Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

September 19, 2019

Meeting Summary

Attending: Amy Costello, APCD Council; Bernie Inskeep, United HealthCare; Chris Krawczyk, OSHPD; Dolores Yanagihara, Integrated Healthcare Association; Jill Yegian, OSHPD Consultant; Jonathan Mathieu, Freedman HealthCare; Linda Green, Freedman HealthCare; Mike McKinney, Covered CA; Michael Valle, OSHPD; Phil Smith, OSHPD Consultant; Scott Christman, OSHPD; Tara Zimonjic, OSHPD; Ted Calvert, OSHPD Consultant**;** Wade Iuele, OSHPD Consultant.

Attending by Phone: Amol Parab, Blue Shield; April Blaazik, Aetna; Clair DeCastro, CalPERS; Dave Falla, Kaiser; Eleanor Shinsky, Cigna; Eric Lee, SCAN Health Plan; Jesse Pannell, Aetna; Katie Heidorn, Health Net; Matthew Nakao, CalPERS; Michelle Santiago, Aetna; Patrick Hurley, HealthNet; Sheryl Turney, Anthem; Steven Vo; SCAN Health Plan; Tina Fitzgerald, CalPERS; Viraj Desilva; Walter Suarez, Kaiser.

Agenda Item	Meeting Summary
Welcome & Roll Call	Tara Zimonjic facilitated a welcome and introductions and provided an overview of the agenda.
Recap of September Review Committee Meeting	Scott Christman provided a quick review of the September 15 Review Committee discussion. Topics included an overflow discussion from the August meeting on data quality and Review Committee members voted on and approved the remaining data quality recommendation. The committee also had a discussion and vote on recommendations regarding privacy and security. The only edits made were on the first recommendation to clarify that it was specifically in regard to patient privacy principles. The committee also did not feel that the proposed 1c recommendation was necessary, and so they voted to remove that. The committee moved forward and approved all of the privacy and security recommendations presented at the September meeting, with a few amendments outlined below. Privacy and Security Recommendations: 1. **Privacy Principles:** The Review Committee recommends the HPD Program adopt the following patient privacy principles: a. The HPD shall protect individual patient privacy in compliance with applicable federal and state laws. b. The HPD is established to learn about the health care system and populations, not about individual~~s~~ patients. ~~c. The purpose of the HPD is to serve the intent of the Legislature.~~ 2. **Authority to Submit and Collect Personal Information:** The Review Committee recommends that legislation clearly authorize data submitters to send, and OSHPD to receive, personal information to meet the legislative intent of the HPD. To support

	the submission of data by voluntary submitters, legislation should clearly specify public health as one of the intended uses of the HPD. 3. **Access to Non- Public Data:** The Review Committee recommends that only aggregate de-identified information will be publicly accessible. OSHPD should develop a program governing access to non-public HPD data, including a data request process overseen by a data access committee. 4. **Information Security Program:** The Review Committee recommends the HPD program develop an information security program that uses existing state standards and complies with applicable federal and state laws.
Discussion of APCD-CDL™ Pharmacy Claims File	In preparation for this meeting the Technical Workgroup was asked to review specific elements of the Pharmacy Claims File in the APCD-CDL™. The workgroup discussed each of the file elements listed below. Wade Iuele led this conversation. Questions and comments raised during the Workgroup are captured in the "Questions? Comments?" column below.

CDL Element #	Data Element Name	CDL Rules/Description	Questions? Comments?
CDLPC024	Paid Date		Confirmed that if there is no paid date, use process date.
CDLPC026			Reference to the pharmacy NCPDP transaction may not be accurate. Should be 403-D3. Post-meeting note: There are several NCPDP file formats. The APCD-CDL ™ references the elements in the NCPDP Uniform Healthcare Payer Data Standard.
CDLPC030	Compound Drug Name or Compound Drug Ingredient List	If CDLPC029 (Compound Drug Indicator) = Y, then provide the name of the compound drug. If no compound drug name is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs.	Oftentimes the drug names are very long, and do not fit in the space provided. There was a question if NDC codes would work. Using the space as a delimiter does not make sense, as a drug name might have more than one word to them. Suggestion to work with the APCD Council to revisit this element and perhaps allow for

