

Office of Statewide Health Planning and Development

**Healthcare Payments Data Program
Review Committee Meeting**

May 16, 2019

Draft Meeting Minutes

Members Attending: Charles Bacchi, California Association of Health Plans (CAHP); Anne Eowan, Association of California Life and Health Insurance Companies (ACLHIC); Terry Hill, California Medical Association (CMA); Amber Ott, California Hospital Association (CHA); Emma Hoo, Pacific Business Group on Health (PBGH); Ken Stuart, California Health Care Coalition; Joan Allen, Service Employees International Union- United Healthcare Workers West (SEIU-UHW); Cheryl Damberg, RAND Corporation. John Kabateck, National Federation of Independent Businesses (NFIB); Mary June Diaz, Health Access California; William Barcellona, America’s Physician Groups.

Attending by Phone: No members attended by phone.

Not Attending: All members were present

Presenters: Scott Christman, Chief Information Officer, OSHPD; Jill Yegian, Consultant, OSHPD; Dolores Yanagihara, Vice President, Analytics & Performance Information, Integrated Healthcare Association; Rachel DuPré Brodie, Director, Performance Information, Pacific Business Group on Health; Isaac Menashe, Associate Director of Policy, Evaluation and Research, Covered California; Ted Calvert, Consultant, OSHPD; Emily Sullivan, Deputy Director, National Association of Health Data Organizations (NAHDO); Bobbie Wunsch, Consultant, OSHPD.

Others: Denise Love, Executive Director, NAHDO; John Freedman, President, Freedman Healthcare

Public Attendance: 10 members of the public attended.

Agenda Item	Meeting Minutes
Welcome and Meeting Minutes	<p>The Review Committee Chair, Ken Stuart, brought the meeting to order and facilitated introductions.</p> <p>The April 18 Review Committee meeting minutes were approved, with some minor formatting edits that Anne Eowan will provide to the Review Committee Coordinator.</p> <p>Bobbie Wunsch went over the ground rules for the meeting.</p>
Deputy Director’s Report	<p>Scott Christman provided an overview of what was discussed in the April Technical Workgroup meeting. He noted that the group spent some time discussing the APCD-CDL™ which is the preferred format for commercial health plan data collection. Additionally, the Technical Workgroup discussed alternative payment models and considered the Oregon and Massachusetts models. There was an agreement that the Massachusetts model was more user friendly. Finally, there was a discussion about the Kaiser Fee-for-Service (FFS) equivalent model. For a full summary of the April Technical Workgroup please see: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-</p>

<p>Follow Up from April 18 Meeting</p>	<p>Meetings/Documents/HPD/HPD-Technical-Workgroup-4.18.2019-Meeting-Summary-Final.pdf</p> <p>Ken Stuart pointed out that the use cases that were submitted by both Review Committee members and the public were shared with the committee and with the public. They are available on the OSHPD website at: https://oshpd.ca.gov/data-and-reports/cost-transparency/healthcare-payments/hpd-review-committee/#past-meetings-archive</p> <p>Ken Stuart also noted that after the last meeting he had a sense that the committee was ready to make decisions and move the work forward. As such, beginning with the May meeting, Review Committee members will review, edit, and vote on draft recommendations developed by OSHPD. The committee will be following a voting process of motions and seconds, all of which will be noted in the minutes.</p> <p>For the May meeting, the committee will be considering the following recommendations:</p> <ol style="list-style-type: none"> 1. Three sources: The HPD System should establish collection methods and processes specific to three sources of data: 1) DHCS (for Medi-Cal), 2) CMS (for Medicare FFS), and 3) All other. 2. Leverage Medi-Cal data: The HPD System should pursue the collection of Medi-Cal data directly from DHCS, in formats that leverage existing DHCS processes and systems. 3. Incorporate Medicare: The HPD should pursue the collection of Medicare FFS data, in the formats specified by CMS. 4. APCD-CDL™: The HPD should use the APCD-CDL™ for all other submitters. 5. Three years of history: The HPD should initially require submitters to provide three years' worth of historical Tier I "core" data (enrollment, claims and encounters, and provider). 6. Supplemental files: The HPD should collect non claims-based payments through required supplemental files to support total cost of care analyses in California's heavily capitated environment. 7. Flexibility to adjust: Additional legislation should provide OSHPD the authority to specify data collection formats for HPD submitters through regulation.
<p>Multi-Payer Claims Data Collection in California: Lessons From the Front Lines</p>	<p>Jill Yegian moderated a panel of California organizations with experience collecting claims and encounter data from multiple payers in California. The presenters provided an overview of activities and lessons learned to inform the development of the Healthcare Payments Data (HPD) Program.</p> <p>The three presenters were: Dolores Yanagihara, Vice President, Analytics & Performance Information, Integrated Healthcare Association (IHA); Rachel DuPré Brodie, Director, Performance Information, Pacific Business Group on Health (PBGH); and Isaac Menashe, Associate Director of Policy, Evaluation and Research, Covered California.</p> <p>Dolores Yanagihara's presentation focused on collecting various forms of cost data and the IHA total cost of care measure. Rachel Brodie's presentation was focused on issues around quality of data, specifically in regard to the California Healthcare Performance Information System's (CHPI) experience with provider level data and issues around attrition. She also touched on the role of data lags, particularly when it comes to Medicare FFS data from the Centers for Medicare and Medicaid Services (CMS). Isaac Menashe's presentation focused on Covered California's initial experience collecting data in their Healthcare Evidence Initiative (HEI) and some recommendations that they have for OSHPD and the Review Committee to consider in the development of the HPD.</p> <p>For the full presentation please see slides 8-35: https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-5.16.2019-Final.pdf</p>

