

# Healthcare Payments Data Program Review Committee

March 21, 2019

Office of Statewide Health Planning and Development

2020 W. El Camino Avenue, Sacramento, CA, 95813

Conference Room 900 A

# Welcome

Robert P. David, Director, OSHPD

# Oath of Office

Robert P. David, Director  
OSHPD

# Review Committee Member Introductions

Ken Stuart, Chair, Review Committee

# GROUND RULES

- Purpose of Review Committee is implementation not interpretation of legislation
- Public meeting rules – Bagley Keene – will be followed
- Chair and Vice Chair have been chosen by OSHPD
- Review Committee will not have delegates or substitutes
- All meetings in person; no call in for members due to Bagley Keene rules
- Public Comment after each item and at end of meeting
- Agenda flexible and we have a lot to accomplish at each meeting; please be prepared and read advance materials
- Need to hear all voices of Review Committee members regularly
- If OSHPD can't answer a question, it will be recorded in summary and answer provided at next meeting
- Agreement/decision-making process will be used

# More GROUNDRULES

- Temporary badges for Review Committee members to go in/out
- Room for Review Committee members to make calls if necessary
- WiFi available for Review Committee; not for public attendees
- Public can go down to 1<sup>st</sup> Floor; to return must come to 8<sup>th</sup> floor and be escorted
- Please do not use the stairs
- Lunch procedures for Review Committee and Public
- Location of restrooms
- Ask OSHPD staff if you need additional help

# What is an All Payer Claim Database (APCD)?

Denise Love, Executive Director, National Association of  
Health Data Organizations (NAHDO)

and

Scott Christman, Chief Information Officer, OSHPD



# All-Payer Claims Database Overview

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## About NAHDO

The Corporation is organized for the charitable and educational purposes of assisting state health data organizations, state agencies responsible for management of state health data assets, and members of the public by creating, exchanging, and providing information and resources that promote the effective collection, analysis, and dissemination of health care data.

A national network of health information professionals to:

- Balance privacy protections with appropriate exchange, sharing, and reporting of information
- Promote comparability through standardization of data and practices
- Disseminate and share best practices in data collection and use



## About the APCD Council

The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

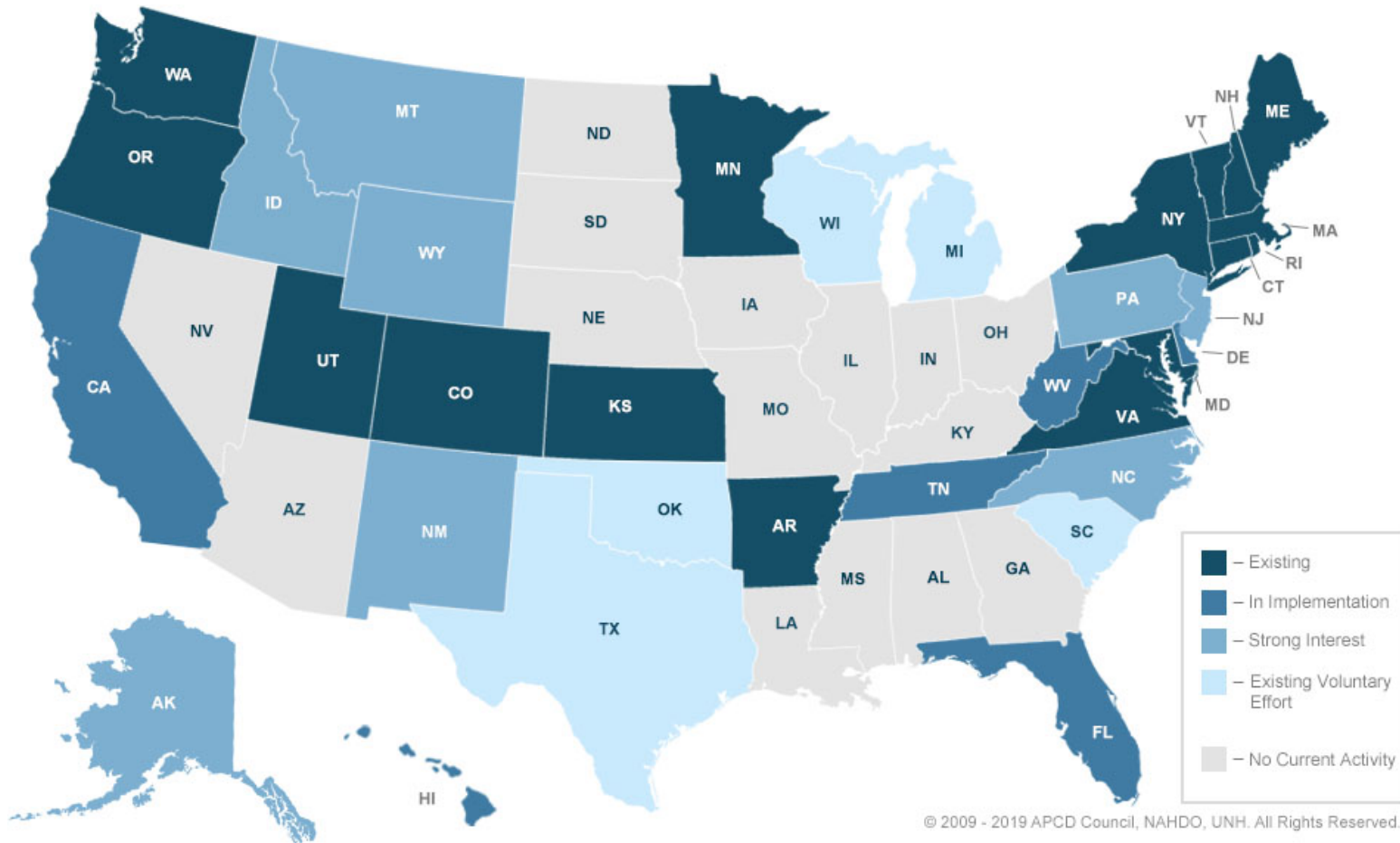
## Our Work

- Early Stage Technical Assistance to States
- Shared Learning
- Catalyzing States to Achieve Mutual Goals
- Advocacy for state/federal policies

Databases, created by state mandate, that typically include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers:

- Insurance carriers (medical, dental, TPAs, PBMs)
- Public payers (Medicaid, Medicare)

# March 2019 State Progress Map



© 2009 - 2019 APCD Council, NAHDO, UNH. All Rights Reserved.