				use of the NDC if it is a compound, which would allow for the space delimiter and would not have the issue about running out of space.
	CDLPC031	Formulary Indicator	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1=Yes; 2= No; 3= Unknown; 4= Other; 5= Not applicable.	No comments on this field.
	CDLPC034	Drug Unit of Measure	Report the code that defines the unit of measure for the drug dispensed in CDLPC032 (Quantity Dispensed). Valid codes are: EA= Each; F2= International Units; GM= Grams; ML=Milliliters; MG= Milligrams; MEQ- Milliequivalent; MM= Millimeter; UG= Microgram; UU= Unit; OT=Other.	In pharmacy claims (NCPDP standard) this is field 600-28, which only has EA, ML and GM as valid codes- the additional codes that are available here are not aligned. Post-meeting note: There are several NCPDP file formats. The APCD-CDL ™ references the elements in the NCPDP Uniform Healthcare Payer Data Standard. There was a question about whether or not morphine equivalent is included here. It was clarified that the morphine equivalent measure (MME) would have to be calculated using other elements .
	CDLPC035			It was noted that the correct NCPDP standard is 402-D2. Post-meeting note: There are several NCPDP file formats. The APCD-CDL ™ references the elements in the NCPDP Uniform Healthcare Payer Data Standard.

	Field	Name	Description	Comments
	CDLPC038	Allowed Amount	When payment arrangement type in CDLPC049 (Payment Arrangement Type Flag) is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. If there is not an allowed amount, such as state supplied vaccine, report 0. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed. If there is not an allowed amount, report 0. Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	No comments on this field.
	CDLPC041	Postage Amount Claimed	Postage amount associated with the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	It was asked if this field is required. OSHPD clarified that the expectation is that all fields are required, though some are situational. If a health plan does not have a piece of information that the APCD-CDL™ is requesting, they will not be required to submit it and there will be an exemption process to identify those fields.
	CDLPC049	Payment Arrangement Type Flag	Indicates the payment methodology. Valid codes are: 01=Capitation;	It was commented that not each of the listed codes are available, depending on the platform that is being used. For example, if it is a

			02=Fee for Service; 03=Percent of Charges; 07=Other.	percentage charge, but the platform only has the dollar amounts, code “3” will not be able to be used.
	CDLPC050	Prescribing Physician ID	Payer assigned provider ID for the prescribing physician. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	This information is not always available. The availability of this field depends on the storage of data, and sometimes this field is not available or not received by health plans. Another example would be if it is a provider out of network, this data would not be available. It was noted that there are multiple ways of mapping to the provider file- which is why there is more than one field requesting similar information. It was noted that tracking physicians in an APCD has proven to be challenging, which is the reasoning behind having multiple identifying fields.
	CDLPC054	Pharmacy NCPDP Number	Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP).	This maps to service provider ID 201-B1 in the NCPDP standard. Post-meeting note: There are several NCPDP file formats. The APCD-CDL ™ references the elements in the NCPDP Uniform Healthcare Payer Data Standard.
	CDLPC056	Pharmacy Tax ID Number	Dispensing pharmacy federal taxpayer’s identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data).	It was noted that there will need to be further analysis to see the accurate mapping for the pharmacy ID.
	CDLPC062	Mail-Order Pharmacy Indicator	Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include:	It was noted that there will need to be further analysis to see if there is a NCPDP standard that maps to this field.

			1=Yes mail order pharmacy; 2=No-not a mail order pharmacy; 3=Unknown; 4=Other; 5=Not applicable.	
	CDLPC063	Carrier Associated with Claim	For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. See Appendix H: External Code Source, National Association of Insurance Commissioners.	There was a confirmation that if the data comes from the PBM the NAIC code for the medical coverage plan would be included. It was noted that it might be helpful to include some examples to illustrate this. It was also asked what if the medical carrier does not have an NAIC code. It was noted that PBMs don't have NAIC codes, and there might be a time when the medical coverage plan does not have an NAIC code, for example, a TPA. If a PBM is submitting data on the behalf of a TPA, there might not be an NAIC code at all. In this case you would need to match to the member. The intent is to tie the data coming from the PBM with a medical plan.
	CDLPC064	In Plan Network Indicator	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes.	There are issues here if there are leased networks, therefore they do not who the prescribing providers are and if they are in network. They do not maintain a network, per say, since it is leased. Suggestion to add a third value "L" for leased network.
	CDLPC066	Claim Line Type	Report the code that defines the claim line status in terms of adjudication. Valid codes are:	Same notes as from medical claims line. Void and backout are pretty synonymous, so please select which one OSHPD would

		O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	like plans to use.
CDLPC068	Carrier Specific Unique Member ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	Periodically this can change, same comments from the medical claims file discussion. If the system changes, the unique member ID changes. This field, like many other member identification fields, was created as way to have multiple ways to get at members, regardless of which plan is providing the data.
CDLPC069	Carrier Specific Unique Subscriber ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	Same feedback as for Carrier Specific Unique Member ID.

