# Healthcare Payments Data Program Review Committee

July 18, 2019

Office of Statewide Health Planning and Development

2020 W. El Camino Avenue, Sacramento, CA, 95833

Conference Room 1237

OSHPD

Office of Statewide Health Planning and Development

# Welcome and Meeting Minutes

Ken Stuart, Chair, Review Committee

# Deputy Director's Report

Scott Christman,

Deputy Director and Chief Information Officer,

OSHPD

# Follow Up from June 20 Meeting

# Recommendations approved by Review Committee

- The HPD System should establish collection methods and processes specific to three sources of claims and enrollment data : 1) DHCS (for Medi-Cal), 2) CMS (for Medicare FFS), and 3) All other.
- The HPD System should pursue the collection of Medi-Cal data directly from DHCS.
- The HPD should pursue the collection of Medicare FFS data, in the formats specified by CMS.
- The HPD should use the APCD-CDL™ for all other submitters.
- The HPD should initially pursue three years' worth of historical Tier I "core" data (enrollment, claims and encounters, and provider) from submitters.

# Recommendations approved by Review Committee (cont.)

- The HPD should collect non-claims-based payments, in order to capture the total cost of care. Since these payments are not included in the APCD-CDL™, OSHPD will work with-stakeholders to specify the format(s) and source(s) of the supplemental file(s).
- Ensure broad authority for OSHPD to securely collect available personally identifiable Information.
- The HPD Program should use robust methodologies to match patients, providers, and payers across datasets.

# Mandatory Data Submitters

Jill Yegian, Consultant,
OSHPD
Linda Green, Vice President—Programs,
Freedman HealthCare

# Today's topics

1. Who is responsible for submitting data?

   Mandatory Submitters:  Types of organizations required to submit data to HPD

2. What lines of business must be submitted to HPD?

   Lines of Business – required and excluded

   Coordination of submission – mandatory submitter is responsible for completeness of data, including for subcontracted pharmacy and behavioral health services

