Agenda Item V: Supplemental Data Collection: Non-Claims Data

Jill Yegian, HPD Consultant, HCAI

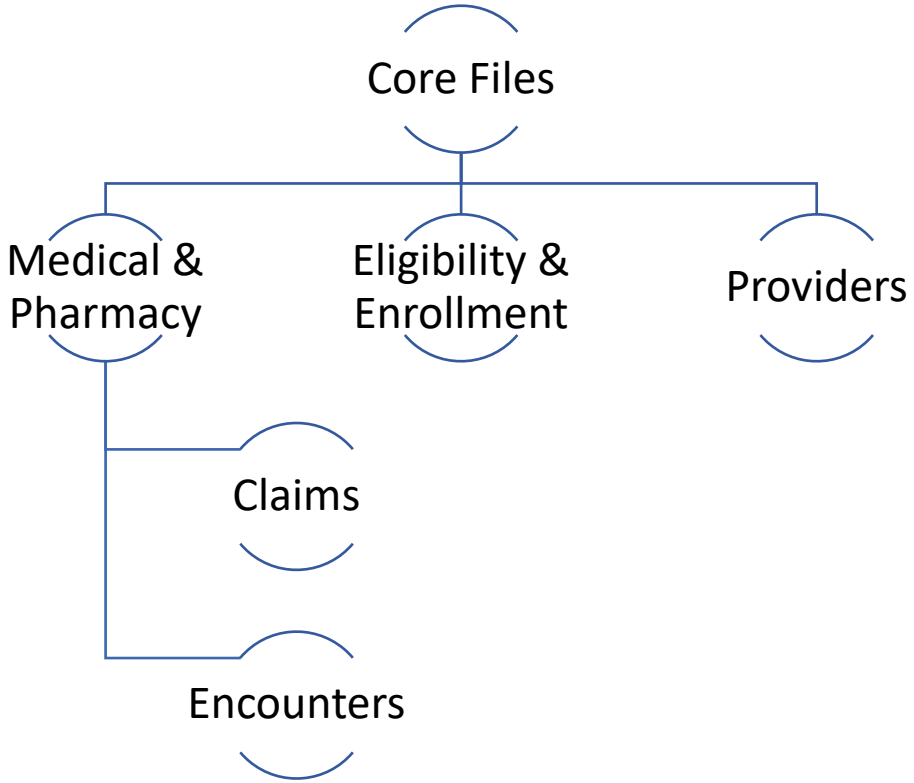
Non-Claims Data Collection for HPD

For Today

- Overview of non-claims data
  - What is non-claims data?
  - Importance of non-claims data in California's market
  - Use cases for non-claims data
- State APCD approaches to non-claims data collection and reporting
- Proposed approach to non-claims data collection for HPD

What is Non-Claims Data?

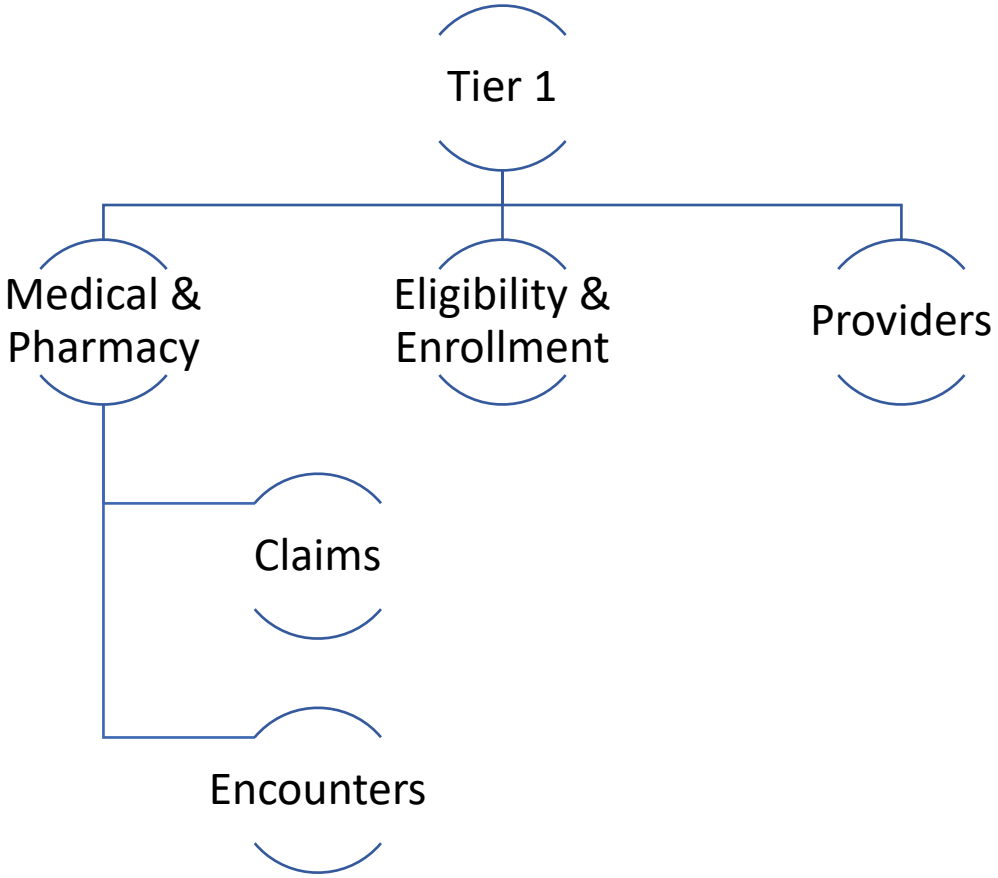
Core Files Do Not Include Important Payment Data



