OHCA Draft Revised THCE Regulations – CAHP Comments (*dated 01/31/25*)			
Page	**Section**	**Draft Language**	**Comment or Recommended Edit**
1	§ 97445 Total Health Care Expenditures Data Submission.	(a) "Affiliated," as used in section 97449(d) of these regulations, refers to a situation in which an entity controls, is controlled by, or is under common control by another entity.	CAHP reiterates prior concerns shared about the definition of "affiliate," as noted in our comments on the cost and market impact review (CMIR) regulations. The Proposed Rule expands the definition of "affiliated" to broadly include affiliates or other entities that control or have financial responsibility for a health care entity. This provides an unlimited and overly broad scope of entities to be captured under the law, potentially pulling in out-of-state affiliates and other entities not intended to be included. To limit the broad scope of this definition, we respectfully request that OHCA clarify or add additional parameters around what is meant by "Affiliated."
2	§ 97449 Total Health Care Expenditures Data Submission.	"In order for the Office to measure total health care expenditures and per capita total health care expenditures, the reporting requirements for payers and fully integrated delivery systems to submit data and other information are as follows: (a) Who must submit. A payer or fully integrated delivery system shall be subject to the requirements of this Article if any of the following criteria in subsections (a)(1) through (3) are met: (1) The payer or fully integrated delivery system is a Medi-Cal managed care plan contracted with the State	Medi-Cal Managed Care Plans (MCP) provide the information requested for this Total Health Care Expenditures Data submission at a granular level. We highly recommends that OHCA work with DHCS to understand what data elements are available to eliminate overlapping efforts and to help plans avoid additional difficulties for reporting.

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		Department of Health Care Services to provide full scope benefits to 40,000 or more Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The number of Medi-Cal beneficiaries shall be calculated as of December 31 of each calendar year prior to the submission year."	
4	§ 97449 Total Health Care Expenditures Data Submission.	"(h) Annual Data File Submission Deadline. All registered submitters shall submit data files through the Data Portal annually by September 1 of the year following each reporting year as specified in the Guide."	OHCA should consider holding further discussions with Medi-Cal payers on this, as there are still many unanswered questions. Perhaps it makes more sense not to include a Medi-Cal Managed Care File in 2025, and instead further work with DHCS and MCPs to determine how best to leverage existing data at DHCS. Many payments from the State for the Medi-Cal providers (i.e., directed payments) are not yet settled by September of the year following each reporting year. We highly recommend that OHCA leverage the data that MCPs submitted to DHCS via MLR reporting to satisfy this data submission, because that data is already robust in the level of information it captures. We also recommend finalizing updates to the DSG earlier than March of the same year in which payers submit. Payers need time to adequately review changes and resource adequately to submit the files on time.

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N/A	General	General	It would be helpful if OHCA could provide more information on the anticipated timing of future updates to the Data Submission Guide. For example, will updates occur on an annual basis with stakeholder previews and opportunities to comment?
N/A	General	General	We recommend that OnPoint, OHCA's vendor, explore additional methods to streamline the error-handling process. One recommendation would be to implement a consolidated review process for payers to address all data file errors simultaneously, rather than engaging in an ad hoc approach. Last year, the submitted files would kick back error-by-error. This was a very tedious process where each time one error had to be fixed and then the file had to be encrypted again and another error would be kicked back. We recommend that OHCA update their error checking process to send a full list of errors just once so that the payer can resolve one time and reduce the back and forth. We also note that the requirement to submit files for each registered entity will simply make this error process/resolution even more arduous if it is like last year. This will also be more difficult with the addition of new APM and primary care files.
N/A	General	General	We recommend OHCA implement solutions to resolve data discrepancies for partial benefits reporting. This year's data submission guide instructs payers to estimate the expenses for members whose benefits are carved out (e.g., pharmacy). We warn that this requirement unduly creates an incomplete and potentially inaccurate picture for any given payer's year-over-year medical expenditure trend. It also creates an issue