- Social Security Number
- Patient demographics (date of birth, gender, residence, relationship to subscriber)
- Type of product (HMO, POS, Indemnity, etc.)
- Type of contract (single person, family, etc.)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPC, CDT)
- NDC code / generic indicator / other Rx
- Revenue codes
- Service dates
- Service provider (name, tax id, payer id, specialty code, city, state, zip code)
- Prescribing physician
- Plan charges & payments
- Member liabilities (co-pay, coinsurance, deductible)
- Date paid
- Type of bill
- Facility type
- Other 835/837 fields

- Services provided to uninsured
- Denied claims
- Workers' compensation claims
- Referrals
- Test results from lab work, imaging, etc.
- \*Premium information
- \*Alternative payment models

\* States exploring/piloting collection

**Commercial / TPAs /  
PBMs / Dental / Medicare  
Parts C & D**

**Medicaid FFS / Managed  
Care / SCHIP**

**APCD**

**Medicare Parts A & B**

***FUTURE:  
TRICARE & VA & IHS &  
FEHB***

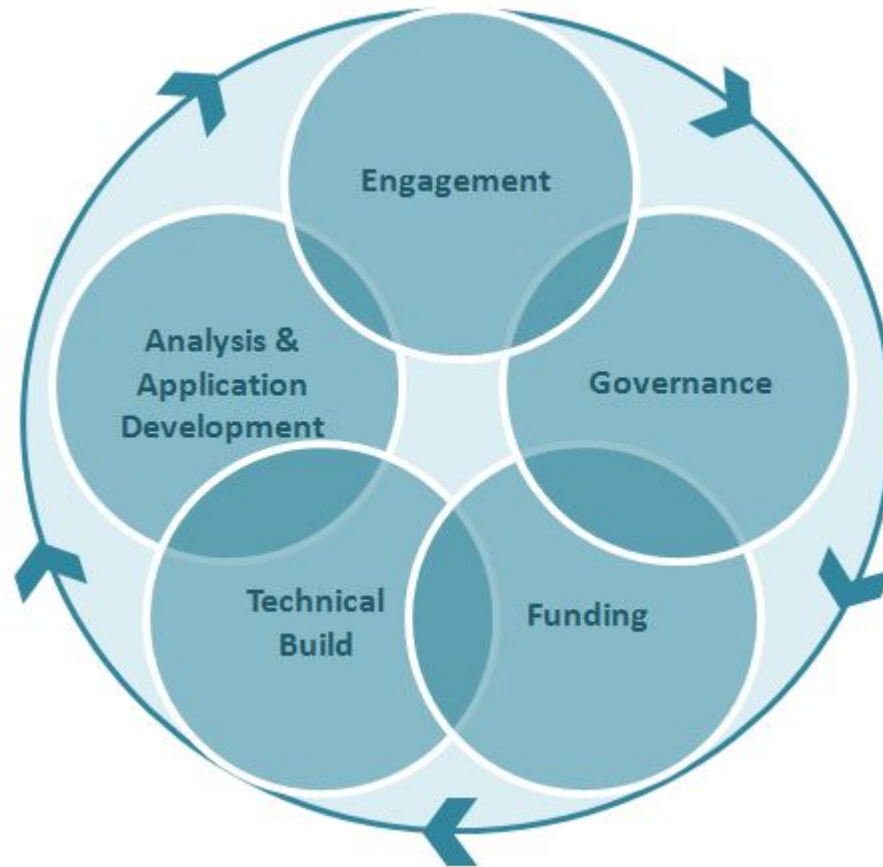
PROVIDER FILE

ELIGIBILITY FILE

- APCDs provide an almost-complete sample of state’s insured population
  - Large sample size = more precise estimates for individual payers, providers
  - Large numbers protect patient confidentiality when analyzes populations and certain conditions
- APCDs are filling critical information gaps for state agencies
  - Payment reform planning and evaluation
    - ACOs have no way of tracking total cost of care per patient
  - Transparency tools and clearer picture of health cost, quality, use
- Supplements other healthcare data systems



- Develop Multi-Stakeholder Approach
  - Form Provider Relationships
  - Form Payer Relationships
- Be Transparent and Document
- Understand Uses and Limitations
- Seize Integration & Linkage Opportunities
- Develop Use Cases



# Healthcare Cost Transparency Database

Scott Christman, Chief Information Officer, OSHPD

# Legislative Intent

- Establish a system to collect information regarding the cost of health care and a process for aggregating such information from many disparate systems, with the goal of providing greater transparency regarding health care costs.
- Improve data transparency to achieve a sustainable health care system with more equitable access to affordable and high-quality health care for all.
- Encourage use of such data to deliver health care that is cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.

# Legislative Requirements

- Convene Review Committee of healthcare stakeholders and experts
- Submit a report to the Legislature by July 1, 2020 outlining a proposed plan for the establishment, implementation, and ongoing administration of the Healthcare Cost Transparency database
- Substantially complete the development of a Healthcare Cost Transparency Database by July 1, 2023

# Role of the Review Committee

- Provide input for the development of the legislative report
- Represent the perspective of representative stakeholder group



# Requirements of the Legislative Report

What data will be collected?

For what purpose(s) will that data be used?

What use cases will this data fulfill?

What are the potential technology solutions to build the database, and which one is the best choice?

Who will be required to submit data?

What privacy and security policies need to be employed to protect individuals' privacy?

How can we leverage existing technology and data?

How will the database map to other data sets (including public health, morbidity and mortality, clinical data, and social determinants of health)?

What legislation is needed to ensure that the data is appropriate and high quality, and that individuals' privacy and confidentiality is protected?

How will the database be funded on an ongoing basis?

Who will administer the database, and what is the governance structure for its operation?