Review Committee Discussion:

Bill Barcellona, APG, had a clarifying question for Rachel Brodie regarding the number of physicians that were included in the CHPI database. In her presentation Rachel noted that there was a starting group of 185,000 physicians, however Bill Barcellona believed that there are only 120,000 licensed physicians in California. Rachel noted that at the time when CHPI was in existence that was their data set.

Ken Stuart, California Health Care Coalition, asked Dolores Yanagihara and Rachel Brodie about the differences between the IHA and CHPI data. Dolores Yanagihara noted that, there had been conversations about a joint data collection as the data was very similar and included many of the same plans and Medicare FFS. The biggest difference was that IHA has always collected cost information while CHPI did not. Ken Stuart followed up to inquire if the cost data included the amount billed, the amount allowed, and the amount paid. Dolores Yanagihara confirmed that currently IHA receives all three of those elements and also gets the data broken down by plan paid versus the patient cost sharing. The group discussed that one of the key reasons CHPI was not able to get this data, while IHA has been able to, had to do with the unit of measurement. CHPI reported data at the provider level, while IHA data reporting is at the plan level.

Ken Stuart, California Health Care Coalition, followed up with a question for all three presenters, inquiring if there is anything not within the APCD-CDL™ that would be of value to collect. Dolores Yanagihara noted that she has not seen the most up to data CDL layout, but her suggestions would include: provider organization attribution, ACO attribution, risk type attribution, all of which are elements specific to California and critical to understanding plan performance in California. Rachel Brodie also noted that supplemental clinical data is important. Isaac Menashe added that it could be helpful to find out if there are elements the suppliers would want to have provided back to them that could be included in the HPD.

Amber Ott, CHA asked Isaac Menashe at what level of detail the data is made available to data requesters. She noted that claim-level details of payments made for hospitals could result in an antitrust violation by revealing confidentially negotiated rates. She asked how this data could be aggregated in such a way that it is still useful but does not reveal these confidential rates. Isaac Menashe noted that this is a critical issue for the group to think through. He noted that while the detailed level of information is helpful to collect, the group will need to determine how to implement data governance that provides access to researchers, for example, and also allows data suppliers to have the confidence that the data released will not violate antitrust. Ken Stuart followed up with a question for Amber Ott whether publishing a range of rates would be more acceptable? Amber Ott noted that it depends on how the range is defined. Dolores Yanagihara also added to the discussion noting that IHA is governed by data use agreements, which allow the data to be used around specific purposes, and any other proposed uses have to be discussed with the governance committee. She also noted that for health plans, regarding contracted rates, in order to share this information publicly or share with another health plan, the cost information needs to be based on information from at least three plans and with no one plan having too much concentration. Another option is that the results can be rounded to create fuzziness around the numbers. Isaac Menashe closed by saying that whatever data deidentification guidelines are developed they need to ensure that submitters have confidence and trust that the data will be protected.

