Healthcare Payments Data Program Review Committee

May 16, 2019
Office of Statewide Health Planning and Development
2020 W. El Camino Avenue, Sacramento, CA, 95833
Conference Room 1237
Welcome and Meeting Minutes

Ken Stuart, Chair, Review Committee
Data Sources & Formats: Approach

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.
Deputy Director’s Report

Scott Christman,
Chief Information Officer and Deputy Director,
OSHPD
Follow Up from April 18 Meeting
Multi-Payer Claims Data Collection in California: Lessons From the Front Lines.

Jill Yegian, OSHPD Consultant
Dolores Yanagihara, Vice President, Analytics & Performance Information, IHA
Rachel DuPré Brodie, Director, Performance Information, PBGH
Isaac Menashe, Associate Director of Policy, Evaluation and Research, Covered CA
HPD Review Committee Meeting

May 16, 2019
Dolores Yanagihara
IHA Data Infrastructure Coverage

IHA has performance information covering about 75% of California’s population

- California Total Population: 39.4 million
- Population in IHA’s Infrastructure: 30 million

<table>
<thead>
<tr>
<th>Payer</th>
<th>Product</th>
<th>Source</th>
<th>Covered Lives</th>
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<tbody>
<tr>
<td>Commercial</td>
<td>HMO</td>
<td>10 health plans</td>
<td>9.0 M</td>
</tr>
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<td>PPO</td>
<td>6 health plans</td>
<td>4.7 M</td>
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<tr>
<td>Medicare</td>
<td>Advantage</td>
<td>7 health plans</td>
<td>1.7 M</td>
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<tr>
<td></td>
<td>FFS</td>
<td>CMS, research DUA</td>
<td>~3 M</td>
</tr>
<tr>
<td>Medi-Cal*</td>
<td>Managed Care</td>
<td>DHCS</td>
<td>~10 M</td>
</tr>
<tr>
<td>(full-scope)</td>
<td>FFS</td>
<td>DHCS</td>
<td>~1.6 M</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>22.9 M</strong></td>
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<td></td>
<td><strong>~30 M</strong></td>
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</tbody>
</table>

* Receive results (numerator, denominator), not member level data
Data Submission Guide (DSG) Overview

• All-Payers Claim Database (APCD) layout
  – Aligned with format used by CHPI and CalPERS
  – Very similar to Common Data Layout

• Specifications for five data files:
  – Eligibility – Monthly enrollment segments
  – Medical Claims/Encounters
  – Pharmacy Claims
  – Cost – includes Capitation broken out into professional, facility, global
  – Lab Results

• [https://www.iha.org/sites/default/files/resources/onpoint_iha_data_submission_guide_version_2.1_20190219.pdf](https://www.iha.org/sites/default/files/resources/onpoint_iha_data_submission_guide_version_2.1_20190219.pdf)

• Collecting 3 years of data ideal; 2 years acceptable for most measures
Member/Benefit Characteristics Collected (by month)

- Member zip code of residence
- Payer/product type
- PO attributed to
- ACO attributed to
- HDHP
- Risk Type (FFS, Professional Cap, Facility Cap, Global Cap)
- Covered CA (including metal tier and actuarial value)
- Employer Group Size
- Race & ethnicity (not well populated)

➤ Monthly enrollment segments allow tracking of coverage changes over time
Total Cost of Care (TCOC) Measure
*Developed by HealthPartners, NQF Endorsed*

- **Description:** Total amount paid to any provider to care for members for a year
  - Professional, facility (inpatient and outpatient), pharmacy, and ancillary costs
  - Capitation, fee-for-service, member cost share, administrative adjustments

- **Eligible Population:** Ages 1 through 64; Minimum 9 months of enrollment

- **Risk Adjustment:** Johns Hopkins Concurrent ACG System adjusts for age, gender, diagnoses, and procedures

- **CA Geography Adjustment:** CMS Hospital Wage Index derived Geographic Adjustment Factor adjusts for geographic input cost differences

- **CA Exclusions:**
  - Mental health and chemical dependency services
  - Acupuncture and chiropractic services; dental and vision services
Total Cost of Care and Capitation

- Nearly 2/3 of CA commercial market has some exposure to capitated payments
- In commercial HMO, >99% of non-Kaiser PO contracts include capitation
- POs taking more risk represent disproportionate share of member enrollment

