Q&A Session for
Are We There Yet—How Will We Know If Health Care Reform Is Working? Using OSHPD Data to Track the Impact of the Affordable Care Act on Access to Primary Care

Q: [During Sonier’s presentation] Who is going to collect this data?

From Julie Sonier: Much of the data needed for tracking the ACA’s [Affordable Care Act] impacts on coverage, affordability and comprehensiveness, and access to care is already collected through numerous sources. Where gaps exist, in many cases it is possible to fill them by adding to existing data collection infrastructure. The SHADAC report available at www.shadac.org/publications/framework-tracking-impacts-affordable-care-act-in-california and provides extensive detail on existing data sources and potential ways of filling the gaps in existing data.

Q: The issue of affordability has been recently highlighted because it poorly reflects the true cost. The financial burden is calculated based on a single insurance policy and not family coverage, which is considerably high. How does this group address this issue?

From Julie Sonier: The measure of financial burden in SHADAC’s recommended framework is calculated at the family level, in order to reflect the financial burden of insurance premiums and out of pocket spending on family budgets. This issue is a concern for many reasons, including the concern expressed by the questioner about whether the premium subsidies available through the exchanges will adequately address affordability problems faced by families for employer-based coverage. (Proposed federal regulations relating to eligibility for premium tax credits to purchase coverage through the health insurance exchange define “affordability” based on the percentage of income that a family would have to pay for employee-only coverage through an employer. The concern that has been expressed is that since employee contributions for family coverage are typically much higher than for single coverage, some families that face high actual cost burdens may not be eligible for exchange subsidies.)
Q: Is there a budget for the data entry for items? Are you streamlining paperwork to bypass the number of people required to accomplish this? (Like Careware in FL)

From Julie Sonier: As noted above, much of the data recommended to track the impacts of the ACA in California is already available through existing sources. SHADAC’s recommendations about new data sources attempt to leverage existing data collections to the degree possible.

Q: Reviewing the priority measures for Access to Care for Individuals, were culturally and linguistically competent services considered as a barrier to care?

From Julie Sonier: Ability to access culturally and linguistically competent services could show up as a barrier to care in several of the recommended framework measures. It could be cited as a reason why people forgo needed care, or could be reflected in the measures that relate to difficulty getting access to care in a timely way.

Q: Different sources collect the data to inform the measures, but is anyone overseeing the analysis of the complete measure set?

From Julie Sonier: SHADAC’s work was funded by the California HealthCare Foundation, which is using the framework in its planning for how to monitor the impacts of health reform over time.

Q: In your priority measures, will you be tracking changes in employers offering coverage? e.g. some initially offer it, then drop out and elect to pay the penalty.

From Julie Sonier: Yes. This information is currently available in California, and it will be important to monitor changes over time. Understanding changes in the degree to which employers offer health insurance coverage is a key component of monitoring the ACA’s impacts over time, since the law relies heavily on the existing private health insurance system. The number of employers paying the penalty for not offering coverage is also a measure in the recommended framework.
**Q:** How do you propose to collect data on commercially insured Californians who obtain care from organized medical groups or solo practitioners to parallel your data from the state-designated primary care clinics?

**From Jonathan Teague:** OSHPD’s data collection authority derives from the specific licensing requirements to which health care facilities or providers may be subject. Organized medical groups and solo practitioners do not have any statutory obligation to report data to OSHPD and so are not included in our data.

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**Q:** Is it possible to get down to the county level?

**From Denard Uy:** The statewide dataset could be filtered down to county level and a variety of other geographical boundaries such as cities, MSSAs, Health Service Areas, and legislative districts. The Primary Care Clinics Pivot Profiles would allow for this in simpler format. Pivot Profiles are derived from the statewide dataset.

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**Q:** When do you anticipate the 2011 data being available?

**From Denard Uy:** We anticipate that the 2011 Final Primary Care Clinics Dataset will be available mid-October 2012.

**From Jonathan Teague:** The Public use files for the patient-level data (Patient Discharge Data and Emergency Department Data) are available now.

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**Q:** How reliable are the estimates for the patient numbers (versus the encounter numbers) from the data?

**From Denard Uy:** The data is self-reported by clinics themselves. However, our online reporting system checks data anomalies within a report and requires the report preparer to explain if needed. Also, our staff verifies the data reported.

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**Q:** How does OSHPD verify the self-reported data by providers?
From Denard Uy: The ALIRTS reporting system has built-in validation edits that checks the report for data that may seem incorrect or out of the norm. Report preparers are required to include an explanation for the error flags prior to submission of the report. OSHPD staff verifies the explanations provided by the report preparers and additional explanations or corrections are made to the report if necessary.

Q: What is the reason why County clinics are not required to report to the state? Do they report to another entity?

From Denard Uy: County-owned or operated clinics are not licensed by the CDPH, therefore are not required to submit the data to OSHPD. If they receive federal grant money, they typically submit the federal UDS data, which is similar to OSHPD data.

Q: How do you differentiate a preventative care visit from a regular doctor visit?

From Julie Sonier: The data for this measure would come from a population survey - so you would ask individuals whether they had a preventive care visit in the past year.

Q: Marian Mulkey from CHCF [California HealthCare Foundation]: more a comment than question. We're considering developing a portal/website to collect and present, on a regularly updated basis, data to track ACA implementation based on the SHADAC framework. Plans will be clearer by early 2013.