Anne Eowan, ACLHIC inquired about the feasibility of collecting two or three years of data in areas. Dolores Yanagihara noted that IHA was working under a compressed timeline and it was faster to get two years versus three. However, she does recommend three years as there were certain measures IHA could not develop because they only had two years of data. Rachel Brodie noted that

when CHPI did their data collection they collected three years, and it was fine for some of the plans, but one of the plans had to do a different extraction process which took more time, but it got done.

Anne Eowan had a follow up question if social determinants of health data would be included on an enrollment file. Isaac Menashe noted that the CalHEERS system, which is the single streamlined application for Covered California and Medi-Cal, houses a large amount of enrollee data and could be a prospective feed for this information. He also encouraged the Technical Workgroup to discuss what other data feeds exist in the state that have this information that could be used.

Terry Hill, CMA, noted that while he did sit on the IHA board, he did not follow the PBGH CHPI project, but he is very surprised at the concept of public reporting on one measure. Rachel Brodie replied that due to the stringent quality control processes that CHPI had there were a number of measures that could not be included. Had the quality control measures been slightly lower there would have been more responses. Terry Hill followed up noting that public reporting in general is high stakes. Rachel Brodie agreed and noted that an APCD will have much higher volume and should be able to provide this information. She also noted that she still gets contacted at times by patients who are doing research and want access to this information.

Cheryl Damberg, RAND, noted that it is important for this committee to be able to weigh in on the governance issues and recommended that there should be a scientific method in the data governance to provide guidance on how to use the data in a responsible way. She also inquired if performance measures would be submitted by the suppliers, or if the data aggregator would produce those analytics based on the data provided. Dolores Yanagihara noted that IHA has done both paths, and that they are currently heading towards the latter path where the APCD supports the measurements rather than having the providers develop these measures. Isaac Menashe agreed that Covered California has done the same process where the state constructs the measures but reminded everyone that it is a balance to ensure that the data that is being reported is accurate.

Bill Barcellona, APG, asked about the challenges that the speakers have found regarding development of a master patient index (MPI). Dolores Yanagihara noted that IHA has not yet implemented it. While their data vendor, Onpoint, has done MPIs as a part of their process, IHA does not have permission from the plans to do that. Rachel Brodie mentioned that for CHPI they needed an MPI in order to match patients to doctors. Isaac Menashe commented that Covered California has linked customers across health plans, however there needs to be discussion around which data elements to link across as there can be sensitivity around selecting the identifier.

Ken Stuart, California Health Care Coalition, asked about how the speakers handle identifying providers when services were billed under a common Tax ID. Dolores Yanagihara noted that since IHA was doing the data analysis at the provider organization level or geography level they have not yet had to contend with that issue. With other IHA work including Symphony, they have had to grapple with this issue and noted that mapping is key. Isaac Menashe noted that it is a big issue and that clean provider data is critical. Rachel Brodie noted that for CHPI they had data on rendering providers but, it was not a huge barrier. She noted that the challenges associated differed from provider to provider and from insurer to insurer.

Charles Bacchi, CAHP, noted that he appreciated that Rachel Brodie stated the purpose of CHPI which was to ensure that the quality of networks they were contracting with was good. He inquired about what the operating mission for IHA is. Dolores Yanagihara noted that for the Align, Measure, Perform (AMP) program it is to try to have a standard set of measurements to measure provider organizations and to make the information available for incentive payments and recognition awards to improve care. For the Atlas program, the mission is transparency. To have a source of standard

information to look at performance. Charles Bacchi followed up noting that IHA was able to get a higher participation than CHPI, which to him sounded like it had to do with negotiations on what can be and cannot be done with the data, and who can and cannot have the data. He noted that it is important for the APCD to have a clear purpose and that different purposes will lead to different results. He also mentioned that governance is a critical issue and that IHA is not subject to the same requirements as a government agency. Dolores Yanagihara agreed but noted that with IHA there is a very explicit data use agreement in place.

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John Kabateck, NFIB, inquired about the kinds of challenges the speakers had with the employer community, or if they had any recommendations on engaging that community. Dolores Yanagihara noted that the biggest gap IHA has in their data collection is self-insured employers. She noted that the challenge is that there are the third party administrator contracts, and the plans say they need individual permission from employers to submit data. However, she does believe that purchasers would be interested in seeing their own data against others. There is a lot of value that can be gleaned from their participation in an APCD and that needs to be communicated. Rachel Brodie also noted that governance should not only be controlled by data suppliers, which can create barriers to getting the data out, but should include purchasers and users as part of governance decisions.