<table>
<thead>
<tr>
<th>Capitated Services</th>
<th>Fee For Service</th>
<th>Shared Risk</th>
<th>Dual Risk</th>
<th>Global Risk</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Professional</td>
<td>Professional, Facility (paid separately)</td>
<td>Professional, Facility (paid together)</td>
</tr>
<tr>
<td>% of Enrollment</td>
<td>0.04%</td>
<td>53.6%</td>
<td>31.1%</td>
<td>15.3%</td>
</tr>
<tr>
<td>% of Physician Organization Contracts</td>
<td>0.4%</td>
<td>74.4%</td>
<td>12.7%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

- Plan FFS Payments
- Member Cost Sharing
- Capitated PMPM for delegated services
- Total Cost of Care
Cost Service Category Breakdowns

- Collect capitated payments by member in cost file

Overall Total Cost of Care

- Inpatient Facility
  - Newborn
  - Maternity
  - Non-Maternity

- Outpatient Facility
  - Hospital
  - ED Visits
  - ASC
  - Other

- Other Facility
  - Pharmacy
    - Specialty
    - All Other
  - Professional FFS
    - Professional
    - Facility
    - Global
  - Other FFS

Behavioral Health: Not included in Overall Total Cost of Care
Program Oversight

Committee Structure for Health Plan & Physician Organization Involvement

Governance Committee

Technical Payment Committee
Contracting, Actuarial, and Medical Economics Experts

Technical Measurement Committee
Clinical and Data Reporting Experts

IHA Staff

Partners

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Some Learnings

- Leverage existing standard specifications; don’t recreate wheel
- ETL and DQ are multi-faceted and nuanced – and critical to get right; they are the basis for all measurement and analysis that follows
- Identifying data quality or file issues specifically is necessary for timely resolution by plans; requires substantial technical expertise
- Strong relationships built on trust are essential
- Stakeholder engagement throughout process builds trust and buy-in
  - E.g., public comment, preview, appeals process, governance process
Questions?
Appendix
IHA does not receive or access any PHI
## Primary Use Cases

<table>
<thead>
<tr>
<th>Program</th>
<th>Common Measure Set</th>
<th>Participant Reports &amp; Benchmarks</th>
<th>Recognition Awards</th>
<th>Public Reporting</th>
<th>Incentives</th>
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</thead>
<tbody>
<tr>
<td><strong>AMP</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Commercial HMO</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage</td>
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<td></td>
<td>Optional</td>
<td></td>
</tr>
<tr>
<td>Commercial ACO</td>
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<td>TBD</td>
<td>Optional</td>
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<td>Medi-Cal Managed Care</td>
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<td>TBD</td>
<td>N/A</td>
<td>Optional</td>
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<tr>
<td>Atlas</td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- IHA analysis for industry insights
- Researcher access to data
Actual Uses/Planned Uses

• Re-consideration of how plan markets PPO products based on Atlas findings
• Identification of and outreach to chronically lower performing organizations
• Examination of total cost, member OOP spending, and average risk by Covered CA metal tier, actuarial value, product type, region, and age group compared to off-exchange individual plans
• Analysis of high-need patient population in various California regions, how many and which medications these high-need patients take, and what services they use for what reasons
• Analysis comparing the total costs under a capitated model versus FFS model for members with the top ten cost-driving conditions
• Analysis of end of life care in Medi-Cal, replicating a study done on Medicare population
• Evaluation of network performance, including physician groups or geographic aggregates of physicians who serve PPO or EPO networks
Multi-Payer Claims Data Collection in California: Lessons Learned from the Field
California Healthcare Performance Information System
May 16, 2019

Rachel Brodie
Director, Performance Information
CHPI’s Mission

To serve as a trusted source of healthcare information by accurately measuring the quality and cost of care, reporting performance ratings, educating the public about healthcare value, and helping drive improvements in healthcare in California.