3. How often must data be submitted?  On what population?

   Population and frequency of data submission

4. How can non-mandatory submitters contribute data to HPD?

   Provisions to encourage submission of data from voluntary submitters

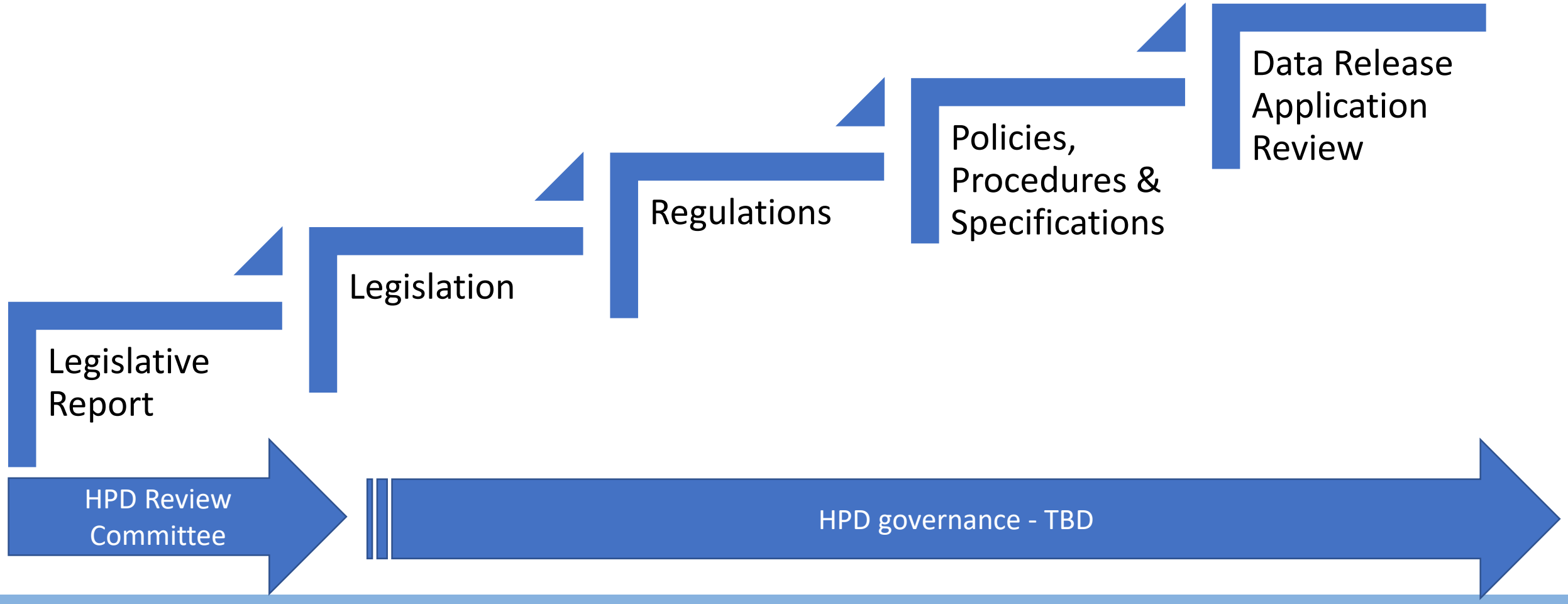
# Approach to Defining Data Submitters

- How do we create the right “umbrella” for collecting the data that supports HPD use cases?
- What can we learn from how other states have structured their APCDs?
- What are the key decisions, options, and tradeoffs?
- What makes sense for California?
- Anchor question: “Is the juice worth the squeeze?”

Our “ask:”

- Provide guidance on content
- Hold off on specifying language for the legislation, regulation and policy documents

# Design and Implementation Guidance



# California's Health Care Payers

| | Estimated Population (M) |
|---|---|
| **Medi-Cal** | |
| Managed care | 10.7 |
| Fee-for-Service | 2.3 |
| **Medicare** | |
| Medicare Advantage (Part C) and MA with Prescription Drug Coverage (MA-PD) | 2.6 |
| FFS (Parts A and B) | 3.6 |
| Prescription Drug Plans (Part D) | 2.2 |
| **Commercial** | |
| Fully insured | 14.1 |
| Self-insured ERISA **(voluntary)** | 4.8 |
| Self-insured non-ERISA | 0.9 |
| **Dental** | |
| Commercial dental plans | 10.0 |
| Medi-Cal | 12.2 |

**Notes and Sources:**

- Individuals can have more than one coverage source during the year; largest source of duplication is dual eligible (Medicare plus Medi-Cal) with 1.4 million.
- Medi-Cal figures from DHCS Medi-Cal Monthly Enrollment Fast Facts, November 2018
- CMS Medicare Enrollment Dashboard Data File, April 26, 2019
- Commercial numbers from CHCF 2019 Edition - California Health Insurers
- ERISA refers to the Employee Retirement Income Security Act of 1974. Self-insured ERISA vs. non-ERISA estimates are based on 2016 bulletin from the Census Bureau; according to Table 3A, 84% of self-insured employer-sponsored coverage in California in CY 2015 was private (assume ERISA) and 16% was public (assume non-ERISA). Apply those percentages to 5.7M estimate for self-insured CY 2017 (CHCF 2019 data).
- Dental estimates from California Association of Dental Plans

# Framework for Data Submission

## Mandatory

- Fully insured commercial health plans
- Public Payers
  - Health plans for Medicare Advantage
  - Medi-Cal managed care plans (through DHCS)
  - Medi-Cal FFS (through DHCS)
  - Self-insured non-ERISA (public employers, trusts)
- Dental insurers
- PBMs and Behavioral Health Organizations providing care to Commercial and Public Payer populations

## Voluntary or Not Subject to State Law

- Third Party Administrators managing ERISA self-insured plans
- Private Taft-Hartley Trusts
- Federal Health Benefits
  - Federal Employee Health Benefits Program
  - TRICARE
  - Veterans Affairs
  - Indian Health Service