Other Comments:

There was a question if it is possible to add into each field "if available" rather than going through an exceptions process. Amy Costello commented that there is an opportunity for updates to the CDL, via the Data Maintenance Process. Ted Calvert also commented that through this process of the Technical Workgroup reviewing the file formats, OSHPD can compile a list of all of the comments and changes proposed, review those back with the Technical Workgroup, and then submit to the APCD-CDL™ data maintenance process.

It was also requested that the business case be provided for the usage of the Carrier Specific Unique member identifier. IHA noted that they use this field to link to other files.

One of the topics proposed for a future meeting would be to compile this list of proposed changes to the APCD-CDL™ and share with the Technical Workgroup.

Discussion on Feeds per Submitter	Wade Iuele thanked everyone for submitting their data feed surveys. See the summary below: • Five plans responded • The number of feeds varied from 2 to 16 feeds per plan • The number of covered lives per file varied from 750 to several million • Files were organized differently across plans. Some organized by lines or business, others pulled out subsidiary companies, or had separate feeds for dental or behavioral plans

	• One plan lumped the entire eligibility file together, but had multiple feeds for different claims and provider files There was a discussion on opportunities to consolidate the feeds prior to submission. Plans noted that it may be challenging to consolidate the feeds. Health plans are HIPAA covered entities and have all of the privacy standards that apply to them. Each of the subsidiaries owns their own data and will be their own separate submission. There is no mechanism to bridge all of this data. Additionally, when there is feedback on the data, it will need to go back to the data owners in their organization anyway, so combining the data may make it harder to troubleshoot issues and respond to questions. One plan noted that they have some larger groupings of claims data, but they segment out behavioral health, Medicare, and Medicaid. Dolores Yanagihara noted that from a practical perspective, sometimes consolidation can be challenging from a size perspective. She noted that it would take longer to transmit and process a larger file. However, there may be some consolidation that would make sense, but that would depend on the organization. Phil Smith noted that as technology is moving toward distributed systems, the mindset of large files and consolidation might be depreciating.
Upcoming Technical Workgroup Topics	Jill Yegian thanked the workgroup for their work and engagement on the challenging topics we have covered thus far. The goal of this conversation is to look ahead at topics planned for the future months. Proposed October topics: • Technology Alternatives – the Review Committee will discuss technology options to receive, store, and structure data; to incorporate other data sets for research; and to analyze data and publish reports. Please review the slide deck for the Review Committee meeting in advance and come prepared to provide your organization's perspective on the recommendations, with a focus on data intake and collection processes. • Data Submission Policies and Procedures – governance will be discussed by the Review Committee in December, and the October Technical WG is a timely opportunity to obtain input from TWG members. We anticipate seeking input on topics related to policies and procedures on data submission and resubmission – especially how much time plans would like to have between the deadlines for different stages during the ramp up, e.g., number of months between the deadlines for receipt of test data and for historical data. Specific discussion topics and materials will be distributed two weeks in advance. • APCD CDL™ – Provider file elements Proposed November topics: • Data Release/Access: governance will be discussed by the Review Committee in December, and the November Technical WG is a timely opportunity to obtain input from TWG members. We anticipate seeking input on topics related to data governance, including policies and procedures for obtaining HPD data. • APCD CDL™ – Dental component (outreach sent to California Association of Dental

	Plans) Proposed December topics: • Sustainability will be discussed by the Review Committee in January, and the December Technical WG is a timely opportunity to obtain input from TWG members. Specific topics TBD. Question: What additional issues, topics, or concerns do you have that we should consider in planning upcoming Technical Workgroup Meetings? Comments: For the data submission policies, it is important to consider how much time the plans will have from receiving the APCD-CDL™ final submission requirements and then being required to submit the data. Typically, it takes plans about 6 months to update their systems to be ready to submit data. Plans also commented on the importance of knowing the data quality processes and the data quality audits that will be done. The more data submitters know about the expectations, the better the data will be when first submitted. Suggested that there be a discussion on what data submitters see as best practices in data quality communications. Data Release/ Data Access will be a robust conversation with a great number of considerations will be critical that the plan representatives will have input on. Additional Topics: • Summary of proposed changes to APCD-CDL™ • Non-Claims Based Payment Data sub-workgroup • Formal establishment of an evaluation plan that document the actual achievement for goals and purposes of APCD ○ Suggestion to look into the California Research Bureau as an entity to do this evaluation.
Next Steps & Closing	The Technical Workgroup will discuss elements of the Provider file at the October Technical Workgroup Meeting.