Cheryl Damberg, RAND, inquired about the master provider directory. She noted that her work on mapping tax IDs to NPIs and tax IDs to systems has proven to be very challenging but is critical for the analyses that can be done with this data. Cheryl Damberg followed up noting that OSHPD should think through strategies for mapping to providers.

MJ Diaz, Health Access California, noted that she aligns herself with Review Committee comments regarding purpose and use of the database. As consumer representatives Health Access does not want the database to have a negative impact on the healthcare system, but they do want the system to be accountable and equitable and shed light onto the costs that consumers bear. Health Access advocated for the inclusion of the contractual agreement in Attachment 7 for Covered California, as it was an innovative way to hold plans accountable to reducing health care disparities while also providing quality and cost measures. Health Access would like to see the database include some of these innovative measures that Covered California is doing and further help to find innovative ways at reducing costs for consumers.

Public Comment:

Adam Francis, California Academy of Family Physicians (CAFP), noted that CAFP aligns their comments with Terry Hill noting that it is not only a concern for physicians, but CAFP has also heard from patients that inaccurate information was being released which is harmful.

Bernie Inskip, United Health Care, echoed the comments about the APCD-CDL™ being a preferable format. She noted that there have been a number of comments on perceived data quality. United Health Care participates in many, if not all, data collections and the amount of rework based on perceived data quality can be reduced with improved communication, and the APCD-CDL™ provides a way to do that. She also made comment regarding Alternative Payment Method (APM) data, noting that she has heard it discussed a lot around Accountable Care Organizations and that is just one small part of APMs, all of which will be really important for the success of the Healthcare Payments Data (HPD) program.

Data Collection

Ted Calvert and Emily Sullivan provided an informational presentation to support the review of the proposed data collection recommendations. Ted Calvert first reviewed the recommendations that the committee will be considering and then presented on the types of data that typically are included in APCD collection, the different streams of data collection, and the California payer and submitter landscape. Emily Sullivan gave a recap overview of the APCD-CDL™, including the processes for updating and phasing in of the APCD-CDL™. For a full presentation please see slides 37-54 (<https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Public-Meetings/Documents/HPD/Review-Committee-Master-PowerPoint-5.16.2019-Final.pdf>)

Review Committee Discussion on Presentation:

Cheryl Damberg, RAND, inquired regarding the three streams of data if CMS will only be submitting Medicare FFS data, how will the APCD be collecting Medicare Advantage data. Ted noted that the Medicare Advantage data would come through plans.

Terry Hill, CMA, inquired if labs are included in the four core files. Ted noted that the lab results are not included but the procedure code is.

Emma Hoo, PBGH, had a clarifying question if the facility capitation amount is tied to the portion of facilities that have facility capitation. She noted that she assumes there is relatively few capitated facilities, and Dolores agreed and noted that the number presented is spread across the 13.7 million commercial lives.

Joan Allen, SEIU-UHW, had a question regarding restricted scope Medi-Cal if that data is available through a similar process. Ted said it is, the Department of Health Care Services (DHCS) has all of the data.

Amber Ott, CHA, noted that CHA has been doing a lot of work with DHCS to improve encounter data quality as supplemental payments are now tied to encounter data. Therefore, by the time the APCD gets up and running that data will be much more reliable than it has been historically.

Emma Hoo, PBGH, confirmed that in her experience the Part D Medicare data has a considerable lag, but there are organizations that were able to get the data at less of a lag. Additionally, she noted that, regarding social determinants of health data, there are ways to make specific requests to CMS for data from the beneficiary file. Cheryl Damberg added that there are different beneficiary data files depending on what data you want.

Joan Allen, SEIU-UHW, inquired that in regard to the three streams of data presented, who is missing from the universe of potential data suppliers. Ted Calvert noted that we are missing self-insured payers, the VA, prisons, Tricare, military, Indian health services and the uninsured.

Emma Hoo, PBGH, added that among PBGH members there are very large organizations who have control plans in other states, such as Wal-Mart, therefore that data would not be part of a California APCD. John Freedman noted that there are ways to, on a voluntary basis with limited success, get participation from self-insured plans. Emma Hoo followed up noting that Blues intelligence database has expanded which might be a source of data for out of state control plans.