## Excluded

- Defined as not health insurance in Insurance Code section 106b
- Supplemental insurance, including Medicare supplemental
- Stop-Loss
- Student Health Insurance
- Vision-only, chiropractic-only, discount

## Acquisition

- Medicare FFS from CMS ("State Agency" agreement or Qualified Entity/QE), including Medicare Part D (pharmacy) from CMS

# Defining Mandatory Submitters

# Comparison of Select APCDs on Mandatory Submitters

| | Oregon | Colorado | Massachusetts |
|---|---|---|---|
| Commercial Carriers including Exchange | x | x | x |
| Medicaid Managed Care Organizations | x | x | x |
| Medicaid Fee-for-Service | x | x | x |
| Medicare Advantage (Part C) | x | x | x |
| Non-ERISA Self-Funded Plans including State and Municipal employees | x | x | x |
| Dual Eligible Special Needs Plans (D-SNPs) | x | | x |
| Vision only Plans | | x | x |
| Dental only Plans | | x | x |
| Pharmacy Benefit Managers | x | | x |

# Medicaid Agency as a Mandatory Submitter

- 13M Californians on Medi-Cal – essential contributor to HPD
- Streamlines compliance by using plans' existing data submission process; avoids duplicate effort
- Uses existing DHCS contract authority for data submission
- Builds on DHCS data quality monitoring and improvement practices

States taking this approach:

- Oregon
- Colorado
- Massachusetts
- Arkansas
- Delaware
- Hawaii

## Recommendation:

## 1. Mandatory Submitters

1. The Review Committee recommends that definitions for the types of organizations required to submit data as previously defined to the HPD ("mandatory submitters") should be based on existing California laws and definitions, and include:

   a. Health care service plans (as defined in H&SC 1345) and health insurers as defined in IC section 106 (b)

   b. The California Department of Health Care Services, for Medi-Cal managed care plan and fee for service data

   c. Pharmacy Benefit Managers (as defined in HS&C 1385.001)

## Previously Approved Recommendation:

## Definition of "data"

"Data" refers to the type of data previously approved by the Review Committee for inclusion in the APCD:

- Core APCD data such as the data included in the APCD Council's Common Data Layout™, or similar data formats available from CMS for Medicare and DHCS for Medi-Cal: enrollment, claims and encounters, and provider.
- Non-claims based payments that are not included in the APCD-CDL but are necessary in order to capture the total cost of care.