BREAK



# California's Landscape and OSHPD's Unique Role

Scott Christman,  
Chief Information Officer, OSHPD

# Past APCD Initiatives in California

Bill	Summary	Status
Assembly Bill (AB) 1 (Nunez, 2007):	Proposed creating a California Health Care Cost and Quality Transparency Committee tasked with developing a plan to strategize the collection of cost and quality data.	Died as inactive
Senate Bill (SB) 1322 (Hernandez, 2013)	Mandated CHHS contract with one or more private, independent, nonprofit organization(s) to establish and administer the CA Health Care Cost and Quality Database; would require mandatory submission by certain health care entities.	Died on Assembly inactive file
SB 26 (Hernandez, 2015)	Directed the CHHS Agency to contract with a nonprofit to create the California Health Care Cost and Quality Database.	Died in committee
SB 1159 (Hernandez, Chapter 727, Statutes of 2016):	Required the CHHS Agency to research the options for developing a cost, quality, and equity transparency database that is consistent with the confidentiality of medical information existing law.	Passed; report issued in 2017
SB 199 (Hernandez, 2017):	Required the CHHS to convene an advisory committee to provide recommendations for the development of a California Health Care Cost, Quality, and Equity Atlas which would draw upon the 2017 report.	Died in committee
AB 2502 (Wood, 2018)	Required the CHHS to establish and administer the California Health Care Payments Database.	Died in committee
AB 1810 (Committee on Budget, Health, Chapter 34, Statutes of 2018):	Part of the budget bill and established the Health Care Cost Transparency Database under OSHPD.	Passed; current HPD effort

# Voluntary Efforts in California

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California  
Department  
of Insurance  
(CDI):  
California  
Healthcare  
Compare

Provided healthcare prices and quality information on a centralized public facing website

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Partnership with University of California, San Francisco

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Funded by a federal grant program administered by the Centers for Medicaid & Medicare Services

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Website was active September 2015 – December 2018.

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Grant funds expired.

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# Voluntary Efforts in California

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## California Healthcare Performance Information System (CHPI)

A Multi-Payer Claims Database that consisted of claims from California's three largest health plans— Blue Shield, Anthem Blue Cross, and UnitedHealthcare—and the Medicare FFS program.

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CHPI included both insured and self-funded PPO, HMO and Medicare Advantage claims and encounters from Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare, representing ~7 million patients.

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These data provided information on services provided by hospitals, emergency departments, ambulatory surgery centers, ancillary providers, pharmacies, and physicians.

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Program is no longer in operation

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# Voluntary Efforts in California

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## Integrated Healthcare Association (IHA)

The California Regional Health Care Cost & Quality Atlas was established as collaboration between IHA, the California Health Care Foundation, and California Health and Human Services Agency.

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Ten health plans including commercial HMO and PPO, as well as Medicare Advantage data as applicable.

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Fee For Service (FFS) Medicare data provided by Centers for Medicare & Medicaid Services and Medi-Cal managed care and FFS data provided by the Department of Health Care Services.

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Tracks clinical quality measures spanning preventive, acute, and chronic care; hospital utilization measures and frequency of selected commonly used procedures; and average annual cost of care per member

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Program is still in operation. Completed for 2013, 2015 and 2017(in progress)

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# OSHPD Mission

OSHPD advances safe, quality healthcare environments through innovative and responsive services and information that:

- Ensure safe facilities
- Finance emerging needs
- Cultivate a dynamic workforce
- **Support informed decisions**

# OSHPD Healthcare Data Programs

- Healthcare utilization
  - Patient Level: Inpatient, emergency department, ambulatory surgery
  - Facility Level: hospital, long term care, clinic, home health and hospice utilization data
- Healthcare quality
  - Coronary Artery Bypass Graft (CABG), risk-adjusted outcome studies, safety and prevention indicators, readmission rates
- Cost transparency
  - Financial statements, community benefit plans, chargemasters, discount payment policies, prescription drug cost information (SB 17).

# Healthcare Data Program Goals

- Engage audiences around OSHPD data analytics through Use Cases
- Leverage and evolve data management platforms
- Expand healthcare **cost and quality** reporting



# National Landscape of APCDs

Denise Love, Executive Director, NAHDO

# National Landscape of APCDs

## State Learning Network Activities

- Initial/Early:
  - Understanding overall and categorical costs for care (e.g., CO, NH, ME, VT, UT, MA, MD)
  - Consumer tools (e.g., MA, NH, ME)
  - Intrastate cost variation (e.g., CO, ME, NH, VT)
  - Benchmarks for purchasers (e.g., NH)
  - Medical home evaluation (e.g., VT, NH)
  - Accountable care – regional cost profiles (e.g., NH)
  - Risk assessment
  - Population health and management
  - Low value services and waste calculators
  - Opioid patterns of prescribing/use

# APCD Showcase: States Leading by Example

Welcome to the APCD Showcase where examples from state all-payer claims databases (APCDs) have been organized in order to provide stakeholders with tangible examples of APCD reports and websites. The examples have been organized by intended audience, and are also searchable by additional criteria. We invite you to explore the site and learn more about the value that APCDs provide to states and their stakeholders.



Choose from the categories below or [See all Case Studies >](#)



## Consumers

Consumer websites primarily focused on cost and quality



## Employers

Employer and purchasing coalition efforts



## Providers

Accountable Care Organizations and quality



## Researchers

Academic and "think tank" research



## Population Health

Incidence, prevalence, quality, and utilization



## Insurance Department

Regulatory and market use cases



## Medicaid

Comparisons between Medicaid and Commercial populations



## Health Reform

Medical Home, Accountable Care Organizations & Triple Aim

<https://www.apcdshowcase.org/>

- **Providers:**
  - Quality and utilization of provider and peer group care
  - identify and monitor quality improvement projects.
- **Payers:**
  - Comparative performance of provider networks to statewide benchmarks
  - Identify variation in utilization and cost efficiency.
- **Employers:**
  - Increased transparency in the cost and utilization of health care to stabilize the cost of health coverage for employers.
  - Larger population/sample size and benchmarks.
- **Policy Makers:**
  - Inform support public policy with information on how the health care system is operating and support data-driven improvements in access, quality and cost of healthcare.
- **Public Health Practitioners:**
  - Variation in utilization of health care services to target “hot spot” opportunities to improve population health
  - Cost burden of chronic diseases such as diabetes, cardiovascular disease and asthma.
  - Evaluate public health programs

# Primary care spending: What's included?

To calculate the percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary care providers is divided by the sum of total claims-based and non-claims-based payments to all providers (illustrated below). As the denominator, total payments include all payments for members including specialty care, mental health care, hospitalizations and more. However, total payments do not include prescription drugs.

$$\frac{\text{Claims-based payments for primary care} + \text{Non-claims-based payments for primary care}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}} = \text{Percentage of medical spending allocated to primary care}$$

## Claims-based payments

### Payments to primary care providers and practices:

#### Primary care providers

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic providers
- Physicians' assistants, and
- Nurse practitioners

#### Primary care practices

- Primary care clinics
- Federally qualified health centers (FQHCs), and
- Rural health centers

### For primary care services:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, including delivery, and
- Other preventive medicine

## Non-claims-based payments

### Payments to primary care providers and practices:

- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home or patient-centered medical home recognition
- Payments to reward achievement of quality or cost-savings goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers



# First, Do No Harm

## Calculating Health Care Waste in Washington State

February 2018

[www.wacommunitycheckup.org](http://www.wacommunitycheckup.org)

To offer feedback or share ideas for new reports, or to find out more about how self-insured employers can safely contribute de-identified health care data to the MN APCD, email the Minnesota Department of Health at [health.apcd@state.mn.us](mailto:health.apcd@state.mn.us).