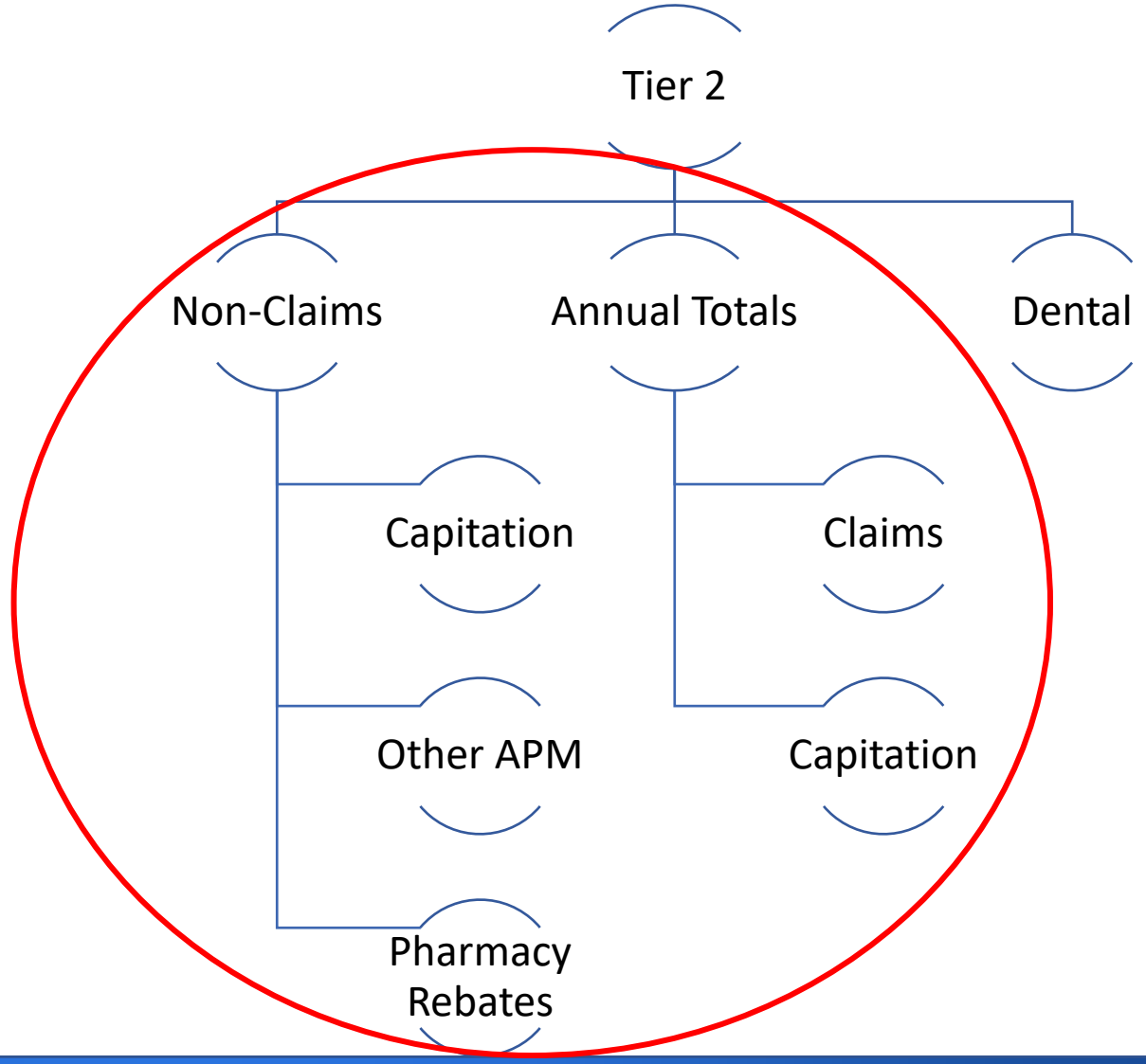
Payment data not included in HPD's core files:

- Capitation
- Performance incentives
- Health information technology incentives
- Shared savings or loss payments
- Care management fees
- Bundled payments
- Pharmacy rebates

Core Data (Tier 1)



Expansion Data (Tier 2)



APM = alternative payment model

Types of Non-Claims Data

Capitation	• Population-based payment, usually per member per month • May cover professional services, professional + facility, or other services as negotiated • Level = Member
Other Alternative Payment Models	• Varied and may be complex, intended to shift toward value • Examples include performance incentives, shared savings/risk • Level = Contract
Pharmacy Rebates	• Price concessions paid by a drug manufacturer to a pharmacy benefit manager or health plan • Level = Drug Class

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Data Source: Finance Department

- Non-claims data and annual totals are generated by the health plan/insurer's finance department for the prior year
  - Timeline needs to allow for runout, contract settlements (e.g., for shared savings),
- Contrast with claims and encounters, which flow from providers to payers for each service
- Annual totals are the plan/insurer's record of amount paid to each billing provider over the prior year
  - Claims
  - Capitation
- Annual totals for claims, capitation, other APMs, and pharmacy rebates estimate total cost of care

Importance of Non-Claims Data in California's Market

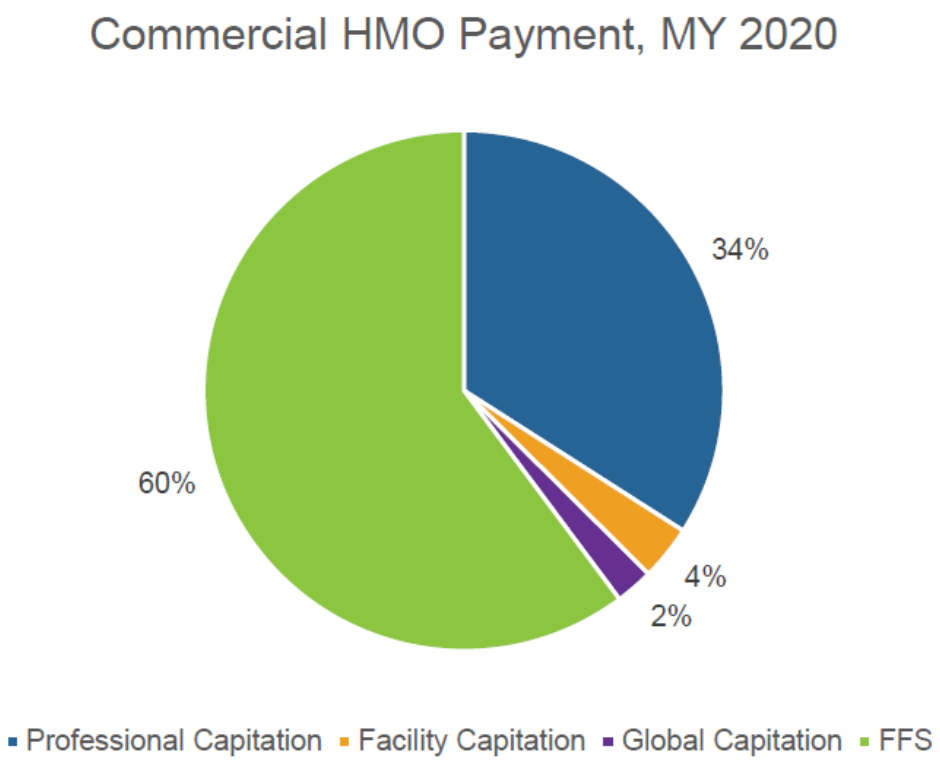
HPD Payers, Payment Arrangements, and Data