## Recommendation:

## 2a. Required Lines of Business

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

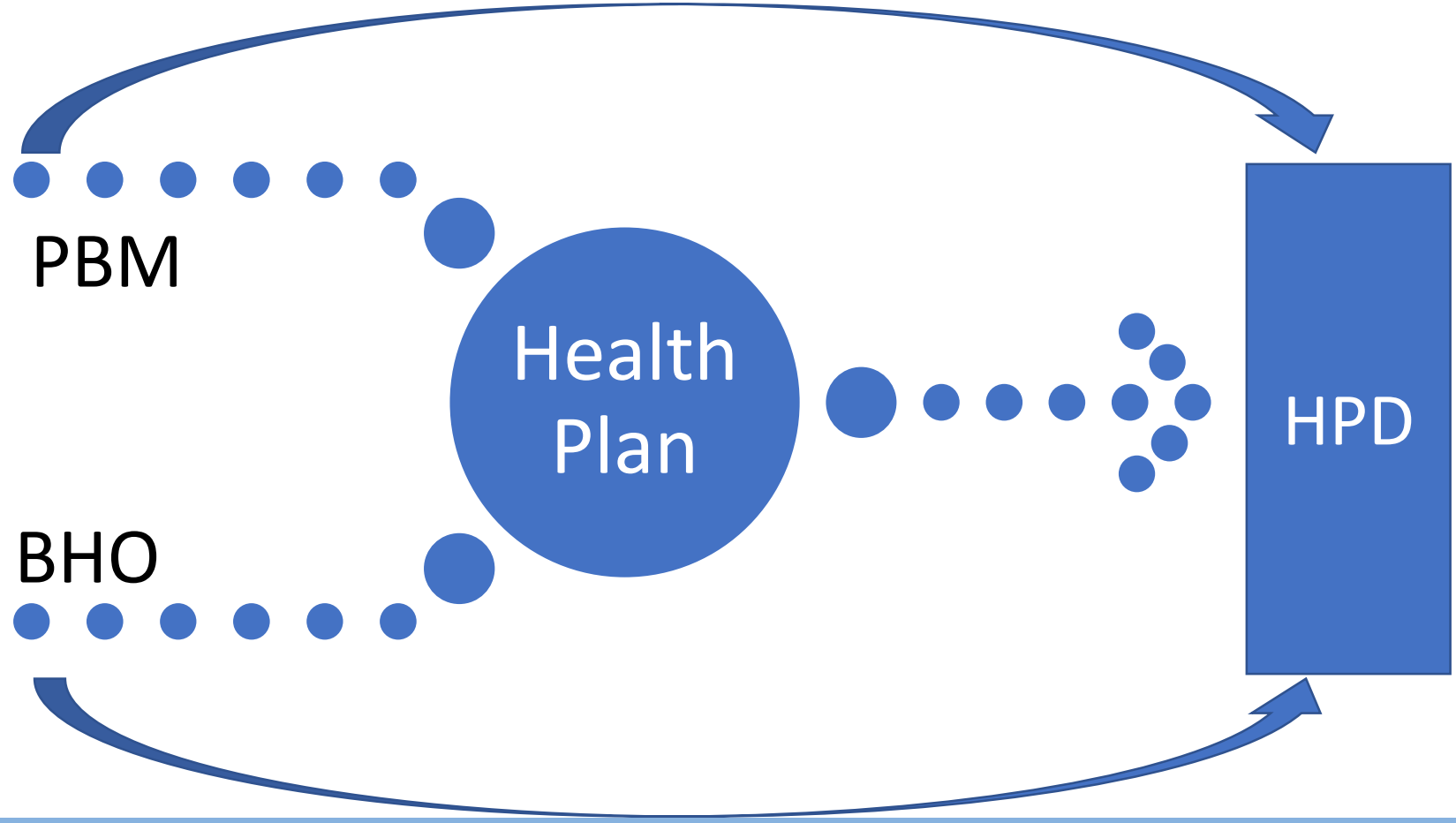
a. Required lines of business:

1. Commercial: individual, small group, large group, Medicare Advantage
2. Self-insured plans not subject to ERISA
3. Dental
4. Medi-Cal

# Mandatory Submitters: Coordinating Submissions

The Health Plan directs Pharmacy Benefit Manager (PBM) & Behavioral Health Organization (BHO) to submit data to the Health Plan **OR** to the HPD system.

# Coordinating Submissions for All Types of Care



## Recommendation:

## 2b. Coordination of Submission

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

b. Coordination of submission: The mandatory submitters are responsible for ensuring complete data submissions, including data feeds from pharmacy benefit management companies, behavioral health organizations, and other services carved out to a subcontracting organization.

# Mandatory Submission - Exceptions

# Which entities are NOT mandatory submitters?

- Priority:  balance cost and burden of data collection with the imperative to create as complete a database as possible on Californians' utilization and cost
- Categories:
  - **Excluded**.  If not health insurance under CA law or limited data➔ excluded due to incomplete portrait of health care utilization/cost.
  - **Exempt**.  Small size ➔ Exempt.  Submitter may fall into mandatory category, but be exempt due to size (number of enrollees).
  - **Not Subject to State Law**: ERISA pre-emption and federal health benefits programs ➔ voluntary submission.

# Exclusions from Mandatory Submission

# Exclusions: Other State APCDs

| Line of Business -Excluded |
| --- |
| Accident |
| Automobile medical |
| Disability |
| Hospital Indemnity |
| Liability insurance |
| Long-term care insurance |
| Medicare supplemental insurance |
| Specific disease policy |
| Stop-loss plans |
| Student Health Insurance |
| Supplemental insurance |
| Vision-only |
| Workers Compensation |

# In CA, what is health insurance? And what is **not**?

"An individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits." Insurance Code § 106

**Excluded** from the definition:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2 .

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01 .

