Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

June 20, 2019

Meeting Summary

Attending: Anne Eowan, ACLHIC; Amber Ott, CHA; Bernie Inskeep, United HealthCare; Christina Wu, CAHP; Deborah Haddad, DMHC; Emily Sullivan, NAHDO; Felix Su, Blue Shield; Jill Yegian, OSHPD Consultant; John Freedman, Freedman HealthCare; Jonathan Mathieu, Freedman HealthCare; Michael McKinney, Covered California; Michael Valle, OSHPD; Phil Smith, OSHPD Consultant; Scott Christman, OSHPD; Starla Ledbetter, OSHPD; Tara Zimonjic, OSHPD; Ted Calvert, OSHPD Consultant**;** Wade Iuele, OSHPD Consultant; Yvonne Zhou, Blue Shield.

Attending by Phone: Allison von Horn, HealthNet; Amy Costello, APCD Council; Claire Decastro, CalPERS; David Falla, Kaiser Family Foundation; Denyse Bayer, Cigna; Eleanor Shinsky, Cigna; Emily Sullivan, NAHDO; Jean Writz, Cigna; Katie Heidorn, HealthNet; Lindsay Erickson, IHA; Matthew Nakao, CalPERS; Michelle Santiago, Aetna; Pritika Dutt, DMHC; Randy Smith, San Juaquin Health Plan; Tina Fitzgerald, CalPERS; 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 June 20 Review Committee Meeting	Scott Christman provided a quick review of the June 20 Review Committee discussion. This meeting was focused on data linkage. The committee had an opportunity to review and vote on two recommendations to support the development of an HPD System that can collect linkable data and support successful data linkage across disparate data sets. The committee also had an opportunity to revisit one of the recommendations that was tabled at the May meeting regarding supplemental file formats. The committee moved forward and approved all three of the recommendations presented at the June meeting, with a few amendments. Prior to voting on the proposed recommendations, the committee heard two informational presentations to provide additional context and background. The first presentation was a presentation by Chris Krawczyk, Chief Analytics Officer at OSHPD. Chris 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. Additionally, John Freedman and Jonathan Mathieu from Freedman HealthCare, provided the second informational presentation of the day focusing 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.
Discussion of Supplemental File Formats	Ted Calvert provided a background on supplementary file formats and what the purpose of today's discussion was. Jonathan Mathieu and John Freedman presented information on the Integrated Healthcare Association (IHA), Massachusetts and Oregon supplemental file formats. They presented on the types and categorization of non-claims-based payments collected by each entity, the frequency of collection and the level of collection (by member or by provider). <u>Massachusetts:</u> *Yvonne Zhou, Blue Shield*, inquired if encounters where the member owes $0 would be captured. John Freedman confirmed that under a FFS arrangement there would be a bill submitted and the payer would pay the entire amount. Under a capitation model we cannot confirm that an encounter will be submitted but a bill should be submitted, though there will be no specific payment associated with it since the payment will be under capitation, but the encounter will be captured in the database. *Christina Wu, CAHP,* inquired how often the forms are updated. John Freedman was not sure of what updates have been done, but since submission is annual, he suspected it was not more than annually. Christina Wu followed up asking how the data is submitted, by line of business or by submitter. John Freedman confirmed that the data would be submitted at the submitter level aggregated across all lines of business. *Bernie Inskeep, United HealthCare,* commented that from United's perspective as a data submitter, the key difference is at the level of the APM contract, which is different from the level of a billing provider or a rendering provider. Bernie Inskeep also commented on the Massachusetts Total Cost of Care model. She noted that Massachusetts has put together a Total Cost of Care report which shows the nuances of the different interactions between payers and providers and hospitals etc. She noted that calculating the total cost of care is much more complicated than adding claims and APMs and subtracting pharmacy rebates. John Freedman agreed and noted that the Massachusetts separate supplemental file to calculate Total Cost of Care report requires the payers to do the math to calculate the actual cost of care. Ted Calvert followed up inquiring if part of Bernie's point in mentioning the Total Cost of Care file is that, there is information collected in that file that would not be reflected in the APM file. She noted that there is a lot of focus on reporting on alternate payment methodologies and that there is value in collecting that information, however if the goal is to get at the total cost of care, calculating just claims and APMs will leave you missing some critical information. <u>Oregon and IHA Discussion:</u> *Felix Su, Blue Shield,* inquired if the IHA total cost of care file is the same as the Massachusetts file discussed earlier, or if they just share the same nomenclature. Jonathan Mathieu noted that the capitation categories are similar, however the IHA model is not quite as comprehensive. There is some common nomenclature but not an exact correlation. *Amber Ott, CHA,* noted that in capitation arrangements it is not uncommon for hospitals to be payers and if that information has been captured in other states. Ted Calvert noted that he is not sure that any other states have done this level of analysis, and John Freedman confirmed this information is not captured as plans don't know what happens how the capitation gets allocated across payers.