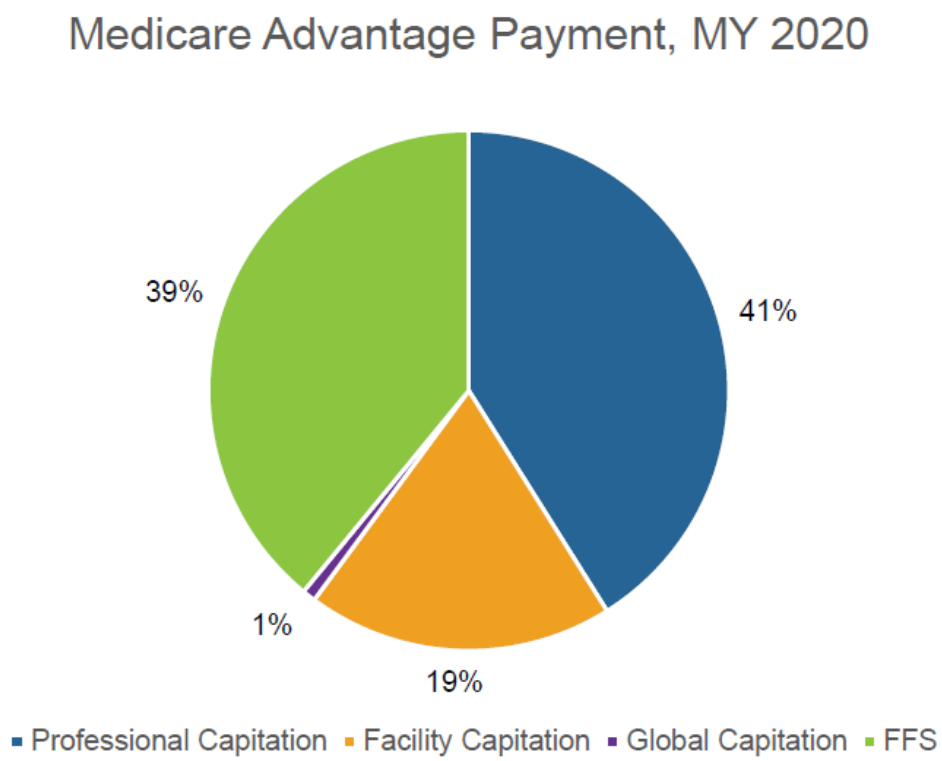
COVERAE CATEGORY		IVES (M)	PAYMENT ARRANGEMENTS AND DATA
Medi-Ca	Managed care	12.9	Health plans pay providers through a mix of capitation and FFS with some APMs, generating both claims and encounters; prescription drug coverage typically generates claims. Many complex additional payment streams in Medi-Cal.
	Fee for service (FFS)	2.0	DHCS pays providers directly FFS–claims generated.
Medicar	Medicare Advantage (Part C) and Medicare Advantage with Prescription Drug Coverage	2.9	Health plans/insurers pay providers through a mix of capitation and FFS with some APMs, generating both claims and encounters; prescription drug coverage typically generates claims.
	Fee for Service (Parts A, B, D)	3.5	CMS pays providers directly FFS – claims generated.
Commerial	Fully insured	14.1	Health plans/insurers pay providers through a mix of capitation and FFS with some APMs, generating both claims and encounters; rescription drug coverage typically generates claims.
	Self-funded (administrative services only)	5.5	

Source for enrollment data: Medi-Cal enrollment figures are for the month of July 2022, from Medi-Cal Monthly Eligible Fast Facts October 2022, Table 7; Medicare figures are for CY 2020, from CMS Program Statistics – Medicare Total Enrollment (table MDCR Enroll AB 2), CY 2020; commercial enrollment figures are for CY 2021, from CHCF's 2022 Edition – California Health Insurers, Enrollment (Katherine Wilson, Wilson Analytics).