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

# Additional Proposed Exclusions

- Supplemental insurance:  only covers consumer cost-sharing
- Stop-loss plans: protects self-insured employers and trusts from catastrophic losses
- Student health insurance: short-term with relatively thin benefits, must be filtered out of data for analysis because not comparable
- Vision-only: pre-payment for eye exams and corrective lenses
- Chiropractic-only: prepayment for chiropractic services
- Discount: prepayment for access to lower provider fee schedules

**Recommendation:**

**2c. Excluded Lines of Business**

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

**c. Excluded lines of business**: all those listed in Insurance Code section 106b as excluded from the definition of health insurance, plus the following:

- Supplemental insurance (including Medicare supplemental)
- Stop-loss plans
- Student health insurance
- Chiropractic-only, discount, and vision-only insurance

# Exemptions from Mandatory Submission

# Exemptions: State APCD Plan Size Thresholds

| Threshold below which plans are exempt: | State |
|---|---|
| **Covered Lives** | |
| >1,000 covered lives | CO, DE, MD, MA |
| >2,000 covered lives | AR |
| >2,500 covered lives | UT |
| >3,000 covered lives | CT, RI |
| >5,000 covered lives | OR |
| >10,000 covered lives | NH |
| **Other Measures** | |
| >$3M in medical or $300k in pharmacy claims/yr | MN |
| >$5M in medical or $1M in pharmacy claims/yr | TN |
| >$2M in adjusted premiums or claims paid/yr | ME |
| >1% market share | KS |

# Scenarios for Exemption from Mandatory Reporting to HPD

| | Submitting | | | Exempt | |
|---|---|---|---|---|---|
| **Threshold – Covered Lives (Commercial/Medicare Adv)** | # of plans | # enrollees | % enrollees | # of plans | # of enrollees |
| **>100,000** | 11 | 15,929,210 | 95.9 | 58 | 679,332 |
| **>75,000** | 12 | 16,014,582 | 96.4 | 57 | 593,960 |
| **>50,000** | 14 | 16,133,763 | 97.1 | 55 | 474,779 |
| **>25,000** | 21 | 16,367,728 | 98.6 | 48 | 240,814 |
| **>10,000** | 31 | 16,538,304 | 99.6 | 38 | 70,238 |
| **TOTAL** | 69 | 16,608,542 | 100 | 0 | 0 |

Source: California Health Insurers Almanac, 2019: Data File, California Health Care Foundation

# Scenarios for Exemption from Mandatory Reporting to HPD –Dental

| | Submitting | | | Exempt | |
|---|---|---|---|---|---|
| **Threshold – Covered Lives (Dental)** | # of plans | # of enrollees | % of enrollees | # of plans | # of enrollees |
| **>100,000** | 22 | 10,121,372 | 93.2 | 35 | 736,469 |
| **>75,000** | 24 | 10,281,309 | 94.7 | 33 | 576,532 |
| **>50,000** | 29 | 10,593,599 | 97.6 | 28 | 264,242 |
| **>25,000** | 32 | 10,708,625 | 98.6 | 25 | 149,216 |
| **>10,000** | 38 | 10,802,917 | 99.5 | 19 | 54,924 |
| **TOTAL** | 57 | 10,857,841 | 100 | 0 | 0 |

Source: Calculations based on 2017 data from DMHC and CDI websites.

## Recommendation:

## 2d. Exemption for Plan Size

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

**d. Plan Size:** Exemption for plans with fewer than 50,000 covered lives for:

1. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
2. Dental

There is no threshold for Medi-Cal.