Charles Bacchi, CAHP, inquired if the presenters had said they would be asking Medi-Cal plans to submit supplemental files in addition to DHCS encounter data. Ted Calvert noted that currently supplemental payment information is not collected by DHCS. Charles Bacchi followed up saying that he is not sure that it is doable to request supplementary files from plans, as plans are already doing

a lot of work for DHCS and the idea of reinventing the wheel is not very plausible. He would like to further discuss this point during the recommendation portion of the discussion.

Ken Stuart, California Health Care Coalition, inquired if the work that the Department of Labor was currently engaging in would align with the APCD-CDL™. Emily noted that NAHDO and the APCD Council would hope so as the impetus for the work was the Gobeille decision.

Emma Hoo, PBGH, noted that in prior meetings the committee had talked about the CDL being a floor not a ceiling. She inquired what other data elements are included in supplemental files that may not be in the CDL. Emily Sullivan noted that metal tiers, actuarial value, and aid codes are included in the CDL, however alternative payment methods are not. She also noted that there is an opportunity to modify the CDL over time. However, the rule of thumb is that if it is not used to pay a claim it is possibly not going to be included. John Freedman also gave an example how in Massachusetts their APCD collects non-binary gender codes while the CDL does not.

MJ Diaz, Health Access, inquired if California wanted non-claims data what would this format not include. Emily noted that if the payers do not maintain the information in their system it cannot be included. Additionally, some of the data might not be at the patient level but may be at a more aggregated level. MJ Diaz followed up asking what if plans says they do not collect a certain element, but we know that they do. Emily Sullivan noted that in her experience, the plans who are involved in this agreed that if they have the information they will provide it. However, there are caveats to that and there can be some plans do not maintain certain information.

Cheryl Damberg, RAND, followed up on this conversation inquiring about the race variable, for example and if commercial plans categorized race differently? Emily Sullivan noted that they code to Office of Management and Budget and that the APCD-CDL™ was made with states and payers in mind.

Ken Stuart, California Health Care Coalition, inquired if other states have committed to automatically adopting the APCD-CDL™. Emily Sullivan noted that yes verbally, they have. The NAHDO board is having a call to action to encourage the participation and it may not happen straight away but NAHDO and the APCD Council are working towards it.

Charles Bacchi, CAHP, wanted to be reminded of who makes up the APCD Council. Emily Sullivan noted that the APCD Council is a non-profit organization staffed by NAHDO and University of New Hampshire. Both state representatives and vendors sit on the council. There are bi-monthly calls with just states and quarterly calls with states and vendors. There will be a committee that will rule on proposed changes to the APCD-CDL™, but it has not been established. Members of NAHDO will be on the committee as will state representatives. Charles Bacchi followed up to confirm that if California were to adopt the APCD-CDL™, that would mean that other states will be deciding how California will have to adjust its data collection format. Emily Sullivan noted that all requests will be made public, and everyone can comment. When developing this process NAHDO and the APCD Council were told this was an inclusive way to approach it.

MJ Diaz, Health Access, noted that she feels a bit anxious about adopting a format that might work for other states that are not like California, especially given California's very high rates of capitation and alternative payments. Denise Love noted that many of the California payers are also payers in other states, so though it might not be at a magnitude of California, they are also dealing with the alternative payments, so there is a benefit of the collective knowledge. She also added that one of the hopes that she has for the CDL is that it saves states about a year in startup time. As the industry evolves and what data elements payers can provide, NAHDO is hopeful these additions can

be shared across states and the CDL is a forum for collective knowledge building. Ted Calvert added that this is also why the staff is asking the committee to consider the recommendation around a supplemental file for all those other things that do not fit on the CDL.

Amber Ott, CHA, commented that Medi-Cal data on hospitals should be better by the time HPD needs it. Hospitals are revising and correcting encounter data in Medi-Cal, and they must submit revised data in order to receive supplemental payments from Medi-Cal, something that they have been working on over the last 8-10 months. She also noted that intergovernmental transfer payments are a huge part of Medi-Cal payments. For example, the hospitals put up \$4 billion to pull down another \$4 billion from the federal government; but in the OSHPD data it looks like \$8 billion in revenue for the hospitals. It is important to note that the \$8 billion is not the case, and that the hospitals must pay money to receive money.

