SANATOR PROVIDER REGISTRY

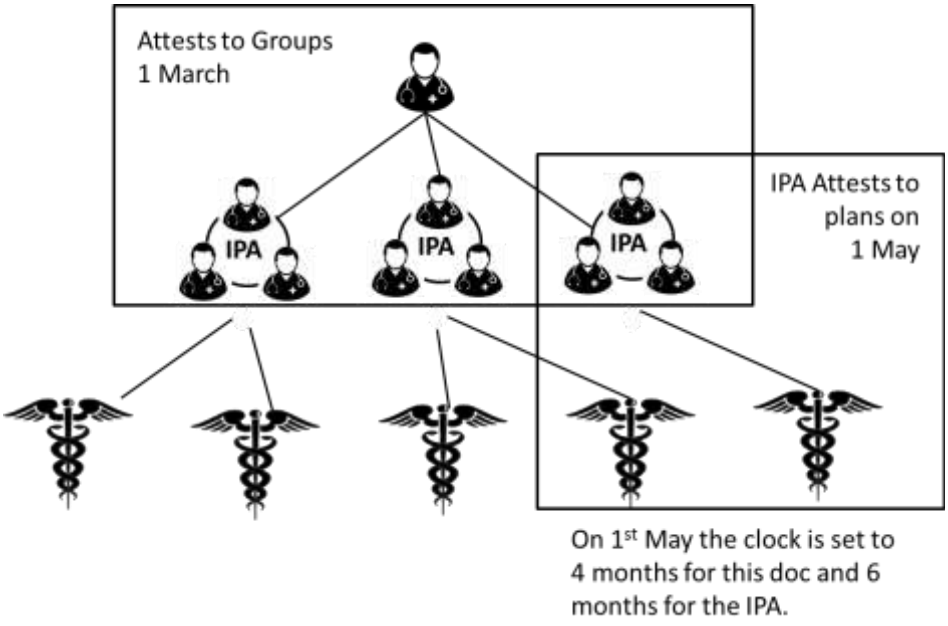
AGENDA	
Meeting Name/Topic:	SB137 Steering Committee
Date/Time:	May 18, 2016, 2:00 PST
Location:	https://global.gotomeeting.com/join/815585589 Bridge: (415) 449-0565, 9#, 1, 50713#

Attendees			
X	CapG - Bill Barcellona	X	Gaine - Martin Dunn (Facilitator)
X	DMHC - Mary Watanabe	X	Gaine - Rajan Shah
X	DMHC – John Boskovich	X	MedPoint - Carrie Hasson
X	Synermed - Tanya Bryan	X	MedPoint - Linda Deaktor
X	Synermed - Quincy Roberts	X	MedPoint - Claudia Fabrocini
	Sharp Rees Stealy - Vicki DeBaca		MedPoint - Jessica Rivas
X	Sharp SCMG - Rachelle Hernandez		
X	Sharp Health Plan - Mary Betlejewski		

Timeline	Topic	Resource
2:05 pm	• **Workflow Definitions**	**Martin Dunn**
	• **Security Admin Model**	**Martin Dunn**
	• **Ownership of Records**	**Martin Dunn**
	• **Data Quarantine Period**	**Martin Dunn**
	• **Coordination with AHIP**	**Bill Barcellona**
	• **Reporting needs of the Regulator**	**Bill Barcellona**
	• **Additional representation on the Steering Committee**	**Bill Barcellona**
	• **Date of Next Meeting**	**Martin Dunn**
3:00 pm	• **Session Ends**	

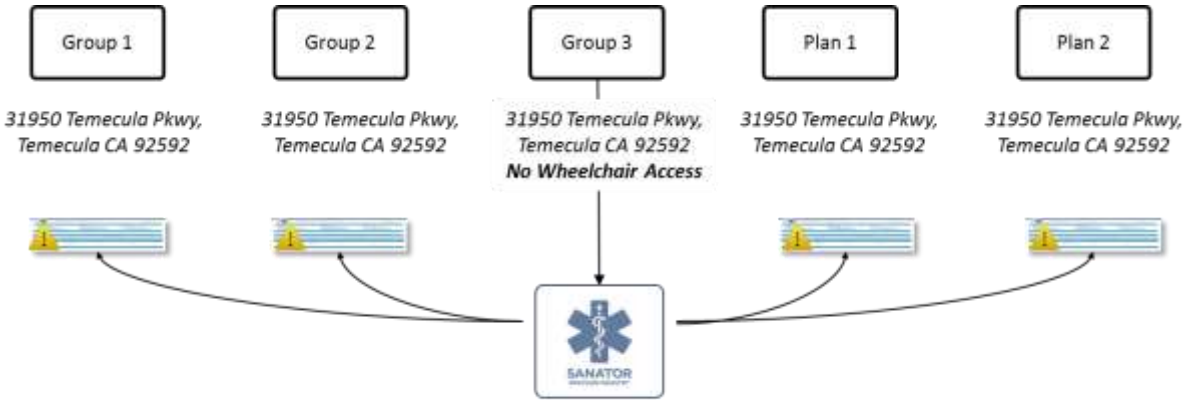
Notes

Topic: Workflow Definitions
Brief Summary: There is some clarity needed regarding attestation timelines. Does the Regulator believe attestations would happen on a specific date for all or can the attestations be on a rolling period based on the provider? To that, if a provider has a change in information that needs to be sent to the plan can that be considered their attestation?