# Vote on Recommendations

## Recommendation:

## 1. Mandatory Submitters

1. The Review Committee recommends that definitions for the types of organizations required to submit data as previously defined to the HPD ("mandatory submitters") should be based on existing California laws and definitions, and include:

a. Health care service plans and health insurers
b. The California Department of Health Care Services, for Medi-Cal managed care plan and fee for service data
c. Self-insured entities not subject to ERISA
d. Third party administrators
e. Dental plans and insurers

## Recommendation:

## 2a. Required Lines of Business

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

a. Required lines of business:

1. Commercial: individual, small group, large group, Medicare Advantage
2. Self-insured plans not subject to ERISA
3. Dental
4. Medi-Cal

## Recommendation:

## 2b. Coordination of Submission

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

b. Coordination of submission: The mandatory submitters are responsible for ensuring complete and accurate data submissions directly, and facilitating data submissions from appropriate data owners, including data feeds from pharmacy benefit management companies, behavioral health organizations, subsidiaries, and other services carved out to a subcontracting organization.

## Recommendation:

## 2c. Excluded Lines of Business

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

**c. Excluded lines of business**: all those listed in Insurance Code section 106b as excluded from the definition of health insurance, plus the following:

- Supplemental insurance (including Medicare supplemental)
- Stop-loss plans
- Student health insurance
- Chiropractic-only, discount, and vision-only insurance

## Recommendation:

## 2d. Exemption for Plan Size

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

**d. <u>Plan Size:</u>** Exemption for plans below a threshold to be defined, between 25,000 and 50,000 covered lives for:

1. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
2. Dental

There is no threshold for Medi-Cal.

# BREAK

# Data Submission Frequency and Population to Be Reported

# Frequency of Data Submission

- Other state APCDs vary for core data, most often monthly or quarterly
- All state APCDs that collect non-claims data do so on an annual basis
- California's scale will result in transmission of very large files, necessitating monthly submission for core data
  - Monthly submission will also enable earlier detection and resolution of any quality and completeness problems with files.
- For supplemental data such as non-claims payment, annual submission balances the burden of submission with timely access to the data

# Defining the Population for Data Submission

- Objective:  balance comprehensiveness with cost and burden of data submission and collection
- All state APCDs collect data about state residents
- Some APCDs add other populations
  - Public sector retirees
  - Out of state residents covered by a plan issued in the state
- For CA, defining population as **state residents** is straightforward and accomplishes the legislative intent for claims data collection

## Recommendation:

## 3a. Frequency

3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows:

**a. <u>Frequency</u>**:

- monthly for all core data (claims, encounters, eligibility, and provider files)
- annually for non-claims-payments data files

## Recommendation:
## 3b. Population

3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows:

b. **Population:** residents of California

# Vote on Recommendation 3

# Voluntary Data Submitters

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# ERISA Preemption of Self-funded Data Collection

- *Gobeille v. Liberty Mutual:* states cannot require self-funded employers to submit data to a state APCD because ERISA pre-empts state authority
- Applies to approximately 4.8M Californians:
  - ERISA Self-funded plans
  - Taft-Hartley trusts (collectively bargained)
- Plans that cover public employees are exempt from ERISA so ruling does not apply
  - CalPERS
  - State/county/municipal; public school teachers/retirees; state university and colleges

# Voluntary Data Collection in Other APCDs

- Make clear that submission is not prohibited
- Inform self-insured employers and Taft-Hartley plans that they may submit data to the state APCD
  - State may conduct own outreach (RI, UT, CO NH)
  - State may require health plans, TPAs, and other administrators to notify clients that they can opt into the APCD (UT)
- Require health plans, TPAs and other plan administrators to submit data to the state APCD when requested by the self-insured client (WA)

## Recommendation:

## 4. Voluntary Submitters

4. The Review Committee recommends that:

- HPD should be statutorily authorized to receive data from voluntary submitters.
- HPD shall develop an appropriate process to encourage voluntary data submission.

