Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

August 15, 2019

Meeting Summary

Attending: Bernie Inskeep, United HealthCare; Denise Love, NAHDO; Dolores Yanagihara, Integrated Healthcare Association; Emily Sullivan, NAHDO; Jill Yegian, OSHPD Consultant; Jonathan Mathieu, Freedman HealthCare; Linda Green, Freedman HealthCare; Matt Maines, Blue Shield of California; Mike McKinney, Covered CA; Michael Valle, OSHPD; Paul Hardstone, Blue Shield of California; Scott Christman, OSHPD; Starla Ledbetter, OSHPD; Sindhuja Chittuluru, Blue Shield of California; Tara Zimonjic, OSHPD; Ted Calvert, OSHPD Consultant**;** Wade Iuele, OSHPD Consultant; Walter Suarez, Kaiser.

Attending by Phone: Amy Costello, NAHDO; Christina Wu, CAHP; Clair DeCastro, CalPERS; Eric Lee, SCAN Health Plan; Jesse Pannell, Aetna; Katie Heidorn, Health Net; Matthew Nakao, CalPERS; Mary Watanabe, DMHC; Rick Lou; SCAN Health Plan; Sheryl Turney, Anthem.

Agenda Item	Meeting Summary
Welcome & Roll Call	Tara Zimonjic facilitated a welcome and introductions and provided an overview of the agenda.
Recap of August Review Committee Meeting	Scott Christman provided a quick review of the August 15 Review Committee discussion. He noted that this meeting was focused on finishing the data submitter conversation, overflow from the July meeting, as well as discussion on data quality. At the meeting the committee members finished an overflow discussion from the July meeting on data submitters. The committee heard the continuation of planned presentations and voted on recommendations on the thresholds, frequency and population for data submissions. There was also a presentation, discussion and vote on recommendations for California on approaches for encouraging voluntary submissions. The committee also had a discussion and vote on recommendations regarding data quality. The committee moved forward and approved all of the remaining data submitter recommendations presented at the August meeting, with a few amendments. The committee approved two of the three discussed recommendations on data quality with one amendment. The committee decided to withdraw the third data quality recommendation regarding resubmission of data as they believed it was subsumed in the amended recommendation 1. The committee decided to table recommendation 4 regarding stakeholder data quality review, which will be discussed at the upcoming September meeting.
Discussion of APCD-CDL™ Medical Claims File	In preparation for this meeting the Technical Workgroup was asked to review specific elements of the Medical Claims File in the APCD-CDL™. The workgroup discussed each of the file elements listed below. Wade Iuele led this conversation.

CDL Element #	Data Element Name	Other Comments / Challenges
CDLMC007 CDLMC008	Version Number Cross Reference Claims ID	At United Healthcare claims are appended and only the new part will be submitted. There are no versions or version numbers for the commercial data. At Kaiser claims are not generated for internal encounters. Medicare Advantage does have version numbers on it. When they send an encounter to other state APCDs they use version numbers. At Blue Shield the claim processing system has date version number rather than claim version numbers. SCAN Health Plan for encounters creates a cross reference claims ID because they do not create the claims themselves. At Aetna the primary system does not version claims, there is a reference claim ID to tie together all the claims. Claim versioning is possible but challenging, as it cannot just be a sum allowed amounts.
9	Insured Group or Policy Number	There is a reference to PACDR and that is the code that should be submitted. This is a code for referential integrity as are the next two and has a similar field in the eligibility file.
12	Plan Specific Contract Number	Noted that this is for the subscriber not for the member. The member information is captured in fields below. This is also a referential integrity field.
23	Patient Control Number	This field links medical claim file to eligibility file. This is also for referential integrity.
24	Paid Date	The instruction say that if there is a no-pay encounter or if the date is not available, the process date is used. IHA noted that they have been using either remittance date or adjudication date, which Kaiser confirmed that they do. UHC noted that they use process date Aetna noted they use paid date on claims and process date on encounters. Consensus landed on using process date when it is a