Discussion of Recommendations:

Proposed Recommendation 1: Three sources: The HPD System should establish collection methods and processes specific to three sources of data: 1) DHCS (for Medi-Cal), 2) CMS (for Medicare FFS), and 3) All other.

Charles Bacchi, CAHP, inquired if Medicare FFS is its own separate bucket because Medicare Advantage would be collected from plans. Ted Calvert noted that was correct.

Joan Allen, SEIU-UHW, noted that she did not see providers listed as a source to collect data from.

Cheryl Damberg, RAND, proposed an amendment to add in collecting data from providers.

MJ Diaz, Health Access California, noted her support to include providers as a collection stream. Ted Calvert noted that this recommendation's data is core data which includes claims and encounter, eligibility, provider, and pharmacy. Scott Christman reminded the group that the recommendations are coming from best practices learned from other states and that adding in provider data would be a different scope.

Cheryl Damberg, RAND, inquired as to how there would be mapping providers to organizations, etc. Ted Calvert noted that the team is imagining a master provider index to assist in mapping. Additionally, utilizing a program like Symphony that maps those connections is a solution the team is looking into.

Bobbie Wunsch offered that the staff can come back with a more specific recommendation regarding providers.

Ken Stuart, California Health Care Coalition, reminded the committee that these are the general buckets and urged the committee to not get too much into the weeds.

MJ Diaz, Health Access California, commented that the committee is voting on the three sources, within each of which there are the four core files: claims & encounters, eligibility, provider, and pharmacy.

Joan Allen, SEIU-UHW, noted that the "all others" bucket does not include providers as data submitters, but that we should leave it in the "parking lot" for consideration later. As long as we are reflecting as a group that we are not finalizing to not include providers in the "all others" bucket.

John Kabateck, NFIB, noted that maybe there is a value to leaving it as broad as it is right now.

Emma Hoo, PBGH, reminded the committee to not to lose sight of behavioral health data. John Freedman reminded the committee that the recommendation here is that there are three major streams of claims data from the three major sources. There are of course other elements that are included in the APCD. He noted that this recommendation is really showing that these three streams are primary sources of claims data.

Anne Eowan, ACLHIC, proposed an amendment to add “claims” in front of the word “data”.

Terry Hill, CMA, made a motion to move the recommendation as amended.

Charles Bacchi, CAHP, seconded Terry Hill’s motion.

Emma Hoo, PBGH, proposed an amendment to add “claims and enrollments” in front of data.

Ken Stuart, California Health Care Coalition, confirmed that the addition of “and enrollment” was agreeable with Terry Hill’s motion, which it was.

Cheryl Damberg, RAND, seconded Ken’s motion.

The committee voted, and the recommendation as amended was approved 11-0

Final Recommendation as amended:

Final Recommendation 1: Three sources: 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.

Proposed Recommendation 2: Leverage Medi-Cal data: The HPD System should pursue the collection of Medi-Cal data directly from DHCS, in formats that leverage existing DHCS processes and systems.

Charles Bacchi, CAHP, noted that he was not comfortable with this recommendation. He noted that health plans are partners with DHCS, and that any changes to the current processes are concerning. He proposed an amendment to strike the word “leverage” and replace with “collect from DHCS.” He also recommended striking “in formats that leverage existing DHCS processes and systems.”

Scott Christman provided some context by letting the committee know that currently OSHPD has a data sharing agreement with DHCS, along with other CHHS sister departments. Scott explained that this recommendation is not intended to interrupt the existing processes. OSHPD plans to give DHCS the option to either provide the data in the format that they already collect it in, and OSHPD would manipulate the files to map them to the APCD-CDL™, or OSHPD would give DHCS the CDL format and ask them to convert the data into that format.

Ken Stuart confirmed that Charles Bacchi made a motion to replace the word “leverage” with the word “collect” and to add a period after DHCS and remove the rest of the sentence which reads “in formats that leverage existing DHCS processes and systems.”

Bill Barcellona, APG, seconded Charles Bacchi’s motion.

The committee did not vote yet as there was subsequent discussion.

Cheryl Damberg, RAND, noted that she felt the recommendation as written reads in a benign way that shows that we are willing to try to accommodate existing processes and formats.

MJ Diaz, Health Access California, also noted that she likes the term leverage because we have spent time talking about how to include what is in other databases to not start from scratch.