Data Sources

• Full-insured and self-funded commercial HMO, PPO, POS and Medicare Advantage claims and encounters from 3 insurers
• Medicare fee-for-service claims from CMS as part of the Qualified Entity (QE) Program
• Aggregated data for approximately 10 million Californians
Nationally endorsed measures selected by Physician Advisory Group

- Breast Cancer Screening
- Cervical Cancer Screening
- Cervical Cancer Overscreening*
- Chlamydia Screening
- Hemoglobin A1c Testing
- Statin Therapy for Patients with Diabetes*
- Nephropathy
- Hypertension***
- Imaging for Low Back Pain**
- CAD: ACE Inhibitor or ARB Therapy-Diabetes***
- Beta-Blocker Treatment After a Heart Attack**
- Cardiac Stress Imaging*
- DMARD Therapy for RA
- Use of Opioids from Multiple Providers or at High Dosage in Persons without Cancer*

- Adolescent Well-Care Visits
- Immunizations for Adolescents
- Childhood Immunization Status*
- Human Papillomavirus for Adolescents*
- Well-Child Visits
- Children with URI
- Pediatric Pharyngitis
- Proportion of Days Covered (PDC)
- Asthma Medication Ratio**
- Medication Management for People with Asthma*
- Monitoring for Persistent Medications**
- Acute Bronchitis
- Osteoporosis Management*
- Appropriate Work Up Prior to Endometrial Ablation Procedure*
CHPI Ratings Methodology

- Attribution methodology
- Physician and practice site results must meet 0.70 reliability threshold
- Reportable measures must have 100 doctors; each with a minimum of 11 patients
- Assign 1 – 4 star ratings
CHPI reported 13 clinical quality measures for ~ 10,000 California physicians and 8,000 practice sites in Spring 2017

Length of time to generate results

- Medicare FFS claims not available for 11 months
- QE review and corrections requirement added additional 5 months to production timeline
- Quality and completeness of commercial claims required multiple submissions
- Complex nature of work with sophisticated attribution, reliability and risk adjustment methodologies

Low proportion of reportable physicians

- 25% of PCPs and 60% of specialists had at least one reportable result
- Rigorous methodology required for public reporting and other high stakes uses
Lessons Learned & Recommendations for CA APCD

• Use the APCD-CDL to streamline data submission and reduce burden
• Consider relationship of use cases and level of measurement (e.g., regional, provider organization, practice site, individual physician)
• Larger scale of APCD will increase potential for individual physician measurement
• Require submission of at least 3 years’ of historical data – many quality measures have lookback periods of 3-5 years
• Accelerate data submission and production timelines to reduce time lag when possible
• For long term development, enhance APCD with supplemental clinical data, patient-reported data, wasteful/inefficient care measures, social determinants of health, etc.
COVERED CALIFORNIA’S
HEALTHCARE EVIDENCE INITIATIVE (HEI)

May 16, 2019 Meeting of the
Healthcare Payments Data (HPD) Review Committee

Isaac Menashe – Associate Director, Evaluation and Research
Policy, Evaluation and Research Division, Covered California
HEALTHCARE EVIDENCE INITIATIVE (HEI): PURPOSE

Covered California’s Healthcare Evidence Initiative (HEI) relies on enrollment and utilization data to:

1. Provide actionable information supporting Covered California’s operations and policy – improving care, lowering costs, and improving health.

2. Provide evidence to inform public and private policies so that purchasing strategies and benefit designs can improve quality, access, and value throughout the health care delivery system.

The initiative furthers Covered California’s vision: To improve the health of all Californians by assuring their access to affordable, high quality care.
HEI DATABASE CONTENTS AND ACCESS

- On-Exchange individual market enrollment since 2014
  - Almost 4M consumers
  - $15B in expenditures
  - 79M claims / encounters, for both medical and Rx

- Layouts are quite similar to APCD CDL, but augmented by Covered California administrative data

- IBM secures PHI and may not share it with Covered CA. It may provide only de-identified data under HIPAA.

HEI IMPLEMENTATION CHALLENGES

- Limitations on financial data imposed by some issuers:
  - Charge submitted, allowed, and net paid amounts
  - Consumer out-of-pocket costs, esp. deductibles
  - Some issuers provide proxy costs. IBM generates proxy costs for others using MarketScan data.

- Reliant on the issuers’ capabilities re: implementation timing and data quality / completeness

- Issuers’ own system changes, e.g., in claims processing and data warehousing, may require extract re-engineering
CONSIDERATIONS for CA HPD

Covered California’s experiences and recommended considerations for the HPD Review Committee are grounded in the research and analytic vision that led to our Healthcare Evidence Initiative, but tempered by some of the challenges we have experienced building a smaller, but similar, analytic tool over the past few years.

