Office of Statewide Health Planning and Development

Healthcare Payments Data Program
Technical Workgroup Meeting

November 21, 2019

Meeting Summary

Attending: Amber Ott, CHA; Bernie Inskeep, United HealthCare; Beth Herse, OSHPD; Denise Love, NAHDO; Emily Sullivan, NAHDO; Jill Yegian, OSHPD Consultant; Jonathan Mathieu, Freedman HealthCare; Michael Valle, OSHPD; Norm Thurston, NAHDO; Phil Smith, OSHPD Consultant; Scott Christman, OSHPD; Starla Ledbetter, OSHPD; Tara Zimonjic, OSHPD; Ted Calvert, OSHPD Consultant; Theresa Myles, OSHPD; Wade Iuele, OSHPD Consultant; Walter Suarez, Kaiser.

Attending by Phone: Amy Costello, APCD Council; April Blaazik, Aetna; Dave Falla, Kaiser; Dolores Yanagihara, Integrated Healthcare Association; Eric Lee, SCAN Health Plan; Gina Gonzales, CalPERS; Jesse Pannell, Aetna; Linda Green, Freedman HealthCare; Sanjay Jin, HealthNet; Tim Brown, California Association of Dental Plans.

Welcome & Roll Call

Tara Zimonjic facilitated a welcome and introductions and provided an overview of the agenda.

Recap of November Review Committee Meeting

The November Review Committee agenda was a departure from the usual Review Committee process. November was left as an “overflow” month, and the overflow was not needed. Instead, stakeholders presented on the purpose for building the HPD system and some practical uses of its data. To see the full slides from the November Review Committee meeting please visit: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Healthcare-Payments-Data-Program-Review-Committee-Master-PowerPoint-11.21.19_ADA.pdf

Submitter Registration Process

Jonathan Mathieu and Ted Calvert led a discussion on submitter registration, including: the payer management process, regular communications with submitters, and development of an annual submitter registration process.

Plans inquired how communication would be managed across big plans in order to accurately identify the correct contact person at each of the plans. The plans also commented that the person at the plan who is registered with the

Department of Managed Health Care (DMHC) might not be the person connected with the APCD work, and it might be a long process to identify the correct contact.

There was a conversation about how the state could be proactively notified as to who the correct contacts are. Technical workgroup members noted that it could be helpful to cc them on communications regarding submitter registration, so that they can ensure the information gets to the right person.

There were also suggestions about communication channels for submitter registration, including: place a submitter registration form on the OSHPD website, work with the California Association of Health Plans to identify submitters and contacts, and work with the Integrated Healthcare Association to identify the correct contacts.

The plans also commented that if the registration process is going to be by the parent company's National Association of Insurance Commissioner (NAIC) code, some health plans' lines of business will need separate submitter codes. To avoid confusion the HPD could use hierarchical submitter registration codes, where the first parts of the code identifies the parent company and the second part identifies the subordinate submitter (e.g. "04" means United Healthcare, "04-01" is the UHC Commercial HMO, and "04-12" is the UHC Dental PPO).

Data Access and Release

Jill Yegian led a discussion on data access and release, in preparation for the December Review Committee meeting which will be focused on governance.

Regarding data de-identification for release, it was noted that there are four data subjects to consider when de-identifying (at the provider level, individual level, plan level and facility level) that will need to be clarified as to which level it is being de-identified at. OSHPD clarified de-identification in this context is related to patients. It was also noted that the California Health and Human Services Agency has developed a set of Data De-Identification Guidelines (DDG) which address patient privacy under both the Information Practices Act and HIPAA. The DDG guidelines drive towards aggregate reporting for public release; they are also relatively conservative and model many of their requirements after what CMS does. OSHPD also noted that anything that is requested at the record-level will require a data use agreement. It was also noted that there will need to be a policy to govern when individual providers/ facilities are included in a data set.