Percent of total cost by payment type

Capitation accounts for 40% of total cost for Commercial HMO and 60% for Medicare Advantage





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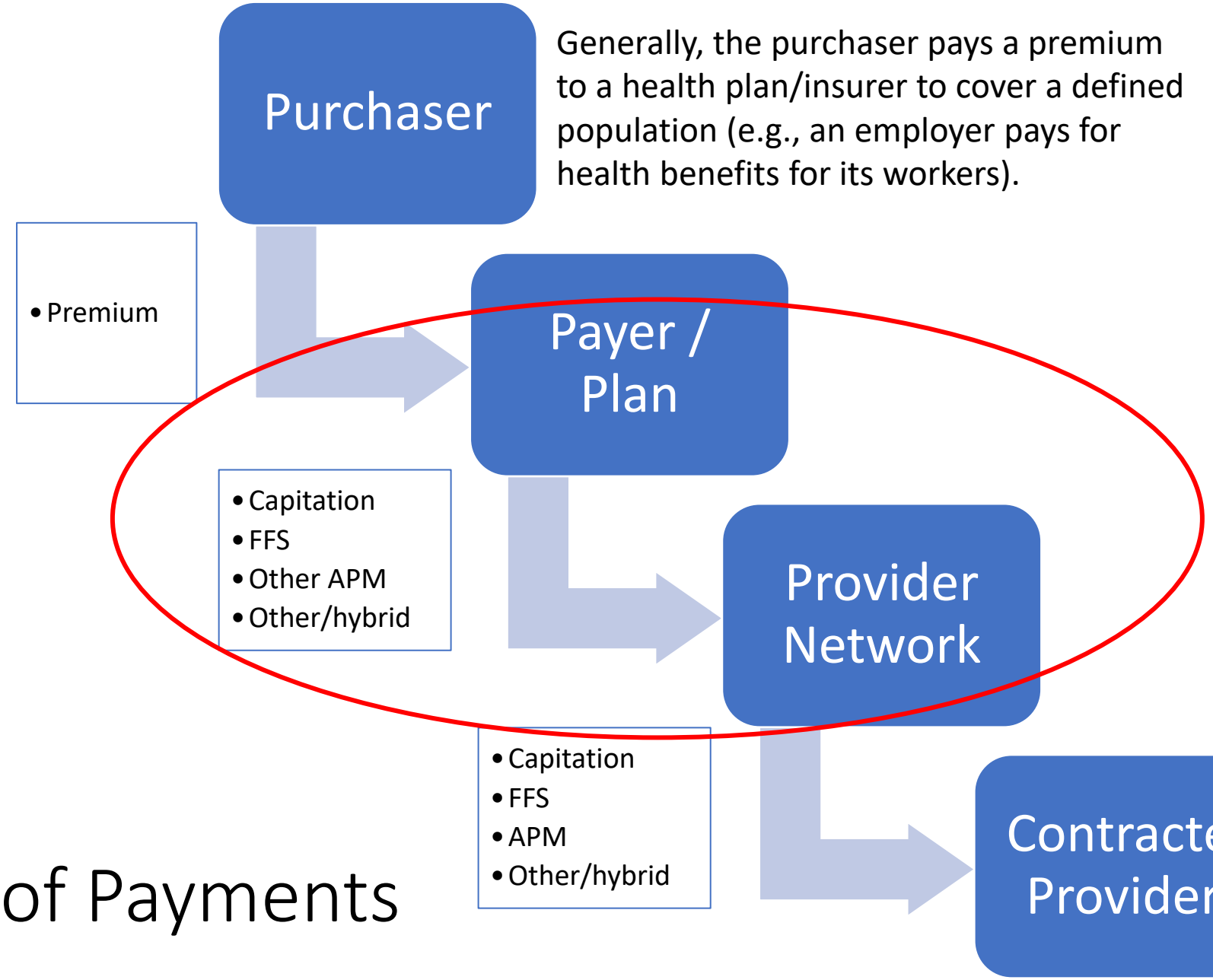
HCAI Department of Health Care Access and Information