Our experiences reinforce many of the recommendations already provided to the Committee, including:

- Producing initial products that increase project buy-in both from data suppliers and users
- Importance and difficulty of data quality -> which is especially hard when correlated with explanatory variables of interest for many analyses!
- Phasing in use cases based on data availability

(These experiences are summarized in our cover letter for a set of proposed Use Cases submitted to the HPD Review Committee.)
CRITICAL DATA ATTRIBUTES

- Allowed Cost: insurer / payer paid amounts and consumer cost share amounts
- Standardized Payer, Provider, and Facility Names / IDs:
  - One-to-many roll-up of practitioners to medical practices / need to show composition of delivery system entities (e.g., ACOs)
- Distinguishing each carrier’s products and networks
- Alternative Payment Model (APM) non-claims financial payments and penalty amounts
- Premium amounts and benefit coverage information for commercial market

Other data attributes added over time:

- Social determinants of health:
  - Age, gender, race, ethnicity, language, income, and location
  - Education, physical environment, etc., and census linkages
- Clinical and patient-reported outcomes data
ANALYTIC ENHANCEMENTS

Analytic capabilities and enhancements:

- Patient severity of illness / risk adjustment system
- Mapping of claims to medical services categories (e.g., imaging, lab, preventive care, primary care, specialty office visits, etc.)
- Measures engine to produce standard cost and quality measures
- Groupers to organize services into acute and chronic episodes of care
- Master Patient Index to allow for longitudinal analysis of the same individual across coverage sources (and claims feeds)
- Wasteful / inefficient care measures
- ZIP Code to census tract mapping
DATA GOVERNANCE CONSIDERATIONS

Like many of the potential HPD stakeholders, we anticipate being both a supplier and a user.

- Safeguard information security and the privacy of all Californians
- Clear user approval and data governance framework
- Public and private contributors and/or consumers of data
- Tiered data user framework with appropriate controls to balance data suppliers’ data sensitivities with making data available to the public:
  - Submitting data must not hamper a contributor’s relationships with or obligations to its own data suppliers, e.g., QHP Issuers
  - Accommodate direct access to data for the data consumers’ own analyses
BREAK
Data Collection

Ted Calvert, OSHPD Consultant
Emily Sullivan, Deputy Director, NAHDO
Agenda

• Review: types of data needed for an APCD
• California’s payer/submitter landscape
• APCD-CDL™
• Feedback on proposed approach to data sources and formats
Review: APCD Data Types
Four “Core” Data Files

• Member Eligibility
  • Information on all persons covered by a particular Health Payer
  • Includes details regarding the Payer, Health Plan, Subscriber/Members, Coverage Status, and Eligibility Time Spans

• Medical Claims and Encounters
  • Information on all services rendered or supplies provided
  • Includes details regarding the Payer, Provider, Patient/Member, Diagnoses, Procedures and Services Rendered, and Payment Details (claims only)
  • Encounters can include FFS-equivalents for capitated arrangements or ACO members

• Pharmacy Claims
  • Information on all prescription drugs, biologics, and vaccines provided
  • Includes details regarding the Payer/Pharmacy Benefit Manager, Provider, Pharmacy, Patient, Drug Name/NDC Code, and Payment Details (claims only)

• Provider File
  • Information for all rendering/servicing, billing, and prescribing providers
  • Includes details regarding Name, Address/Location, Specialty, NPI, License #, Tax ID, etc.
Payments That Do Not Appear on Claims

• Alternative Payment Model Payments
  • Population-Based Payment/Capitation – comprehensive, condition specific, or integrated finance and delivery systems
  • Bundled/Episode-based payment
  • Performance Incentives/Penalties
  • Shared Savings/Risk

• Pharmacy Rebates
## Importance of Non-Claims Based Data

### Distribution of Commercial Plan Payments ($ Per Member Per Year)

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Fee For Service</th>
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<tbody>
<tr>
<td>Inpatient Facility FFS</td>
<td>$1,232</td>
<td>$4,405 PMPY</td>
</tr>
<tr>
<td>Outpatient Facility FFS</td>
<td>$1,167</td>
<td></td>
</tr>
<tr>
<td>Professional FFS</td>
<td>$1,273</td>
<td></td>
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<tr>
<td>Pharmacy FFS</td>
<td>$733</td>
<td></td>
</tr>
<tr>
<td>Global Cap</td>
<td>$394</td>
<td></td>
</tr>
<tr>
<td>Facility Cap</td>
<td>$92</td>
<td></td>
</tr>
<tr>
<td>Professional Cap</td>
<td>$353</td>
<td></td>
</tr>
</tbody>
</table>


