to state, which can create a concern about the comparability of the data. In other states that do not have as large of a capitation rate the bias might not be as bad, however in California this can be a challenge. For IHA, Kaiser creates Fee-for-Service equivalents based on high deductible plans charges. These numbers are not an actual amount that anyone was paid, however they reflect what it could be. Bernie Inskeep, United HealthCare, discussed that there are different ways they are submitting APM data. She noted that the by member with capitated claims is the most straightforward APM. She commented that APMs are connected to the contracts, and APMs are not connected with an individual provider, but rather with a Tax ID, so they become an accounting function. Regarding the existing APM models Bernie Inskeep noted that UHC prefers the Massachusetts model which is the most burdensome model but is the model that is aligned to how the contracts are done. The Massachusetts model starts with the Alternative Payment tax ID or contract and then within that splits it up based on how it was divvyed up. This is in sharp contrast to the models used by Oregon and Colorado which are trying to match the billing providers with APM arrangement by NPI. She also noted that United HealthCare prefers if these files are requested in excel on an annual basis. April Blaazik noted that the alternative payments are not tied to anything, so it is difficult to report on it. April agreed with Bernie that the Massachusetts file is the best one Dolores Yanagihara noted that there are other payments beside capitation, which are also member focused not provider centric. Walter Suarez noted that Kaiser does not fall under a traditional APM model, which is a challenge to consider. Additionally, he inquired what the plan is to achieving consensus on the approach to APMs. He suggested creating a supplemental file workgroup to work on an approach. Ted Calvert noted that this might be a topic for a future Technical Workgroup but also supported the idea of a smaller group to come together. April Blaazik also noted it might be helpful to have Massachusetts come and present on their model as there has been feedback that their approach is preferable. Denise Love, NAHDO inquired if the supplemental file would be collected right away or if this data would be integrated down the line once the database is more mature. The OSHPD team confirmed that supplemental files are in Tier 2 of the data collection following the core data collection.
Topics for Future Meetings	The workgroup also discussed other topics that would be helpful to be discussed with the Technical Workgroup when considering the development of an HPD. • **Supplementary file format:** The group suggested taking this conversation off line to inform the recommendations on what this format should look like. There was also a suggestion to invite Massachusetts to the Technical Workgroup to share their supplemental file format. • **Data Limitations:** The group suggested that it may be helpful to understand what the limitations of the data are, and how far back any re-submissions of the data are feasible or not feasible, when considering state clean claim laws.

	• **Master Patient Index:** The group noted that Social Security Number (SSN) is the gold standard, however health plans are getting less and less SSNs, therefore it would be helpful to discuss what other opportunities are to develop a master patient index without the SSN data. • **Provider Data Quality:** There are various reasons health plans have varying provider data quality, which will be helpful to be aware of. • **Behavioral health data:** As there are special elements to consider it would be worth discussing. • **Federal Rules that could affect APCD:** Assessing the potential impact these regulations may have on a future APCD development.
Next Steps	The June Review Committee meeting will discuss data linkage. Looking ahead to the upcoming Technical Workgroup, supplemental file formats have been a big topic that we will come back to. Additionally, the group discussed that it would be helpful is a breakdown of the APCD-CDL and the elements that can and cannot be provided.