There was a question regarding what would define an "eligible applicant" for the data. It was noted that in other states plan competitors have asked for contracted rates, which could potentially be used for anti-competitive behavior. Some

applicants may choose to use the data for nefarious reasons, and there needs to be a plan in place to address that. One measure to address this concern is having a multi-stakeholder data review committee, ensuring that the perspectives of all stakeholders are represented. That committee would then identify anti-competitive acts and be able to deny the data request.

It was also noted that it would be important to set principles and parameters around what data is being requested by whom and for what purpose.

Another point of discussion was that there will need to be a plan for data record retention and disposition. The HPD data could be in a user's possession for years, and there has to be a timeframe for the data usage. OSHPD noted that their current process uses a letter of attestation that the data was destroyed. It was also noted that the proposed plan to have a research enclave would allow for better monitoring of data usage. However, with an enclave, OSHPD will need to maintain a list of the users who have access to the data. There was a suggestion to have an annual review, where data users contact OSHPD to assess whether or not they are still using the data.

Regarding the research enclave, it was commented that some states have tried the research enclave approach with mixed success. A research enclave can be expensive to build and maintain, and there is a lot of technical support that is needed. It was noted that Wisconsin has a great example, which was built and maintained by Optum — building an enclave is "doable" and the technology is evolving rapidly.

The plans agreed that showing a benefit to the state of California as a data use requirement is a good idea, and they noted that requirement can be helpful when deciding whether to release the data. It was noted that in Colorado the "benefit-to-the-state" requirement generates the most conversation. Currently, hospitals get their data back from OSHPD to utilize and do planning. OSHPD has not provided this data to consultancies requesting this data, but if organizations are using the data to improve their delivery of services, that may be appropriate.

There was a question regarding revenue generation from the usage of the data. As was mentioned at the Review Committee meeting, the research community is often operating off of grants, and the Public Policy Institute of California noted that the majority of researchers would pay to access this data for their research project. In the past OSHPD has not supported the selling of data for commercial purposes. There are user fees that can be collected to help sustain the ongoing operations of the program, but there should be limitations to prevent the HPD from becoming a commercial endeavor.

The last part of the conversation related to stakeholder committees. It was noted that there is always a tension about the appropriate level of scrutiny needed to ensure appropriate scientific methods, value, and patient protections. This tension will need to be balanced when making data release decisions.

There was also a question if the Advisory Committee is a decision-making committee. The OSHPD team shared that current thinking is that OSHPD would seek advice from the committee and OSHPD will ultimately be responsible for the final decisions. Some of the other elements that will need to be considered for the committee is whether it is governed by majority rules or consensus, and what happens if there is a conflict of interest. It was discussed that if there is a conflict of interest it must be disclosed to the committee, and there has to be a quorum to make decisions. OSHPD also commented that that any human subjects review would still go through the Committee for the Protection of Human Subjects (CHHS IRB), as would research requests. This committee will be focused on the data and should still identify what is minimum necessary to complete the research project.

OSHPD noted that there is a tradeoff between the size of the governance groups and efficient operations of their business. In addition to the data release committee, OSHPD envisions a broader Advisory Committee that could include additional representation. The proposed plan also includes other groups of interested stakeholders, such as a data users' group, data submitters group, scientific methodologies group, etc. There will likely be multiple ways to engage stakeholders, and the right, manageable way to achieve effective governance will need to be identified. It was noted that the intention is to not specify the composition of the committee in legislation.

It was noted that as the volume of data requests increases, the committee will start to see a pattern, and start to see multiple versions of the same request. As the committee becomes more comfortable with the process, there will be an opportunity for greater automatic approval processes, and more streamlined approvals. There was a comment that this data set will be of great interest, and there will most likely be a large number of requests. It will be important to develop a streamlined approach to address all of these requests; however, it will also be important to have a process that does its due diligence to protect privacy.