Note: most Kaiser Permanente (KP) payments are included in fee for service categories; KP assigns fee schedule amounts to the detailed encounter records when calculating costs.
California’s Payer Landscape
Health Insurance Coverage for Californians*

- Approximately 36 million Californians have health insurance
- Medicare covers approx. 6 million (17% of insured)
  - 3.5M Original Medicare (FFS)
  - 2.6M Medicare Advantage (Managed Care)
- Medi-Cal covers approx. 13 million (36% of insured)
  - 2.4M FFS
  - 10.6M Managed Care
- Other purchasers and payers cover approx. 20 million (55% of insured)

*Sources: U.S. Census Bureau, 2017 American Community Survey (civilian noninstitutionalized population) and 2017 California Health Interview Survey. Totals add to more than 100% due to overlapping coverage
Medicare Formats

• Original Medicare
  • CMS provides two application pathways to Medicare data
    • State Agency Request
    • Certified Qualified Entity
  • Data formats are the same regardless of pathway: quarterly and/or annual files in CMS-specified formats

• Medicare Advantage
  • APCDs collect directly from participating plans
Medi-Cal Formats

• Managed Care
  • 22 Medi-Cal managed care plans send transactions-based data (post-adjudicated medical and pharmacy formats) on a flow basis to DHCS
    • Plan contracts are county-based, so actual number of submitting “plans” is much higher
    • Model types and specific plans have changed over time; will likely continue
  • DHCS systems receive, edit, monitor, and provide feedback to plans
    • Incentives and penalties for Completeness, Accuracy, Reasonability, and Timeliness (CART)

• Fee for Service and Other Core Data
  • FFS, eligibility, and provider information available from DHCS

• DHCS uses data for their Data Warehouse and also shares with CMS (via T-MSIS, Transformed Medicaid Statistical Information System)
All Other Submitter Formats

• Mix of small and large group insured plans, self-funded plans, Medicare Advantage, and plans sponsored by public organizations (e.g., Covered California, CalPERS)

• Most have experience submitting APCD-like data for other purposes (e.g., IHA, CalPERS, Covered California, other private data warehouses)
Summary: Sources and Formats

- Medicare FFS (CMS Formats)
- Medi-Cal (Leverage Existing + Supplemental, Formats TBD)
- All Other (APCD-CDL™ + Supplemental File(s))

OSHPD HPD
APCD-CDL™
The HPD should use the APCD-CDL™

As a new entrant to the APCD community, California has an opportunity to learn from the work in other states.

Use of the APCD-CDL™ will

• reduce the burden on national health plans that submit data to multiple states, and also
• reduce the burden on OSHPD to maintain and update a proprietary format and data submission guide
APCD-CDL™ Overview

• Developed by consensus (States, Payers, Vendors)
   Largely aligns with existing state APCD data submission guides
   Fields were added, deleted and definitions and formats were aligned across states

• States are moving towards adopting APCD-CDL™
   Virginia updated their submission rules
   Most states will require rule/reg changes
   Is a cost associated with converting existing format to the APCD-CDL™
APCD-CDL™ Format

- Selecting the flat file format by using the APCD-CDL™
  - Payers supportive of the flat file
  - Vendors in space familiar/have capacity

- Both the Post Adjudicated Claims Data Reporting (PACDR) guide and the National Council for Prescription Drug Programs (NCPDP) developed by consensus as the transactional HIPPA standard guides NY adopted

- APCD-CDL™ includes references to the PACDR/NCPDP and national standards code sets
  - When National Standards are updated APCD-CDL™ will update

- Not all APCD-CDL™ elements included in the PACDR/NCPDP-and vice versa. Can be considered to be added
Phasing in of the APCD-CDL™

- Group that worked on developing the APCD-CDL™ agreed that all fields that meet the specifications are required if available (many caveats)
  - Special Conditions- e.g. Admitting diagnosis are only required for inpatient, Medicaid AID category only required for Medicaid claims
  - Not expected that all diagnosis and present on admission fields would be complete as there are 25 of each
  - States to leave blank if data was not collected- for example with R/E definition requires that unknown is only reported when members answers unknown or refuses to answer.