	Bernie Inskeep, United HealthCare, commented that from UHC has encouraged states to get APM data at the contract level. This is because the plans can, from their accounting system, identify who was paid at the contractual level, however they cannot track how those payments were then sub-capitated. Ted Calvert followed up asking if plans can identify which members those capitation payments are attributed to. Bernie Inskeep noted that plans can identify the Per Member Per Month spending. *Walter Suarez, Kaiser*, noted that when Kaiser participates in IHA they submit data at the member level not at the category based. This has been their preferred method. He noted that Kaiser would have a hard time providing provider level capitation data. *Michael McKinney, Covered California,* noted that in Covered California only collects capitation payments, not the more complex APMs. There are some concerns from health plans in submitting this data as Covered California is not health oversight agency. Covered California does have a layout to collect this data which includes by member by month and by provider or group who receives the payment. Only one of the eleven plans provide the capitation information. However, Covered California does receive the encounters with a FFS equivalent usually assigned by their data vendor, IBM Watson. *Tina Fitzgerald, CalPERS,* also noted that the only APMs CalPERS receives is capitation, which is received at the member level. CalPERS is also receiving encounter information which includes the FFS equivalents. She noted that developing the FFS equivalents does take a lot of coordination, working with both their data vendor as well as individual plans. She also noted that CalPERS has contracts with the plans to provide data. Ted Calvert followed up inquiring if the plans are compliant with submitting this data, and how frequently they submit this data. Tina Fitzgerald confirmed that the plans are compliant and that the data is submitted monthly. Ted Calvert asked if there is any understanding of how much of the APM payments are non-capitation payments, which was left as a topic for consideration for a future meeting. *Amber Ott, CHA*, inquired if other states are capturing Medicare APMs, such as shared risk arrangements. She felt that it is important to ensure there is an infrastructure to collect these types of alternative payments as they are becoming more prevalent. John Freedman noted that Massachusetts does collect Medicare Advantage as a global capitation, but he is not sure if there is any other APMs being collected. He also noted APM information for Medicare ACOs is available publicly which could be incorporated into an APCD with a lag. Amber Ott followed up inquiring how Medi-Cal alternative payments would be collected. Ted Calvert responded that DHCS will be providing Medi-Cal data, but the team has not yet fully flushed out how Medi-Cal plans would submit their supplementary payments to the HPD. The committee had a conversation regarding the effectiveness of categorization for the APMs. Anne Eowan, ACLHIC, inquired if the categorization is really that important in terms of getting at the total cost of care. Ted Calvert noted that the goal is to get all or, as many as possible, of the payments. However, he mentioned that for the purposes of analysis it could be helpful to understand if some types of APMs work better than others. For this reason, categorization could be helpful.