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			regarding the comparability of medical expenditure trends across payers. We recommend that OHCA revisit this approach through ongoing discussions with stakeholders to develop an improved approach.
N/A	General	General	Prior to any enforcement action with payers or providers, OHCA should work with stakeholders to develop an appropriate risk adjustment methodology that normalizes for risk. Some payers are concerned that the age and sex data currently being collected is not adequate for this purpose. Without an effective risk adjustment approach, the resulting data may have issues around effectively measuring both payers' and providers' medical expenditure trend performance against the benchmark. We note that the ongoing hospital measurement discussions have significant risk adjustment per case mix adjusted (or CMAD) which goes much further relative to the payer risk adjustment.
N/A	General	General	We request that OHCA implement a robust data quality and feedback process between OHCA and health care entities (payers and providers) before any public reporting or potential enforcement. This is critical for the overall integrity of the program.
N/A	General	General	We recommend OHCA resolve timing issues with Medicare shared savings amounts. We note that payers' 2023 non-claims payments (shared savings) show what has actually been paid to providers as of September 2024. As a result, payers are not

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			reporting Medicare shared savings amounts for 2023 because they did not have these numbers to furnish at this time. Payers currently do not have these numbers because payers are waiting for the final Medicare STARS ratings as well as final Medicare revenue data. These data points are built directly into shared savings arrangements with providers. We recommend that OHCA either adjust its data submission timeline to a later date or revise its instructions so that payers can estimate these shared savings amounts to the best of their ability for the prior benefit year. If OHCA pushed back the submission date, it would need to be in January two years after the benefit year based on the expected timing for Medicare data from the Centers for Medicare and Medicaid Services (CMS) (e.g., a January 2026 submission date for 2025 benefit year shared savings payments).
6	1.2. Data Submission Deadlines	"OHCA plans to release a report on health care spending for covered health care benefits received by California residents during calendar years 2023 and 2024 by June 1, 2026. For this report, payers and fully integrated delivery systems are required to submit THCE data on or before September 1, 2025."	We recommend OHCA allow for public input from payers on a report draft to ensure data is categorized and described accurately. For example, shifts in spending year-over-year may be due to membership changes, benefits mandates, and other factors.
11	3.1. Required Files	"Submitters reporting data for more than one health plan and/or health insurer shall complete separate file submissions for each registered	Requiring submitters reporting data for more than one health plan and/or health insurer to complete separate file submissions for each registered entity will have significant implications on the data.

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		entity. The total medical expenses reported for each registered entity shall be mutually exclusive."	• Sub-entities will have smaller data sets resulting in greater volatility in performance simply because it is a smaller data set with higher variances one year to the next. • Some sub-entities have closed blocks of business which can create odd year-over-year results and performance. • Sub-entities will have greater membership mix changes from one year to the next, which can also create odd year-over-year results and performance. • This change would necessitate multiple legal entities to submit separately, complicating the reporting structure and hindering comparative analysis.
12	3.1.1. Special Requirements for Medi-Cal Data Submission in 2025	"In 2025, submitters are required to report data for the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories in the APM and Primary Care files; submission of Medi-Cal Managed Care data in TME files is voluntary (TME files are enumerated as 1 through 5 above). In 2026, OHCA plans to collect data for all market categories in all files. The table below shows the required (R) and voluntary (v) files for each market category for the 2025 submission."	Medi-Cal Managed Care Plans (MCP) provide the information requested for this Total Health Care Expenditures Data submission at a granular level. We highly recommends that OHCA work with DHCS to understand what data elements are available to eliminate overlapping efforts and to help plans avoid additional difficulties for reporting.
14	4.1.1. Claims Payments	"Submitters shall allow for a claims run-out period of at least 180 days after December 31st of the	Many payments from the State for the Medi-Cal providers (i.e., directed payments) are not yet settled by September of the

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		most recent reporting year (i.e., June 30, 2024 2025 for 2022 and 2023 and 2024 service dates) to allow for continued claims adjudication. Claims shall be included based on the incurred date or date of service, not the date paid or reconciled. Incurred but not reported (IBNR) or incurred but not paid (IBNP) factors shall not be applied. Refer to Appendix A: Claims Service Category to Bill Code Mapping for more information on claims service categories."	year following each reporting year. We highly recommend that OHCA leverage the data that MCPs submitted to DHCS via MLR reporting to satisfy this data submission, because that data is already robust in the level of information it captures
16	4.3.1. Exclusions	"Submitters shall also exclude the following items from data submissions: • Discounts and other member perks, such as gym memberships Reinsurance recoveries or premiums • CMS reconciliation payments, such as Medicare sweep or Part D • Premiums • Affordable Care Act (ACA) risk transfer payments"	Page 16 requests that payers exclude "discounts and other member perks, such as gym memberships." Can OHCA clarify if this means that payers should exclude the cost of mandatory supplemental benefits on their Medicare plans? Additionally, Page 16 requests that payers exclude "CMS reconciliation payments, such as Medicare sweep or Part D Premiums." Since revenue is not reported in the THCE files, from what are payers excluding these payments?
16	4.4. Market Categories	1. "Commercial (Full Benefits) – The Commercial (Full Benefits) market category shall be used when a submitter is able to report information on all claims and/or capitation paid on behalf of a	We would like to confirm our interpretation that this is based only on benefits, and not based on funding source. For example, there may be an instance where a fully insured plan has carved out a pharmacy benefit. We would like confirmation that this would fall under partial, not full, benefits. Additionally,