- Thresholds were not set for this reason. As the APCD-CDL™ is adopted more broadly it may be possible to develop common set of thresholds that vendors, states and payers agree on

- National Payers are familiar with the APCD-CDL™ elements-should be able to provide estimates to CA HPD on what is in their system to establish thresholds. California payers may take a little longer to get up to same %

  Test data for up to three years of historical data will assist develop the thresholds- these may change over time

- Request for exceptions to the threshold-vendors can automate these to approve or deny
APCD-CDL™ Maintenance Process

**Step 1**
- Submit Data Maintenance Request (DMR) Form
- (18 months)

**Step 2**
- APCD Council staff gather and de-duplicate all requests
- APCD Council staff will publicly post for 45 day review (on council website)*

**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.

**Step 4**
- APCD-CDL maintenance committee convenes and staff reviews the requests, comments and recommendations.
- The committee will then vote.

**Step 5**
- The committee sends a copy of the Comment and Response document to the requestors and posts on line.

**Step 6**
- Staff holds a webinar to review the approved changes.

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

Posted at https://www.apcddcouncil.org/common-data-layout
Review Proposed Approach / Draft Recommendations
Data Sources & Formats: Approach

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Healthcare Analytics and Data Linkages

Christopher Krawczyk, Ph.D.
Chief Analytics Officer
OSHPD
Risk-Adjusted Performance Reports

Coronary Artery Bypass Graft Outcomes
Reports on quality ratings for the state-licensed hospitals and surgeons that perform isolated coronary artery bypass graft (CABG) surgery.

Elective Percutaneous Coronary Intervention Reports
Outcomes reports on California hospitals certified to perform elective percutaneous coronary interventions without on-site cardiac surgery.

Volume of Cancer Surgeries Reports
Reports that show the annual number of cancer surgeries ("volume") performed at every licensed hospital in California.

Mortality Following Hip Fracture Repair Reports
Reports that provide performance ratings on hip fracture surgical repair at California's acute care hospitals.

Ischemic Stroke Outcomes Reports
Reports that provide information on the quality of ischemic stroke care at California's acute care hospitals.

AHRQ Quality Indicators
Quality indicators calculated from hospital inpatient discharge data using the methodology developed by the Agency for Healthcare Research and Quality.
### California Hospital Performance Ratings for Coronary Artery Bypass Graft (CABG) Surgery by Region, 2015-2016

#### CABG + Valve Operative Mortality 2015-2016

<table>
<thead>
<tr>
<th>Hospital</th>
<th>County</th>
<th>Performance Measure</th>
<th>Performance Rating</th>
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<tbody>
<tr>
<td>Mercy General Hospital</td>
<td>Sacramento</td>
<td>CABG + Valve Operative Mortality</td>
<td>Better</td>
</tr>
<tr>
<td>Sutter Medical Center</td>
<td>Sacramento</td>
<td>CABG + Valve Operative Mortality</td>
<td>Better</td>
</tr>
<tr>
<td>St. Joseph Hospital</td>
<td>Sacramento</td>
<td>CABG + Valve Operative Mortality</td>
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</tbody>
</table>

#### CABG Operative Mortality 2015-2016

<table>
<thead>
<tr>
<th>Hospital</th>
<th>County</th>
<th>Performance Measure</th>
<th>Performance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy General Hospital</td>
<td>Sacramento</td>
<td>CABG Operative Mortality</td>
<td>Better</td>
</tr>
<tr>
<td>Sutter Medical Center</td>
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<tr>
<td>St. Joseph Hospital</td>
<td>Sacramento</td>
<td>CABG Operative Mortality</td>
<td>Better</td>
</tr>
</tbody>
</table>

#### Post-Operative Stroke 2015-2016

<table>
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<th>Performance Measure</th>
<th>Performance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy General Hospital</td>
<td>Sacramento</td>
<td>Post-Operative Stroke</td>
<td>Better</td>
</tr>
<tr>
<td>Sutter Medical Center</td>
<td>Sacramento</td>
<td>Post-Operative Stroke</td>
<td>Better</td>
</tr>
<tr>
<td>St. Joseph Hospital</td>
<td>Sacramento</td>
<td>Post-Operative Stroke</td>
<td>Better</td>
</tr>
</tbody>
</table>