Protecting individual privacy in the MN APCD is of paramount importance. All identifying patient and provider data is de-identified and encrypted before it leaves the data submitter site and is sent to the MN APCD.

## MINNESOTA HEALTH CARE: High-Value Reports Designed for and by Employers



For further information about the MN APCD:  
Online: [www.health.state.mn.us/healthreform/allpayer](http://www.health.state.mn.us/healthreform/allpayer)  
Email: [health.apcd@state.mn.us](mailto:health.apcd@state.mn.us)



85 East 7th Place, Suite 220, Saint Paul, MN 55101  
(651) 201-3550  
[www.health.state.mn.us/health/economics](http://www.health.state.mn.us/health/economics)



What are the most expensive health care procedures in Minnesota?  
Where are the best opportunities to negotiate lower prices or achieve more competitive contract agreements? Where should your employees go to get more value from each health care dollar?

A new series of reports that focuses on variation in health care prices for common treatments and procedures in Minnesota can help answer these and other questions.



The MN APCD is the most robust dataset in Minnesota, with more than 100 entities contributing data

“This is eye-opening information for the purchasers of health care. Employers have long suspected that there is a great deal of variation in both the quality and the cost of health care, but to be able to see the actual numbers provides them an opportunity to make better purchasing decisions. Employers can also help employees and their family members identify and access more affordable care.”

Carolyn Pare MN Health Action Group





# Reference-Based Inpatient and Outpatient Payment Analysis:

*Reducing Payment Variation as a Potential Cost-Savings Mechanism*

November 2018



CENTER FOR IMPROVING  
VALUE IN HEALTH CARE



# Research on Opioid Prescribing and Chronic Use

and Medicaid and other state public programs such as MinnesotaCare (here, collectively called Medicaid).<sup>2</sup> These unique data cover interactions with the state...

Measures used in this issue brief:

of opioid in the MN APCD. A reduced likelihood prescription.

the number of in the MN APCD enforcement vital for producing ence, compared

Category	Percentage of opioid prescriptions
Medicaid	75.0%
Private	64.9%
Medicare	82.8%
Other	77.2%
Uninsured	77.3%
Other	67.9%

nts (MME) per are of opioid use in average MME 1 opioid potency per both.

verage opioid APCD. An increase in ates an increase in person, an increase

- The number ME per day, ph-dose opioid a greater change

ns (or 626,470 1). The d prescription 4 of covered 3 others age

ISSUE BRIEF | APRIL, 2018

## Patterns of Opioid Prescribing in Minnesota: 2012 and 2015

### Introduction

Opioids are a class of drugs that include prescription opioid medications for pain relief —such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and fentanyl—as well as illicitly produced drugs like heroin and fentanyl-related substances (also called fentanyl analogs).<sup>1</sup> While prescription opioids play a role in the management of some types of severe acute, cancer-related and end-of-life pain, increased opioid use since 1990, including for chronic pain unrelated to cancer, has resulted in sharply rising opioid addiction and overdoses, as well as increased healthcare utilization and costs. Recent Centers for Disease Control and Prevention (CDC) guidelines point out the limitations of the evidence base in support of opioid therapy for pain, recommend non-opioid therapy for chronic pain, and emphasize the risks associated with opioid therapy.<sup>2</sup> In Minnesota, opioids—both prescription and illicit—were responsible for 336 overdose deaths

### Key Findings:

- Overall rates of opioid prescribing declined in Minnesota from 2012 to 2015, but the morphine milligram equivalents (MME) per prescription increased.
- Medicare and Medicaid, where eligibility is determined by age, disability status, and/or income, covered approximately one-third of Minnesotans with general health coverage and accounted for two-thirds of opioid prescriptions filled in 2015.
- Nearly one in three Minnesotans with an opioid prescription in 2015 had multiple prescribers.
- In both 2012 and 2015, 6 in 10 opioid prescriptions were filled within 15 days of the patient's last medical visit; however, 1 in 10 opioid prescriptions were filled without a medical visit in the past 90 days, suggesting

Focuses on opioid prescription patterns among Minnesotans with private or public insurance coverage

Explores:

- Opioid prescription trends by payer
- Patients' diagnoses preceding a prescription opioid fill
- Number of prescribers
- Patients' geographic location

<http://www.health.state.mn.us/divs/hpsc/hep/publications/opioidbrief20185.pdf>

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### Key Findings:

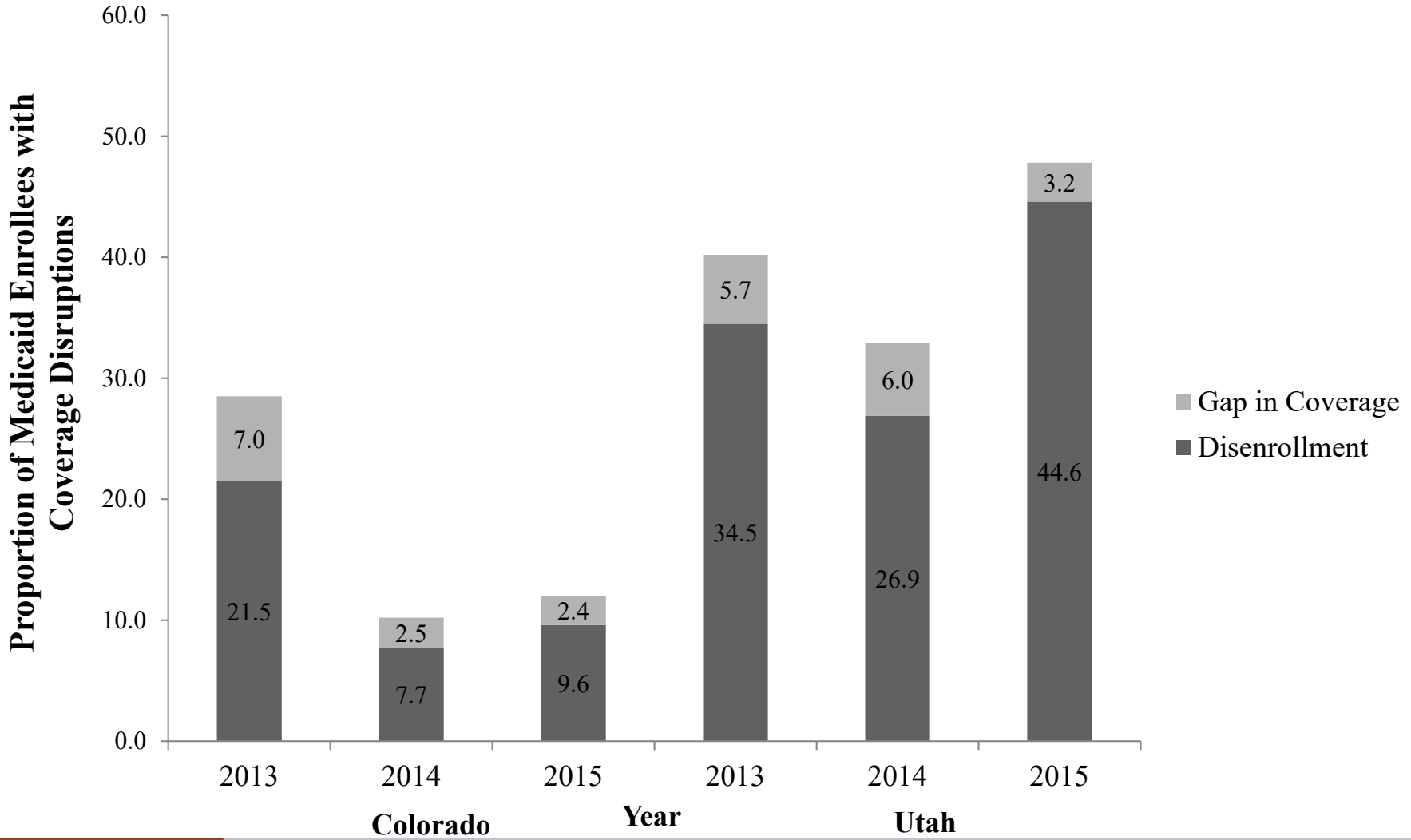
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- Nearly one in three Minnesotans with an opioid prescription in 2015 had multiple prescribers.
- In both 2012 and 2015, 6 in 10 opioid prescriptions were filled within 15 days of the patient's last medical visit; however, 1 in 10 opioid prescriptions were filled without a medical visit in the past 90 days, suggesting closer patient-prescriber communication or opioid oversight may be needed in some cases.

Focuses on opioid prescription patterns among Minnesotans with private or public insurance coverage

Explores:

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- Patients' diagnoses preceding a prescription opioid fill
- Number of prescribers
- Patients' geographic location

# Results: Rates of Disenrollment and Gaps among Medicaid Enrollees in Colorado and Utah, 2013-2015



## State Collaboration for Solutions

ERISA <https://www.apcdouncil.org/scotus-gobeille-v-liberty-mutual-insurance-company-decision>

All Payer Claims Data-Common Data Layout (APCD-CDL™) <https://www.apcdouncil.org/common-data-layout>

SAMHSA 42 CFR-guidance to states

<https://www.nahdo.org/sites/nahdo.org/files/SAMHSA%20Guidance%20FINAL%205%2019%2017.pdf>

Non-claims payments



# Key Regulatory Issues Facing APCD States Post Gobeille v. Liberty Mutual

- Enforceability: APCD statutes are and remain, for the most part, enforceable.
- Scope: Generally, governmental plans are exempt from ERISA's provisions and are not impacted by the Gobeille decision with regard to claims submission
- Voluntary reporting: Who decides? ERISA does not address this situation. According to state regulators, most TPAs seem to be concluding that the plan sponsor (i.e., the employer) has the right to determine whether the TPA continues to voluntarily submit data.
- HIPAA Privacy: Claims data voluntarily submitted by self-funded ERISA plans would continue to comply with HIPAA privacy requirements notwithstanding the Gobeille decision
- Regulatory authority and APCD 'savings' from preemption: The Gobeille decision did not address and does not alter a state's authority to "regulate insurance." The APCD requirements do not have to come from or be administered by the state department of insurance for the savings clause to apply.
- What documentation is required to opt-out of the APCD? States typically have the authority to request documentation or other verification of a plan sponsor's decision to opt-out of (or opt-in to) APCD data submission.

***Nothing about ERISA prevents submission of data- it only prevents states requiring submission***

*These responses are not meant to provide legal advice and should not be relied upon as such. Instead, this is a compilation of opinions and regulatory interpretations that may help guide states as they assess the impact of the SCOTUS decision on APCD efforts.*

- Opt-in reporting models:
  - Specific opt-in mechanism:
    - Required or voluntary
    - Plan issues opt-in form to self-funded employers
  - Opportunity to identify and reach out to employers
    - Plan administrators
    - Chamber of Commerce
  - Reduces plan burden to make determinations
  - Offers protections for insurers
- Challenges
  - Insurers have to program/filter opt-in versus opt-out records
  - Reaching employers to sign the form

## Development process of the APCD-CDL™

- Co-ordinate a state response to Supreme Court decision in Gobeille v. Liberty Mutual
- Cross walked state APCD files for consistency and divergence
  - States had made efforts in the past to harmonize  
<https://www.apcdouncil.org/publication/history-apcd-council-harmonization-efforts>

Weekly calls from May 2016- March 2017 to review every proposed field with states, vendors and payers

- October 2018 states requested NAHDO/APCD Council make APCD-CDL™ available
- December 1 2018, APCD-CDL available by request  
[https://www.apcdouncil.org/sites/default/files/media/cdl\\_request\\_form\\_2018\\_0.pdf](https://www.apcdouncil.org/sites/default/files/media/cdl_request_form_2018_0.pdf)
- APCD-CDL™ advisory committee developing a process for maintenance (Jan 2019-present)



## APCD-CDL™ Purpose

The purpose of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) is to harmonize the claims collection effort across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs and improve accuracy in claims data collection.