Flow of Payments



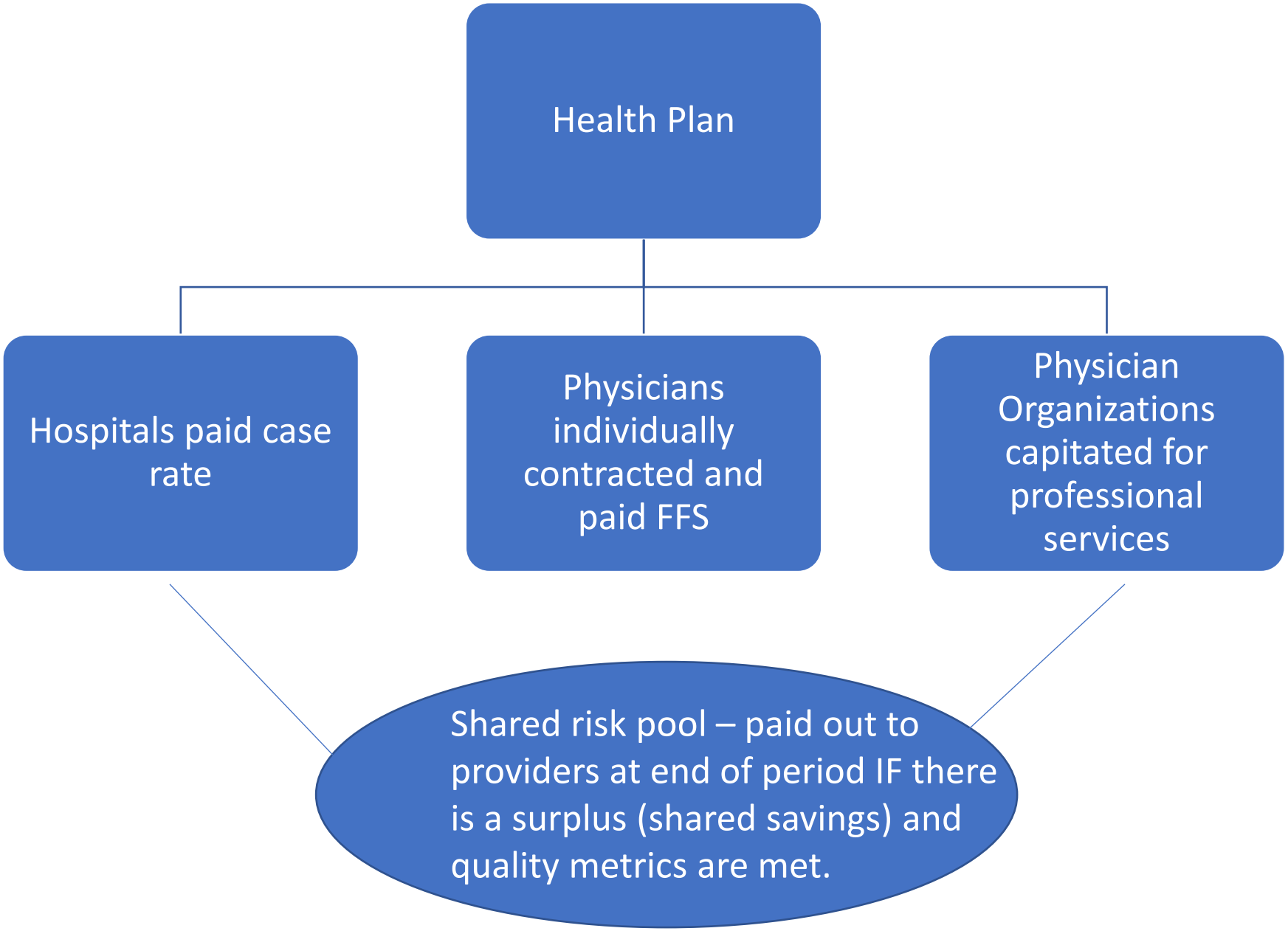
Generally, the purchaser pays a premium to a health plan/insurer to cover a defined population (e.g., an employer pays for health benefits for its workers).

Focus for today is payments from the plan to the provider network (red circle).

The health plan contracts with a provider network (e.g., hospitals, physician organizations, clinicians) to provide services to the population. That provider network may be paid capitation, fee-for-service, or other ways – or a hybrid.

The provider network may pay contracted providers using various payment models.