There was an additional conversation regarding payment data and protecting contractual agreements. In Utah they do not collect allowed amount itself, but all the elements needed to calculate the allowed amount are collected. In Colorado there is a nonprofit payer, for-profit payer, and a hospital on the Data Release Committee. Those entities pay close attention to requests for payment data. Colorado is prohibited from releasing provider, payer, and cost in the same file.

The common theme across states is that the rules of data release have to protect the health plans' contractual agreements.

Discussion of APCD-CDL™ Dental File

Tim Brown form the California Association of Dental Plans joined the call to provide input from the dental perspective.

CDL Element #	Data Element Name	Questions? Comments?
CDLDC025	ICD 10-CM Diagnosis Code NEW: ICD-9/ICD - 10 flag	There was a question if there will be a request for past data, as the dental industry will not have ICD 9 data moving forward. It was noted that the CDL will be collecting three years of historical data. It was noted that only about 20% of dental claims come with diagnostic codes. There was a reminder that some states will be implementing the APCD-CDL ™ sooner than California, and they will need to have a flag for ICD-9 vs. ICD-10 codes. Ultimately though, dental data will rarely have diagnostic codes, and any medical dental will be included in the medical file. If this is an irrelevant field, it will be left blank. If the data is available, it should be reported.
CDLDC028-29 –	Oral Cavity 1 &2	This data will be available if it is required as part of the claim, and if it is not required it will not be included. You will not get oral cavity or tooth surface for every procedure nor every claim. Tim Brown will follow up whether 2 oral cavity procedure fields are sufficient, but there is an opportunity to put 5 in if needed.
CDLDC032 - 62	Tooth – 1-4 Surface – 1-5	These fields are dependent on the procedure itself. Endodontics and restorative procedures would have this

		data. There was a question why this section is so repetitive. It was noted that the CDL is a flat file format. If many of the teeth and surfaces are not involved, they would be left blank. The dental association recognized the situational nature of these fields (use when appropriate, otherwise leave blank). There was a conversation regarding usage of diagnosis codes when the procedure is restorative, or full mouth operations to reduce the number of teeth reported. The dental association noted that conceptually that could happen, but there are very few dentists using diagnostic codes. Of the 20% of claims that use diagnosis codes, they are mostly using medical codes for enhanced benefits provided if a patient is pregnant or has a heart condition, etc. These health conditions allow for additional cleanings or additional procedures. As an industry, dentistry has not yet adopted the usage of diagnostic codes.
CDLDC062	Withhold Amount	It was noted this is not something that is done in dentistry and would suggest removing this field from the CDL.
CDLCD069	Rendering Provider ID	It was confirmed that the clearinghouse will have an internal ID for the provider. It was agreed that if either rendering provider ID or rendering provider NPI can be filled in that will be sufficient.
CDLDC070	Rendering Provider NPI	It was noted that not all dentists have an NPI. If the dentist is not transmitting an electronic claim there is not an NPI, and there are about only 70% of dentists that submit electronic claims. A lot of providers will submit to a clearing house which may then convert

		it, but this does not require an NPI.
CDLDC084	Billing Provider Tax ID	It was noted that there are individual dentists that are using their social security number (SSN), rather than a tax id number. It was noted that dental plans may or may not get the SSN from dental providers. In the data there is a nine-digit number which may or may not be an SSN. Same issue arises with the tax ID. It was noted that all that can be expected of the plans is to send what they have in the data.

Other Comments:

The dental plan association noted that they had bigger concerns with the provider file as there is information being requested such as the NPI and the DEA numbers that would cause issues for dental providers. It was noted that when the health plans evaluated the provider file, it was evaluated specifically for medical providers. It was noted that there may be other objections, as the dental provider files have limited information. OSHPD asked the health plans to provide any dental specific feedback on the provider file for member enrollment file. It was noted that there are some obvious things dentistry would not be able to provide.

Emily Sullivan noted that since the dental file is not yet being used by any APCDs the APCD Council is making some significant edits. The updated version will be made available shortly.

Next Steps & Closing

The January meeting topics will be determined and sent out prior to the meeting.