Joan Allen, SEIU-UHW, inquired about the difference between “leveraging” Medi-Cal data and “incorporating” Medicare. Scott Christman responded that OSHPD does not have any negotiation opportunities with Medicare and the only option is to accept the data in the format that CMS provides it in. However, with Medi-Cal data because DHCS is a part of the CHHS family of departments we have an opportunity to talk through what the best format would be with DHCS.

Charles Bacchi, CAHP, noted that he is concerned if OSHPD come to an agreement with DHCS that requires a change to the collection process that then affects the plans.

Cheryl Damberg, RAND, noted that if we incorporate Charles Bacchi’s proposed amendment to remove “leverage” and replace with “collect”, does that make Recommendations 1 and 2 redundant?

Ted Calvert noted that none of the conversations the team has had say that we are going to change the DHCS processes.

Charles Bacchi, CAHP, made a motion to move recommendation 2 as amended by removing “leverage” and replacing it with “collect” and then adding a period after DHCS and striking the phrase “in formats that leverage existing DHCS processes and systems.”

Anne Eowan, ACLHIC, seconded Charles Bacchi’s motion.

The committee voted 11-0 to approve the recommendation as amended.

Final Recommendation 2: ~~Leverage~~ **Collect** Medi-Cal data: The HPD System should pursue the collection of Medi-Cal data directly from DHCS, ~~in formats that leverage existing DHCS processes and systems.~~

Proposed Recommendation 3: Incorporate Medicare: The HPD should pursue the collection of Medicare FFS data, in the formats specified by CMS.

Recommendation 3 was accepted as was written without any discussion.

Terry Hill, CMA, made a motion to approve the recommendation as it was written.

Cheryl Damberg, RAND, seconded Terry Hill’s motion.

The committee voted 11-0 to approve the recommendation as written.

Final Recommendation 3: Incorporate Medicare: The HPD should pursue the collection of Medicare FFS data, in the formats specified by CMS.

Proposed Recommendation 4: APCD-CDL™: The HPD should use the APCD-CDL™ for all other submitters.

Anne Eowan, ACLHIC, commented that because of the way the APCD-CDL™ has been written there has to be some way for California to check the changes as they come. Ken Stuart, California Health Care Coalition, followed up asking what is the process to ensure that California would have a voice in proposed changes to the CDL. Emily Sullivan, noted that NAHDO and the APCD Council hope California would have a conversation with their data submitters to submit comments, regarding those proposed changes. Those comments would then go to the national team. She also noted that it is possible for states to turn off elements but that is internal. Anne Eowan noted that at some point there needs to be representation, and if California submits comments and they are not adopted, there should be some sort of technical review to ensure these are formats work for California.

Scott Christman noted that there will be a separate discussion on governance and separate recommendations and on what the best practice would be. Scott Christman also noted that we adopt standards wherever possible to minimize the burden on data submitters.

Ken Stuart, California Health Care Coalition, added that he is satisfied with the way this recommendation is written, but noted that it will be important to bring up this topic of adjustments to the APCD-CDL™ when the governance discussion comes up.

Joan Allen, SEIU-UHW, inquired how often the layout is published. Emily Sullivan responded that the APCD-CDL™ was only published in December, but we are hoping for updates no more frequently than every two years.

Charles Bacchi, CAHP, made a motion to move the recommendation as written.

Anne Eowan, ACLHIC, seconded Charles Bacchi's motion.

The committee voted 10-0 to approve the recommendation as written.

Final Recommendation 4: APCD-CDL™: The HPD should use the APCD-CDL™ for all other submitters.

Proposed Recommendation 5: Three years of history: The HPD should initially require submitters to provide three years' worth of historical Tier I "core" data (enrollment, claims and encounters, and provider).

Anne Eowan, ACLHIC, noted that she felt the recommendation sounds pretty standardized. It would be interesting to hear back from plans to hear how this would work for them, if this request is doable for most or if there will be an exemption process.

Cheryl Damberg, RAND, comment on the note regarding data quality checks. If the data will be used, then why would there not be the same data quality checks. Ted Calvert noted that there is of course a need to use quality checks, but it will be difficult to ask plans to follow up and go back to fix three years of historical data. Many plans close their book of business and cannot go back that far.

Charles Bacchi, CAHP, noted that the phrase "require submitters" was problematic. There are some submitters that we cannot require to do anything, for example CMS. Request may be a better word to use.