#### 30-Day Readmission Rate 2015-2016

<table>
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<th>Hospital</th>
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<th>Performance Measure</th>
<th>Performance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy General Hospital</td>
<td>Sacramento</td>
<td>30-Day Readmission Rate</td>
<td>Better</td>
</tr>
<tr>
<td>Sutter Medical Center</td>
<td>Sacramento</td>
<td>30-Day Readmission Rate</td>
<td>Better</td>
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<td>St. Joseph Hospital</td>
<td>Sacramento</td>
<td>30-Day Readmission Rate</td>
<td>Better</td>
</tr>
</tbody>
</table>

### Additional Information

- **Performance Report Products**
- **County**
- **Hospital**
- **Performance Measure**
- **Performance Rating**

---

**CABG + Valve Operative Mortality 2015-2016**

- **Mercy General Hospital**: Sacramento, Average: 0.58, Rating: Better
- **Sutter Medical Center**: Sacramento, Average: 1.67, Rating: Better
- **St. Joseph Hospital**: Sacramento, Average: 0.56, Rating: Better

**CABG Operative Mortality 2015-2016**

- **Mercy General Hospital**: Sacramento, Average: 8.32, Rating: Better
- **Sutter Medical Center**: Sacramento, Average: 5.24, Rating: Better
- **St. Joseph Hospital**: Sacramento, Average: 5.24, Rating: Better

**Post-Operative Stroke 2015-2016**

- **Mercy General Hospital**: Sacramento, Average: 1.76, Rating: Better
- **Sutter Medical Center**: Sacramento, Average: 1.58, Rating: Better
- **St. Joseph Hospital**: Sacramento, Average: 1.58, Rating: Better

**30-Day Readmission Rate 2015-2016**

- **Mercy General Hospital**: Sacramento, Average: 5.03, Rating: Better
- **Sutter Medical Center**: Sacramento, Average: 4.36, Rating: Better
- **St. Joseph Hospital**: Sacramento, Average: 4.36, Rating: Better

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**Core Measures**

- **CABG**: Criterion 1: Internal Mammary Artery Use 2016
- **CABG + Valve**: Criterion 2: Relative Value

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**Endnote**

Performance Report Products are used to evaluate the performance of hospitals and surgeons in performing isolated coronary artery bypass graft (CABG) surgery.
Data Request Services

California Hospitals and Health Departments
Limited Data Sets

University Researchers
Research Data Requests

Committee for the Protection of Human Subjects (CPHS)
Learn more about CPHS and the review of research projects involving human subjects

Customized Data Services
Custom Analyses

Publicly Available Data
Public Use Files, and the CHHS Open Data Portal

About OSHPD Data
Get more information about the types of data and data requests
Data Pulse ~

Severe Sepsis: 30-Day Mortality

Sepsis is caused by the body’s inflammatory response to uncontrolled infections, and it impacts over 1.5 million people in the United States yearly (CDC: Vital Signs 2016). In California alone, sepsis charges totaled $16.8 billion in 2016. Sepsis is a preventable, life-threatening medical condition for which the number of cases and deaths has increased over the past several years. If not treated properly, sepsis can result in a severe condition with multiple organ failure (severe sepsis) and death.

This Data Pulse presents information on patients who were alive at 65 years. If not treated properly, sepsis can result in a severe condition with multiple organ failure (severe sepsis) and death.

Key Findings:

- In 2016, Hospice Care was the most common discharge category, surpassing skilled nursing facility.
- The percent of hospital-acquired severe sepsis patients who died within 30 days of discharge decreased appreciably, while the percent of non-hospital-acquired severe sepsis patients increased slightly.

Figure 1: Place/Locaiton where Severe Sepsis Patients were Discharged or Transferred to Among States Who Died within 30 Days of Discharge: 2010-2016

Information About Sepsis

The following symptoms are signs of sepsis: shivering, fever, or very cool, pale or dusky skin; shortness of breath, and high heart rate.

Alcohol-Related Emergency Department (ED) Encounters in California, 2008-2017

A recent national study on alcohol-related visits to emergency departments (ED) found a nearly 50 percent increase in these visits between 2001 and 2014 (Winkle et al., 2018). In response to this report, the Office of Statewide Health Planning and Development (OSHPD) explored whether a similar trend was occurring in California and found a 6.7 percent increase in alcohol-related ED visits from 2008 to 2017.