Outcome Summary: The general consensus of the group was that rolling attestations would be the least burdensome to the provider and the organizations and would be the preferred method. Additionally, we understand that there are attestations a varying levels dependent on who holds the contract to the plans (either the individual provider or their provider organization) and that attestation dates need to be managed at those levels. The DMHC is still reviewing attestation requirements.

Topic: Data Quarantine Period
Brief Summary: Within the provider registry, we are able to identify conflicts and contested information about a provider. Given the scenario where a change in information leads to a conflict or a contestation of information between parties, we have put in place a quarantine period of 48 hours to facilitate resolving that issue and still be able to meet the 5 day turnaround outlined in SB137. Given the desire to ensure accurate information, can this period of time be extended so that incorrect information is not sent to the plans for the sake of meeting the timeliness deadline?



When key data attributes are in conflict and cannot be resolved within the registry, a notification is posted for all impacted groups.

Until the conflict is resolved and while data is in an uncertain state the Sanator registry will quarantine the conflicted data to avoid distributing potentially incorrect data to health plans.

The quarantine period can be set to any period of time.

Wheelchair Access at Location (example)	
Contributing records	5
Number of values (not null)	1
Corroborating records	0
Conflicting records	0

Outcome Summary: There was no objection to the idea of extending the quarantine period on data that may be in conflict to avoid submitting potentially inaccurate information to the plans. The group was aligned with the idea of potentially holding data in quarantine for as long as 10 days to allow for resolution, especially in circumstances where the provider may not be reachable in the existing 5 day period. This also posed no issue on the plan side regarding directory data resolution requirements of SB137.

Topic: Ownership of Records
Brief Summary: The topic of ownership of records has come up in numerous conversations. Our model allows for multiple owners of the information given the complexity of the contracting relationships a provider may have through their own PPO and group HMO arrangements. Given that, if a provider attests themselves can that cover all their provider organizations?

Additionally, who owns the attestation of the facilities information?

Outcome Summary: There was a consensus to the concept that if a provider attests themselves that it could also cover their multiple provider organizations as long as those provider organizations have visibility into the profile that is being attested to. The DMHC will continue to monitor as that process becomes more defined to ensure that it is acceptable.

The attestation of a facility was not discussed. It will be added to the next steering group agenda if the issue is deemed to be unclear or impactful to the members.

Topic: Security Admin Model
Brief Summary: Can an individual provider have a delegated administrator submit on their behalf? Additionally, does the regulator see any issue with Gaine submitting directly to the plans on behalf of the groups who have contractually signed with Gaine for that service?

Outcome Summary: The concept of a delegated administrator for a provider to facilitate submitting information was not in objection by the group.

Topic: Coordination with AHIP
Brief Summary: There is obvious effort also being put in by AHIP via Better Doctor. Within our provider registry model, we have factored in how that initiative could continue and be another source for the overall provider registry. What are the Regulator's thoughts? Were there other specifics for how the Regulator saw collaboration and coordination between the providers and plans?

Outcome Summary: This will further be discussed during a meeting with the DMHC on 5/26.

Topic: Reporting needs of the Regulator
Brief Summary: Given the filings the plans have had to file with the Regulator, what are the Regulator's thoughts on reporting needs? With the plans' filings so close to July 1, can the reporting needs be extended so that the providers can have the necessary time to review the requirements being set forth within the filings? It would be ideal to get the filing information so that it can be reviewed as soon as possible. Notice period for them to change it?

Outcome Summary: The regulator is still reviewing the plans filings to understand the reporting needs. CAPG has filed paperwork to get that information and all parties are awaiting what the final reporting needs are. There will be reporting standards that the regulator will be developing, but the expectation is that the first year will be challenging until those standards are set forth.

Topic: Additional representation on the Steering Committee
Brief Summary: Who else would best be suited for participating in the Steering Committee to help facilitate furthering the standards and work around SB137 compliance for both the providers and plans?

Outcome Summary: The Committee recommended adding representation of the clinics as well as the CMA. The Committee further agrees that expanding the representation would enable the Committee to have high quality discussions.