## APCD-CDL™ Content

Header and Trailer Records- contained on all files.

### Files

- Member Eligibility
- Medical Claims
- Pharmacy Claims
- Dental Claims
- Provider File

### File Content

- Element name, data type, field length, field description/code, industry standards (in appendices)

Consistent Inter-file Identifier

# APCD-CDL™ Maintenance Process

## Data Maintenance Request (DMR) Form

- Data element
- Change/update requested
- Business reason for request
- Notes from discussions with data submitters

### Step 1

- Submit Data Maintenance Request (DMR) Form (18 months)

Jan 2019-June 2020

### Step 2

- APCD Council staff gather and de-duplicate all requests
- APCD Council staff will publicly post for 45 day review (on council website)\*

July 2020-Aug 2020

### Step 3

- After close of comment period ends, Council staff will gather all comments and deliver DMRs and comments to APCD-CDL maintenance committee.\*\*
- Staff will prepare comments to each DMR request to include a recommendation on whether the committee accepts, modifies or rejects the request.

September 2020

### Step 4

- APCD-CDL maintenance committee convenes and staff reviews the requests, comments and recommendations.
- The committee will then vote.

October 2020

### Step 5

- The committee sends a copy of the Comment and Response document to the requestors and posts on line.

November 2020

### Step 6

- Staff holds a webinar to review the approved changes.

December 2020

Corrections to the APCD-CDL will be made outside of this process on an as-needed basis.

\*Reflecting APCD-CDL™ development process. ALL states, payers, vendors, and data users may submit comments.

\*\*Council staff and state members of NAHDO

## National Interest in APCD-CDL™

States are moving to adopt APCD-CDL™

- Regulatory and submittal manual changes
- Streamline review of their Data Submittal Manuals

Benefits

- Streamlines individual states review and maintenance
- Assist with cross state analytics and benchmarks
- Reduce reporting burden to the payers/data submitters

## Letter to The Honorable Lamar Alexander, Chair, HELP Committee

### Create pathway to encourage development of APCDs

- *We recommend that the Department of Labor use its authority to create a standardized process that state APCDs could use to collect data from self-insured plans or that Congress amend ERISA to allow states to move ahead on their own.*

Jo Porter  
Co-Chair, APCD Council  
[Jo.Porter@unh.edu](mailto:Jo.Porter@unh.edu)

Ashley Peters  
Communications and Research, APCD  
Council  
[Ashley.Peters@unh.edu](mailto:Ashley.Peters@unh.edu)

Amy Costello  
Standards, APCD Council  
[Amy.Costello@unh.edu](mailto:Amy.Costello@unh.edu)

Denise Love  
Co-Chair, APCD Council  
[dlove@nahdo.org](mailto:dlove@nahdo.org)

Emily Sullivan  
Research, APCD Council  
[esullivan@nahdo.org](mailto:esullivan@nahdo.org)

[www.apcdouncil.org](http://www.apcdouncil.org)  
[www.apcdshowcase.org](http://www.apcdshowcase.org)  
[info@apcdouncil.org](mailto:info@apcdouncil.org)  
[@APCDCouncil](https://twitter.com/APCDCouncil)

# LUNCH

# Review Committee Discussion

Bobbie Wunsch,  
OSHPD Consultant



# Review Committee Discussion

- Question 1: How do you envision this new database supporting the goals of the legislation?
- Question 2: What are the challenges that must be addressed in developing and operating such a database?

# Bagley-Keene Open Meeting Act

Beth Herse, Attorney, OSHPD

# Overview

- The Bagley-Keene Open Meeting Act regulates the conduct of state bodies and members of state bodies.
- The Review Committee is a state body as defined and is subject to the Act.
- In California, it is public policy that the people of the state have a right to be informed about the conduct of government. Actions of state agencies must be taken openly, and their deliberation conducted openly.

# What is a Meeting

- Any congregation of a majority of the members of the Review Committee to hear, discuss, or deliberate on any item within their subject matter jurisdiction is a meeting.
  - A meeting of a subcommittee created by the Committee that consists of three or more persons is also subject to the Act.
- A quorum (6 of 11 members) must be present to conduct business.
- Special rules apply for teleconference meetings.

# Serial Meetings

- “Serial meetings” are strictly prohibited.
- A serial meeting occurs when a majority of the members of a state body engages in a series of communications of any kind (including email or phone calls), directly or through intermediaries, to discuss or deliberate on any item within the subject matter jurisdiction of the body.
- As long as they do not discuss any business of the body, members of a state body are not prohibited from meeting at social events or other meetings or gatherings.

# Meeting Notices and Agendas

- Notice of each meeting of the Review Committee, and the agenda for the meeting, must be published at least 10 days in advance of a meeting.
- The agenda must provide a brief description of all items of business to be transacted or discussed.
  - The description of an agenda item should provide enough information to allow members of the public to understand what issues will be discussed or considered.
  - If an item or issue is not on the published agenda, the Committee is prohibited from discussing it at the meeting.

# Conduct of Meetings

- All meetings of the Committee must be open and public.
  - Members of the public have a right to attend any Committee meeting.
  - Members of the public have a right to address the Committee on each agenda item before or during the Committee's discussion or consideration of the item.
- The Committee may only discuss issues that were listed on the agenda. If a new issue arises, the Committee may choose to place it on the agenda for the next meeting.

# Public Records

- All materials provided to the Committee in connection with a matter subject to discussion or consideration at a public meeting are public records.
- Materials that OSHPD provides to the members in advance of the meetings will be available to the public at the meeting and will usually be posted on the HPD Review Committee website in advance of the meeting.



# Legislative Report and Proposed Review Committee Topics and Timeline

Starla Ledbetter, Chief Data Officer, OSHPD

# Legislative Report Requirements

What data will be collected?

For what purpose(s) will that data be used?

What use cases will this data fulfill?

What are the potential technology solutions to build the database, and which one is the best choice?

Who will be required to submit data?

What privacy and security policies need to be employed to protect individuals' privacy?

How can we leverage existing technology and data?

How will the database map to other data sets (including public health, morbidity and mortality, clinical data, and social determinants of health)?

What legislation is needed to ensure that the data is appropriate and high quality, and that individuals' privacy and confidentiality is protected?

How will the database be funded on an ongoing basis?

Who will administer the database, and what is the governance structure for its operation?