OSHPD examined both types of ED encounters: (a) “ED visits,” where a patient was seen in an emergency department (ED) encounter; and (b) “ED admissions,” where a patient was seen in the ED and directly admitted to a hospital for equivalent treatment of an alcohol-related episode.

Key Findings:

- There was a 6.7 percent increase in alcohol-related ED visits from 2008 to 2017, and a 35.9 percent increase for alcohol-related ED admissions (Figure 1). There was a decrease in the numbers of ED visits between the end of 2015 and 2017; however, this may be attributed to the implementation of the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM), which provides codes to identify medical conditions.

The total number of alcohol-related ED visits and admissions for males was almost twice as high as the number for females in 2017 (363,992 vs. 215,493) (Figure 2).

The number of alcohol-related ED visits and admissions increased for all four race/ethnicity groups (Non-Hispanic Whites, Hispanics, Blacks, and Asian/Pacific Islanders) between 2008 and 2017 (Figure 3). Asian/Pacific Islander and Hispanics showed the highest increases, 119.7 and 75.0 percent, respectively.
Data Linkage

• Previous Contractor
  • OSHPD administrative data to vital statistics data
    • Cross-sectional and longitudinal

• Previous OSHPD
  • California Coronary Artery Bypass Graft Outcomes Reporting Program (CCORP)
  • Risk-adjusted analyses involving mortality
  • Analyses of readmissions
Data Linkage - Current

- Machine learning
- Learning phases:

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2016 PDD with 2016 Death</td>
<td>• 2017 PDD with 2017 Death</td>
<td>• 2013-2018 PDD with Death</td>
</tr>
<tr>
<td>• 2015 PDD with 2015 Death</td>
<td>• 2015 PDD with 2015 Death</td>
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<tr>
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<tr>
<td>• 2016 ED with 2016 Death</td>
<td>• 2013-2018 ED with Death</td>
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</tr>
<tr>
<td>• 2016 CCORP* data with PDD and Death</td>
<td>• 2013-2018 CCORP* data with PDD and Death</td>
<td></td>
</tr>
<tr>
<td>• 2016 PDD with 2016 Birth</td>
<td>• 2013-2018 PDD with Birth</td>
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<td>• 2013-2018 ED with Birth</td>
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- CHHSA Record Reconciliation Project
Core Analytics Framework

1. Goal Identification
   - Audience Persona Development
   - What is the purpose of analysis and what key question will this analysis/visualization answer?

2. Knowing the Data
   - Variables
   - Data Preparation (Format/Tool etc.)
   - Do we have the data needed? What are the relevant variables that can help us answering the research question.

3. Data Preparation
   - What is the size and format of data set.
   - Prepare data to match the needs of analytical tool ODP/Tableau/ SAS.

4. Modeling & Analysis
   - Import cleaned data into the platform and create different models/options for analysis and management discussion.

5. Evaluation
   - (Any new insights?)
   - Did we answer the question? Did we discover new insights that can be used in the future?

6. Deployment
   - Data User Feedback
   - Outreach & Engagement
   - Beginning of Product Release & Distribution Process (See next slide)

   - Summarize results, strategize how to distribute information, identify distribution channels. Tell the Story.
Developing the Infrastructure

(Complete Patient Experience Data)

(Data OSHPD Collects)

(Data OSHPD Collects)
Healthcare Analytics

- Administrative and Facility Data [Inpatient, ED, Ambulatory Surgery (limited)]
- Limited Clinical Data
- Limited Registry Data
- Financial Data
- Vital Statistics Data
- Population and Geographic Data

- Data Request Services
  - Researcher data sets, Limited data sets, custom analyses
- Risk-Adjusted Performance Reporting
- Volume and Utilization Reporting – Procedures and Conditions
- Data and Information Products
- Aggregated Data Products
- Open Data Portal
State FY 2019/2020

- Outreach visits to hospitals, partners, stakeholders
- Engagement of audience influencers and innovators
- White papering new collaborations
- New risk adjusted indicators
- Mapping and linking data assets
- Developing geospatial algorithms
- New product pilots (some with social determinants)
- Digitizing Data Request Services
- Product analytics and business intelligence
- Incorporating advancements via technology
Public Comment
Upcoming Review Committee Meeting: June 20, 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.
  - Opportunities for additional enhancements to the database

**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