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		member and the submitter is responsible for all covered benefits including pharmacy. In this scenario, the submitter has a complete picture of the member's total medical expenses, even in the case where a capitated, delegated organization pays downstream claims." 2. "Commercial (Partial Benefits) – If the submitter does not have all of the information on claims and/or capitation paid on behalf of the member (e.g., self-funded pharmacy), the submitter shall use their Commercial (Full Benefits) population spend to create an estimate of expenses for those members on a PMPM basis. The estimate will be added to the spending for members for whom certain benefits are carved out (e.g., pharmacy). The total medical expenses for these members shall be reported in the Commercial (Partial Benefits) market category to indicate a portion of spending has been estimated, and the estimated amounts must be reported in the Submission Questionnaire file."	we would like clarification on whether Medi-Cal Managed Care Plan data would be categorized, given that many mental health and substance use services are excluded from the benefit, as well as the pharmacy. We also request that OHCA remove the requirement to provide estimates where there are partial benefits. Given that plans do manage the other parts of the benefit, we do not think that estimating the costs using full benefits will be helpful, given the resourcing this will require.
18	4.5 Member Attribution	"Member attribution should be performed in the following order: 1. First, identify members for whom utilization management and claims payment functions have been delegated	We continue to highlight that this matching will be difficult without OHCA-issued TINs and NPIs, and given the updates to the addendum this year. Plans would appreciate further discussion on how best to further develop the addendum.

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		to an organization listed on the OHCA Attribution Addendum through a capitated payment arrangement. Report data for these members using the Capitated, Delegated Arrangement attribution method."	
23	4.8.1. Payment Allocation for Payment Arrangements	• "Step 1: Attribute members to the appropriate payment subcategory based on the payment furthest along the continuum of clinical and financial risk." • "Step 2: The total medical expenses for the member should be reported in Total Amount Paid/Allowed (APM008), including all claims, non-claims payments, and the member's financial responsibility. Payments shall not be capped, truncated, or risk-adjusted."	Regarding Step 1, we would like OHCA to confirm the hierarchy for payment categories, as we assume that A at the bottom. Regarding Step 2, given that paid and allowed amounts are different, we request this be changed to "allowed" amount to clear any confusion. Additionally, can OHCA clarify what risk adjusting the reported payments looks like? How should submitters handle capitation based on risk-adjusted revenue?
24	4.9. Primary Care Allocation Methodology	Entire Section	Similar to the above comments, for Managed Care Medi-Cal, MCPs have been submitting all claims and encounters data to DHCS at the service line level that should be able to be summarized. Therefore, we highly recommend that OHCA work with DHCS to understand what data elements available and can be leveraged for this submission to lessen burdens on MCPs for this additional reporting requirement.

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24	4.9.1. Primary Care Paid via Claims	Entire Section	1. Step 2 – Can OHCA clarify why plans have to crosswalk providers to their Annual Network Review file? The concern is that this additional step seems unnecessary. The Annual Network Review file is created annually and therefore only a snapshot of the plan's network. Further limiting the claim subset by the Annual Network Review file will result in excluding legitimate claims. What is the rationale? 2. Step 4 – The logic allows for administration of vaccinations to be considered a primary care service. Many plans allow access to vaccinations through retail pharmacies to increase access to members. The logic does not allow plans to include those retail pharmacy costs because it did not occur in the office setting. Can this be corrected? 3. Step 4 – A big part of preventive costs are vaccines. Can OHCA clarify why only the administration of the vaccines is considered a primary care service and not the full cost of the vaccine?
26	4.9.2. Primary Care Paid via Non-Claims	"Identify payments with 'A' in Payment Category (PRC005) and 'A1' or 'A3' in Payment Subcategory (PRC006), respectively. • Include these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization. • Only include subcategory A1 and A3 payments to multi-specialty practices and	Regarding the first bullet, these care coordination fee (CCF) payments are typically allocated to C5-C6 and given that OHCA instructs elsewhere in the document to categorize spending in the category further along the continuum, we request that OHCA clarify that submitters should categorize these payments as C5-C6. This instruction as written implies that CCF payments for the PPO ACO population should be classified as A1 or A3. Regarding the second bullet, we recommend OHCA allow submitters to estimate such payments in scenarios where a practice receives capitation but A1 payments are not