John Freedman commented that in terms of data quality checks it depends on how far back we go to fix the data. It will be an individual negotiation to determine what can feasibly be fixed if need be.

MJ Diaz, Health Access California, agreed with Cheryl that we need to have a baseline of data that is clean.

Anne Eowan, ACLHIC, noted that the Technical Workgroup would be a good resource to figure out the nits in this discussion regarding data quality.

Terry Hill, CMA, notes that issue of how clean are the data is going to come up over and over again, and he noted that earlier Cheryl Damberg had suggested that there is a scientific committee that would validate the data that may be presented as a recommendation at a future meeting.

Ken Stuart, California Health Care Coalition, supported Charles Bacchi's proposed amendment to change "require" to "request" and then added his own amendment to add "validated" in front of data.

Anne Eowan, ACLHIC, asked what would have to be done to "validate" the data. Ted Calvert noted that is a hard element to define and that he would not recommend adding in validate.

Charles Bacchi, CAHP, made a motion to replace the word "require" with "request."

Cheryl Damberg, RAND, seconded Charles Bacchi's motion.

Joan Allen, SEIU-UHW, noted that she feels it was a huge step back to move from require to request, could the committee find a middle ground to change "require" to "pursue"

Charles Bacchi, CAHP, withdrew his motion.

Joan Allen, SEIU-UHW, made a motion to change the word request to pursue.

Cheryl Damberg, RAND, seconded Joan Allen's recommendation.

The committee voted 10-0 to approve the recommendation as amended.

Final Recommendation 5: Three years of history: The HPD should initially ~~require~~ **pursue** submitters to provide three years' worth of historical Tier I "core" data (enrollment, claims and encounters, and provider).

Proposed Recommendation 6: Supplemental files: The HPD should collect non claims-based payments through required supplemental files to support total cost of care analyses in California's heavily capitated environment.

Cheryl Damberg, RAND, inquired what is included in the bucket of supplemental files. She suggests that the definition be broadened beyond payment files. Scott Christman noted that the challenge is that there are no standards. Can we agree that supplemental files will be included, but we will have to come back with a set of proposals, discussed through with the Technical Workgroup describing what those files would actually look like?

Ken Stuart, California Health Care Coalition, inquired if Scott was suggesting tabling this recommendation. Scott noted that he is proposing that we agree to collecting supplemental files but that OSHPD will have to come back to the committee with a more formalized idea of what those files

would entail.

Terry Hill, CMA, noted that he is impressed that the plans would agree to the word “required” in this recommendation, he noted that he is not sure of everything that is included in a “supplemental” file, so it is a little hard to vote on this one.

Bobbie Wunsch inquired if we can just remove the words “non claims based payments?”

Cheryl Damberg, RAND, commented that this recommendation should round out the payment piece and then there can be another recommendation regarding other non-payments supplemental files.

Anne Eowan, ACLHIC, noted that the word capitated refers to capitation, but there are other payments that can be included. She noted that the word required worried her because we do not know what will be in the file.

Ted Calvert commented that the idea of the recommendation is to have a process that will allow the HPD to get a full financial picture.

Committee ultimately decided to table this recommendation and not hold a vote.

Proposed Recommendation 7: Flexibility to adjust: Additional legislation should provide OSHPD the authority to specify data collection formats for HPD submitters through regulation.

Ken Stuart, California Health Care Coalition, clarified that this is a recommendation to the legislature.

MJ Diaz, Health Access California, noted that because it is so specific are we restricting ourselves with other legislation that may be needed to operationalize the HPD. Scott Christman agreed that this is a very specific recommendation and is meant to reflect an approach to specifying data collection formats similar to OSHPD’s existing healthcare data programs.

Charles Bacchi, CAHP, commented that the idea of a rule making process is to provide certainty to stakeholders about comments period etc. However, because it is also so specific he does not see how this recommendation fits into this conversation and worries that we are jumping too far ahead.

Anne Eowan, ACLHIC, agreed with Charles and noted that this might be one of the things we add in to later discussions around legislation.

Cheryl Damberg, RAND, noted that she fully supports this recommendation and feels that in the past OSHPD has been constrained.

Committee ultimately decided to table this recommendation and not hold a vote.

Public Comment	There was no public comment
Agenda for Upcoming Review Committee Meeting &	Ken Stuart thanked the committee and OSHPD Staff. He commented that the next meeting on June 20 th will be on data linkage.

Adjournment	
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