			no-pay encounter.
	122	Unit of Measure	It was noted that this particular field came as a request from the state of Utah to track data on anesthesiology, but this field applies to all claims. For this field if field 121 for units is blank than this field on unit of measure should also be blank. If the provider is billing for units (DA=Days; MJ=Minutes; UN=Units) then this field wants the specific units being measured.
	123	Charge Amount	This field is defined as the amount charged by the provider. Kaiser noted that they do not have this data. Confirmed that this is the line amount charge claim and there is an element that also captures the line number of the claim.
	124	Withhold Amount	Plans commented that this is information that they do not have this data and it is not being reported in other state APCDs.
	125	Plan Paid Amount	It was noted that for capitate payments this field will always be set to 0
	126	Co-Pay Amount	It was noted that for some plans, fields 126, 127, and 128 might be grouped together, which is not a problem but just might be reported differently. The plans also noted that they know what this number should be, however they cannot assess if it was actually paid.
	127	Coinsurance Amount	(see 126)
	128	Deductible Amount	(see 126)
	129	Other Insurance Paid Amount	It was noted that if this data does not come from the provider the health plan will not have it.
	130	COB/TPL Amount	Any difficulties populating this field for FFS claims? Aetna noted that they do not capture this data and would not know what the other payment should be.
	131	Allowed Amount	It was noted that the phrase “will pay to a provider” may be confusing if this is expected to be filled in with a FFS equivalent amount of encounters. The goal is to get to a point where plans would put something in that would signify what the allowed amount would have been. It was noted that for this field a variance form would be helpful. The plans noted that there are multiple ways of

			calculating a FFS equivalent, and if each submitter develops their own methodology this number might be unreliable. OSHPD noted that it will be critical to figure out the ways to develop a reliable FFS equivalent.
	132	Payment Arrangement Type Flag	The APCD-CDL™ definition says that this field "indicates the payment methodology. 01= Capitation 02= FFS etc.…" So if you have a no-pay encounter you put a number 1. This field does not capture charity care
	134	Rendering Provider	It was noted that sometimes some networks are leased and this information is not provided. It was also noted that often this data elements has no business case and therefore is not collected. Changing that business model to make it so that rendering provider is collected would cost billions of dollars and would not be a business case. Aetna noted that they do not collect this information and do not use it. The similarity between field 134 and 153 was noted as being a second chance to get the data. There was a suggestion for a future field to capture "leased" network flag, which could then inform the thresholds for fields 134 and 153.
	153	Attending Provider NPI	There was a question if this field has an X12 or PACDR reference and it was confirmed that it can be found in loop 2310A and it is also in the 837
	159	Claim adjustment reason code	The APCD-CDL™ instructions specify this is to be completed only for denied claims. Field 159 is only filled if field 158 is "1." There is a mechanism to communicate what is the reason for the adjustment
	160	Claim Line Type	Base on United Healthcare's experience, claim line type is not defined in the same way and it is important to make it clear what is expected to be filled in here.

Closing comments on Medical Claim File:

The committee discussed the difference between subscribers and members, and it was identified that there are certain fields in the APCD-CDL™ that specify members and others that specify subscribers.

	A question was raised regarding the process that OSHPD will use to decide which of these data elements are not reportable by whom. The OSHPD team confirmed that there would be an onboarding process where OSHPD would meet with submitters to determine their thresholds for data elements. It was also mentioned that health plans might have different ways of identifying certain elements, that might not be named what they are in the CDL, so the onboarding process will help to identify how plans can successfully submit data in the APCD-CDL™ format. A suggestion was made to do an itemized variance report to identify which plans are going to not have which elements, and this process could be built into the automatic process of data quality check
Discussion on Feeds per Submitters	Jill Yegian led a conversation regarding the need for OSHPD to understand how many feeds they should be expecting per submitter. This is important information so that OSHPD is able to understand the scale scope and diversity in the number of fields the HPD might expect. It was also noted that this is not an attempt to dictate how plans submit data but rather a want to plan for how submitters will plan to submit the data. To get this information OSHPD assigned a homework assignment to each of the data submitters to fill out a "Data Feeds Survey" which will consist of the following: • number of feeds you would expect to submit • number of covered lives represented in each of those feeds Of note, this information includes commercial and Medicare Advantage and excluded Medi-Cal as that data would come through DHCS. Questions and comments Regarding the Assignment: • How the data will be used will determine how a plan may choose to send it. • OSHPD is giving plans an opportunity to decide if they prefer to roll it up to one big file for all the lines of business or will there be separate. • Submissions might also vary across file types (i.e. provider file versus enrollment file) • Are Federal programs included: FEHB – there was a memo from the Office of Personnel Management that prohibited from distributing this data Indian Health Services- depends on state law if it would be included. VA Health, Tri Health not allowed to be collected. It was noted that flexibility will be much appreciated as data processes might be different for smaller regional carriers.
Open Forum	There was a note that here is a new 42CFR proposed rule coming Federal Rule amendment that is being currently developed that may ease the restrictions on getting 42CFR data.
Next Steps	The Technical Workgroup will be discussing elements of the Pharmacy Claims file at the September Technical Workgroup Meeting as well as .