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		health systems as primary care spending in Amount Paid for Primary Care (PRC008) if paid for a primary care program as identified by the payer."	distinguished as primary versus specialty care. This calculation could be performed similar to that in Figure 3 for D2 spending.
28	Figure 2	Equation for Allocating Shared Savings and Recoupments to Primary Care	How should payers account for the fact that encounter data is incomplete from providers?
32, 38, 45	5.3. Statewide TME File; 5.4. Attributed TME File; 5.5. Regional TME File	Entire Section	Changes were made to the Statewide, Attributed, and Regional files with respect to the Member Responsibility field that are not consistent. We request that OHCA align all three files to be consistent. • Statewide file - the Member Responsibility was removed completely • Attributed and Regional files – Member Responsibility field was split into 2 – one for capitation and one for claims.
54, 57	5.8. Alternative Payment Model (APM) File; 5.9 Primary Care File	Payment Categories	Can OHCA confirm that the Payment Category=X: FFS in the Alternative Payment and Primary Care files does not include retail pharmacy?
67	Appendix B; Population Health and Infrastructure Payments	Population Health Payments is described as: "Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer	Can OHCA clarify why payer personnel and internal expenses not allowed? There are concerns that this is not consistent with the MLR regulations. An example is a health plan can decide to not pay a vendor to do care management for asthma and bring it in house. Under this interpretation, if the plan paid a vendor the plan could include costs, but if the plan does it in house

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		information technology systems or other internal payer expenses."	they cannot include. We recommend OHCA reconsider this exclusion and follow MLR guidelines for quality reporting.
96	HCPCS/CPT Primary Care Services	Entire Section	We request that OHCA add immunization related CPT codes, given that primary care providers often administer immunizations to patients. These would include CPT codes associated with office administered drugs and preventive immunizations.

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N/A	General	General	Can OHCA clarify why it removed so many organization names and parent names? What was the reason for the removal of all of these provider entities?
N/A	General	General	How should payers handle TINs and NPIs that repeat and cut across multiple organizations?
N/A	General	General	OHCA should explore pathways to ensure that provider entity spending is accurately attributed, reported, and consistently aggregated across payers for the program to be meaningful and effective. Asking payers to aggregate provider entity medical expenditures by name alone creates significant data integrity and provider attribution issues given that the names in payers' systems can take on a variety of spellings.

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			Without more specificity around defining provider entities, the reporting across payers is subject to individual payers' interpretation. As one alternative, OHCA might consider looking to the Integrated Healthcare Association AMP (Align. Measure. Perform) program. Per the OHCA Attribution Addendum (Addendum)2, payers would be instructed to map provider entities to the organization code in the Addendum in same manner as they do today for the IHA AMP program. There are significant benefits to this approach, including: • Consistency across payers: • Consistency with a well-established measurement program already in operation in the state; and • Leveraging an existing framework and approach that has familiarity and buy-in from both providers themselves and payers.

From: Roberts, Donna <Donna.Roberts@MolinaHealthCare.Com>
Sent: Thursday, January 30, 2025 12:42 PM
To: HCAI OHCA <OHCA@HCAI.ca.gov>
Cc: >>> MHC Government Contracts <MHCGovernment.Contracts@MolinaHealthCare.Com>
Subject: THCE Data Submission - Feedback on Proposed Updates to Regulations and the Data Submission Guide - Molina

Good afternoon,

Below are questions from Molina regarding the revised Data Submission Guide:

- Page 16 requests that we exclude “discounts and other member perks, such as gym memberships”. Does this mean we should exclude the cost of mandatory supplemental benefits on our Medicare plans?
- Page 16 requests that we exclude “CMS reconciliation payments, such as Medicare sweep or Part D Premiums”. Since revenue is not reported in the THCE files, from what are we excluding these payments?
- Page 23 requests that reported payments “not be capped, truncated, or risk-adjusted”.

What does risk adjusting the reported payments look like? How should submitters handle capitation based on risk-adjusted revenue?

Please let me know if you need additional information. Thank you!

Donna Roberts
Molina Healthcare of California
Government Contracts Program Manager
[redacted]