# Vote on Recommendation 4

# Appendix

# California Health Insurance Coverage by Payer Type, 2017

| Coverage Sources - California | Covered Lives (M) | % of Total |
|---|---|---|
| | | |
| **Total Medi-Cal** | **13.0** | **31** |
| • Medi-Cal Managed Care | 10.7 | 26 |
| • Medi-Cal fee-for-service (FFS) | 2.3 | 5 |
| | | |
| **Total Medicare** | **6.1** | **15** |
| • Medicare Advantage | 2.6 | 6 |
| • Medicare FFS | 3.5 | 8 |
| | | |
| **Total Commercial** | **19.8** | **47** |
| • Commercial Fully insured | 14.1 | 34 |
| • ASO/Self-insured | 5.7 | 14 |
| | | |
| Uninsured | 2.8 | 7 |
| **Total** | **41.9** | **100** |

**Notes and Sources:**

- Total adds to more than the state population because individuals can have more than one coverage source during the year; largest source of duplication is dual eligible (Medicare plus Medi-Cal) with 1.4 million.
- Medi-Cal figures from DHCS Medi-Cal Monthly Enrollment Fast Facts, November 2018
- CMS Medicare Enrollment Dashboard Data File, April 26, 2019
- Commercial numbers from CHCF 2019 Edition - California Health Insurers
- Uninsured figures from State Health Facts, Kaiser Family Foundation for 2017

# California Health Plans, 2017 Enrollment

(Commercial & Medicare Advantage)

| Plan | Covered Lives |
|---|---|
| Kaiser | 7,727,446 |
| Blue Shield | 2,483,266 |
| Anthem | 2,292,915 |
| UnitedHealth | 1,253,978 |
| Centene (Health Net) | 773,911 |
| Aetna | 469,668 |
| CIGNA | 342,542 |
| SCAN | 174,470 |
| Molina | 142,729 |
| Sharp | 137,076 |
| Western Health Advantage | 131,209 |
| Humana | 85,372 |
| Sutter | 68,970 |
| Western Growers | 50,211 |
| **Total** | 16,133,763 |

Source: California Health Insurers Almanac, 2019: Data File, CHCF

# California Health Insurance Enrollment, by Regulator, by Market Sector, 2017

| California Enrollment | CDI | DMHC | Total |
|---|---|---|---|
| Individual | 165,907 | 2,054,124 | 2,220,031 |
| Small Group | 205,208 | 2,083,110 | 2,288,318 |
| Large Group | 685,028 | 8,951,846 | 9,636,874 |
| **Commercial Total** | 1,056,143 | 13,089,080 | 14,145,223 |
| Medicare Managed Care | 111,183 | 2,352,136 | 2,463,319 |
| Medi-Cal and Other Public Managed Care | 0 | 10,726,016 | 10,726,016 |
| **Public Managed Care Total** | 111,183 | 13,078,152 | 13,189,335 |
| **Commercial & Public** | 1,167,326 | 26,167,232 | 27,334,558 |
| Student | 896,403 | 0 | 896,403 |
| Mini-Med | 1,190 | 0 | 1,190 |
| Other DMHC | 0 | 750,004 | 750,004 |
| From Other Plans (FOP) | 0 | 3,845,343 | 3,845,343 |
| **Other Total** | 897,593 | 4,595,347 | 5,492,940 |
| **Insured Total** | 2,064,919 | 30,762,579 | 32,827,498 |
| Administrative Services Only (ASO) | 4,723,907 | 993,669 | 5,717,576 |
| **Commercial & Public + ASO** | 5,891,233 | 27,160,901 | 33,052,134 |

Source: California Health Insurers Almanac, 2019: Data File

# Rationale for Exclusion: Student Health Insurance

- Tends to be short-term with relatively thin benefits
- Regulated by the California Department of Insurance.
- Enrollment was approximately 900,000 in 2017
  - One plan with 620,000 enrollees, 7 other plans
- Several other APCDs collect student health insurance data, but there have not been any strong use cases to date
- Data must be filtered out for analysis of total cost of care and other key metrics because the coverage is qualitatively different than standard medical benefits

# Public Comment

# Upcoming Review Committee Meeting : August 15, 2019

# Updated Healthcare Payments Data Program Review Committee Meeting Topics

## March

**Kickoff**

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

## April

**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

## May

**Data Collection**

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

## June

**Enhancing Database Analytics**

- What other relevant data sets can be linked to the HPD data system.

## July

**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

## August

**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

## September

**Data Governance and Privacy**

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

## October

**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

## November

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

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

## December

**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