# Healthcare Payments Data Program Review Committee Meeting Topics

March

April

May

June

July

## Kickoff

- Welcome & Introductions
- Background on APCDs
- Goals for the Committee

## Data Types and Use Cases

- Types of Data in the System
- Claims Data 101
- Use Case Categories
  - Cost & Utilization
  - Quality
  - Coverage & Access
  - Population Health
  - System Performance

## Data Governance and Privacy

- California privacy landscape
- Privacy considerations for data collection, use and dissemination

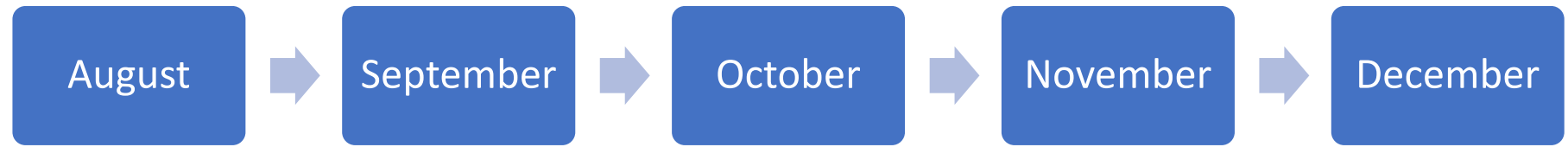
## Data Collection

- Data collection format options
- Streams of data collection (Medicare, Medicaid, Commercial)
- Data collection considerations in California's complex managed care environment

## Data Submitters

- Considerations of who will submit data to the database
- Differences between voluntary and mandatory submitters
- Requirements for frequency of data submission

# Healthcare Payments Data Program Review Committee Meeting Topics



**Data Quality**

- Roles and responsibilities in ensuring data quality throughout its lifecycle
- Effective collaborations with submitters to ensure data quality
- Documentation processes for data quality

**Technology Alternatives**

- Technology options to receive, store, and structure data
- Technology options to incorporate other data sets for research
- Technology options to analyze data and publish reports

**Sustainability**

- Discussion on associated costs of the database
- Role of fees for data usage or data submission
- Recommended business plan elements to fund the operations of the database

**Governance:  
Administrative Plan for  
Operating the Database**

- Considerations for effectively governing a data management system
- Opportunities to leverage existing data governance structures

**Enhancing Database  
Analytics**

- What other relevant data sets can be linked to the HPD data system.
- Opportunities for additional enhancements to the database

BREAK

# Top Healthcare Data Questions

Michael Valle, Chief Strategy Officer, OSHPD

and

Jill Yegian, OSHPD Consultant

# Purpose of Use and Use Cases

## From AB 1810:

The office shall submit a report to the Legislature that includes...the **purpose of use** and **use case definitions** to assist in prioritizing areas of development [for the database].

*Summary of HSC §127672 (d)(1)(A)*

# What Is a Use Case?

- A “**use case**” is a defined scenario in which a product or service could potentially be used.
- Use cases focus design towards accomplishing a specific **goal** for a specific **audience**.
- OSHPD employs use cases when it develops data systems and products, including for SB 17 (<https://bit.ly/2TJ2uaU>)
- Uses cases can help frame the recommendations, including **what** data is needed, **who** needs access to it, **when** it is released, and in **what** format
- Use cases also help define the iterative value that can be delivered during the early, mid, long -terms and allow the database to evolve over time



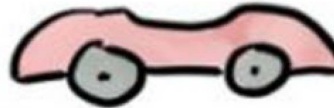
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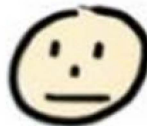
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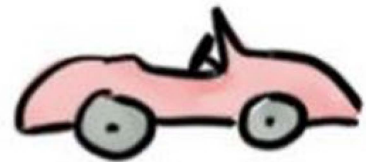
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# Use Case Example: Utilization, Spending, and Total Cost of Care

## Overview

- **Key metrics on utilization and spending**, both total and components:
  - overall and for specific procedures;
  - across payers, geography, age group, and gender
- **Total cost of care** to be added later, more complex and requires additional data

## Audience

- **Primary:** Policymakers (legislators, regulators) and Public Purchasers (DHCS, Covered California, CalPERS)
- **Secondary:** Payers and Purchasers (health plans, trusts, self-insured employers); Providers (hospitals and systems, medical groups and IPAs, community health centers)