	Ted Calvert also proposed that to create what the supplemental file format would look like, it would be helpful to convene a sub-workgroup to specifically develop the format that would be used. Walter Suarez, Bernie Inskeep and Michael McKinney volunteered to be a part of the sub-workgroup. The OSHPD team will be following up with the Technical Workgroup to solicit further volunteers.
Discussion on Draft Recommendations for Data Submitters	Jill Yegian presented a draft of recommendations for data submitters that the Review Committee would be reviewing and discussing at the July meeting. The recommendations were split into the following seven categories: 1. Mandatory Submitters 2. Required Lines of Business 3. Frequency of Submission 4. Populations included 5. Thresholds for submission 6. Excluded entities 7. Voluntary Submitters The technical workgroup provided feedback on each of the proposed recommendations. <u>Mandated Submitters:</u> • Carriers and TPAs – medical • Department of Health Care Service for all Medi-Cal members • Carriers and TPAs – dental (Tier 2) • Pharmacy Benefit Managers (for pharmacy rebates, Tier 2) *Discussion:* *Anne Eowan, ACLHIC,* reminded the group that as there are no dental representatives on the technical workgroup nor on the Review Committee. She noted that it would be important to engage the dental association, so they can be aware of these pending requirements and to ensure that they will indeed be able to submit the data being requested. *Walter Suarez, Kaiser,* inquired what exactly was meant by the term “medical.” Jill Yegian commented that it refers to all core data discussed previously (claims, encounter, etc.) and represents the entire continuum of care. Walter Suarez followed up suggesting for the recommendation to possible include examples of “medical” data. <u>Required Lines of Business</u> • Medicare Advantage (Part C) • Individual • Small group • Large group • Self-insured plans not subject to ERISA • Medi-Cal • Dental *Discussion:* *Christina Wu, CAHP,* inquired if Medicare Advantage excludes Prescription Drug Plans. Jill Yegian noted that the OSHPD team is assuming that all parts of Medicare Advantage would come through the plans. Christina Wu followed up inquiring if the idea was that if plans have

	both Part C and Part D Medicare would the HPD require them to submit both or would they be decoupled. *Bernie Inskeep, United HealthCare,* also commented that some plans might have Part C and Part D data in separate warehouses, and those plans would want to keep the two as separate streams of business, while for other plans they might have Part C and Part D in the same warehouse, so they might submit the same data. Walter Suarez, Kaiser, noted that the Kaiser preference is for Part D to come from CMS. <u>Frequency</u> • Monthly for core data: claims/encounters, eligibility, provider files • Monthly for dental data (Tier 2) • Annual for non-claims (Tier 2) <u>Population</u> • Residents of California <u>Thresholds</u> • Commercial (including Medicare Advantage): Covered Lives > 50,000 • Dental: Covered Lives > 50,000 • Medi-Cal: No threshold (data from DHCS) • Medicare FFS: No threshold (data from CMS) *Discussion:* *Bernie Inskeep, United HealthCare,* inquired what the proposed plan was for subsidiary companies that may fall below the threshold. She noted that United HealthCare is well above the 50,000 covered lives threshold and would be submitting data, however, UHC also has small subsidiary companies that are a part of UHC however, have much less than 50,000 covered lives. She inquired if there would be an exemption process. She also commented that another option to consider regarding threshold is to define threshold by unique submitting entities. There could also be two thresholds, one for the parent company threshold and another for submitter thresholds, which is traditionally set at 1,000 covered lives. <u>Excluded</u> • Accident • Automobile medical • Disability • Hospital Indemnity • Liability insurance • Long-term care insurance • Medicare supplemental insurance (pays cost-sharing) • Specific disease policy • Stop-loss plans • Student Health Insurance • Supplemental insurance (pays cost-sharing) • Vision-only

	• Workers Compensation *Anne Eowan, ACLHIC,* commented that most of the entities on the excluded list are defined in the insurance code (Section 106b) and are listed as excluded out of "health insurance". She noted that vision-only is in a specific category of specialized plans which can also include chiropractic-only as well as behavioral-health only. *Christina Wu, CAHP,* followed up inquiring if we would be then assigning a behavioral-health only plan to be considered as a mandatory submitter. Jill Yegian noted that the assumption to date has been that the data from the behavioral health plans would come through the commercial plans. Christina followed up noting that there is some nuance to the behavioral health only plans that should warrant a separate discussion. <u>Voluntary</u> • Clarify that submission is not prohibited (Self-insured ERISA, federal government) • Require carriers and TPAs to provide claims data to HPD (or vendor) upon request *Discussion:* *Anne Eowan, ACLHIC,* reminded the group that TPAs will only be able to submit what they have due to Gobeille. Jill Yegian clarified that it is the self-insured employers that will be requesting to have their data be submitted to the HPD *Bernie Inskeep, United HealthCare,* commented that the language used for the voluntary request info may not be effective due to contractual obligations
Next Steps	The Technical Workgroup was reminded of the offer to volunteer for the supplementary file sub-workgroup. The group was also given a pre-work assignment for the July meeting to review the APCD-CDL™ Eligibility file, in order to come prepared to discuss elements that could be an issue to submit data on.