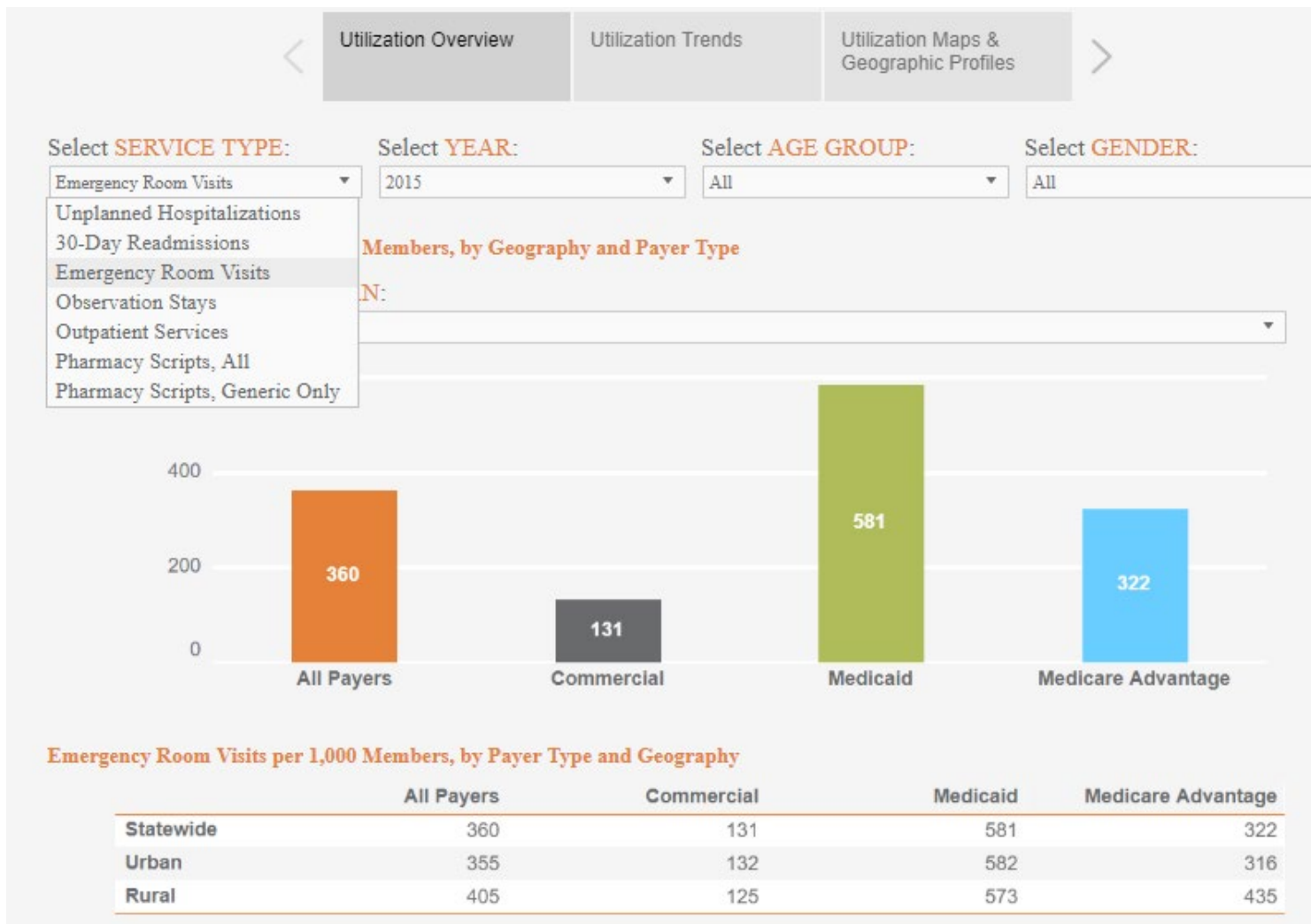
## Output

- Data on website and for download
- Fact sheets, infographics, data stories
- Maps showing geographic variation
- Reports on variation (by geography, payer, etc.) and trends over time

## Value

- **Policy:** Document variation in utilization and spending by region, age, gender; generate state-wide report card; identify disparities in spending, utilization
- **Business:** Compare own utilization and spending to same product and geography; reward top performers (combine with quality data) Inform network decisions

# Example: Dashboard from Colorado's APCD



Source: Center for Improving Value in Health Care (CIVHC)

# Invitation to Submit Use Case Example

- Share your ideas about the top health care data questions
- Submit one or more use case examples using the template.
- We will review, categorize, and incorporate into upcoming Review Committee discussion
- Submit to: [hpd@oshpd.ca.gov](mailto:hpd@oshpd.ca.gov)
- Deadline: April 4

# Use Case Template

## Overview

- **What information does the user need?**

## Primary Audience

- **What type of organization and/or role will likely be most interested in this information?**

## Secondary Audience

- **What additional stakeholder groups, organizations, or roles might also be interested in this information?**

## Output

- **What kind of end product would be most useful?**

## Value

- **What is the desired outcome or the value proposition of the information to the user?**

# Housekeeping

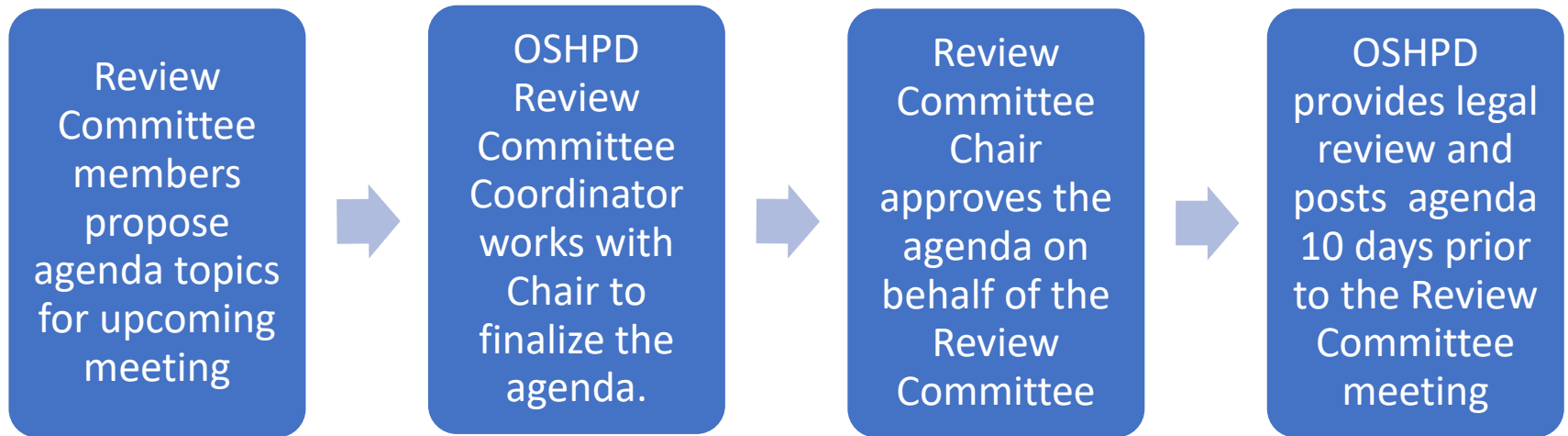
Bobbie Wunsch,  
OSHDP Consultant

# Proposed Future Committee Dates

- Monthly half-day morning meetings (9:00 a.m. – 1:00 p.m.)
- In-person meetings
- Third Thursday of the Month
  - April 18, 2019
  - May 16, 2019
  - June 20, 2019
  - July 18, 2019
  - August 15, 2019
  - September 19, 2019
  - October 17, 2019
  - November 14, 2019
  - December 19, 2019

# Future Agendas

- Enabling legislation requires Review Committee to set its own agendas
- Proposed Agenda Development Process:





# Other Logistics

- Travel Reimbursements
  - Review 1 page document shared in welcome packet
  - Save all receipts
  - Lunch is reimbursed for half-day meetings (\$11)
  - Submit all required documents to Tara Zimonjic
- Communications outside of Review Committee
  - Bagley-Keene serial meeting rules apply
  - Any communications shared will also need to be shared with the public
  - Tara Zimonjic is the point of contact for all Review Committee communications
- Conflict of Interest Form 700s
  - Will be contacted by OSHPD Filer to submit forms.
  - Form 700s will be due back to OSHPD by Friday April 19, 2019

# Public Comment

# Closing & Upcoming Review Committee Meeting