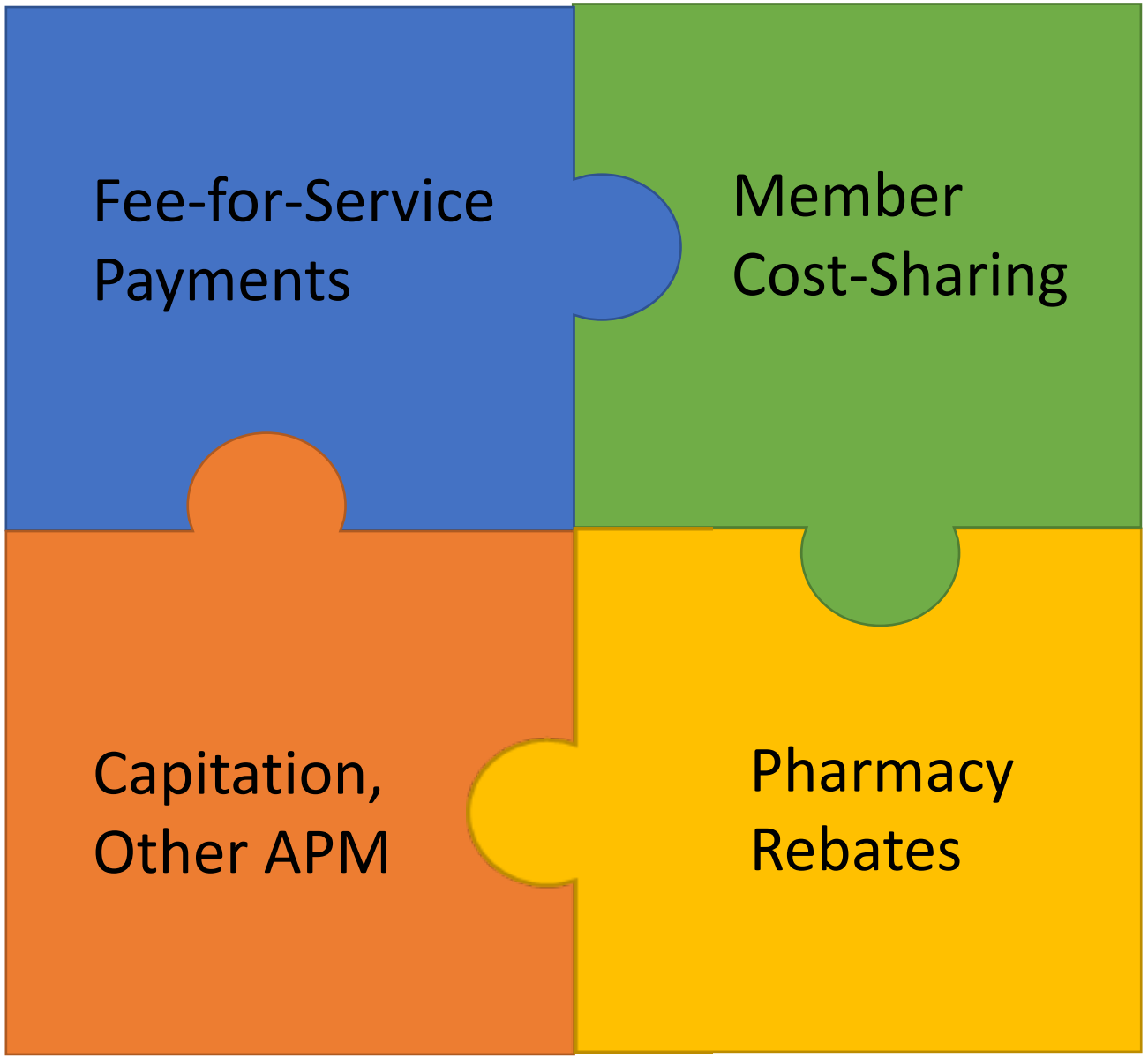
Payment Arrangement Example (Simplified)



Use Cases for Non-Claims Data

Total Cost of Care

- HPD will obtain FFS payments and member cost-sharing through submission of claims and encounters.
- HPD and HCAI's Office of Health Care Affordability (OHCA) will align on definitions and coordinate on collection of non-claims data, including capitation, APM, other non-claims, and pharmacy rebates.



Why does HPD need non-claims data?

- Annual totals for claims and capitation, along with other non-claims data (including pharmacy rebates) are needed for **total cost of care** (aka total medical expenditures), essential for variation and trend analysis.
- Total cost of care is needed for various analytics, e.g.:
  - Share of spending by service category such as inpatient, professional
  - Share of spending for primary care, behavioral health
- Capitation and other non-claims data will support a wide range of research questions, e.g. on the comparative effectiveness and cost of different models of care.
- Non-claims data will support OHCA's use cases.

Office of Health Care Affordability: Summary of APM-related Provisions

Intent: promote shifting from FFS payments to APMs that provide financial incentives for **equitable high-quality and cost-efficient** care.

OHCA will:

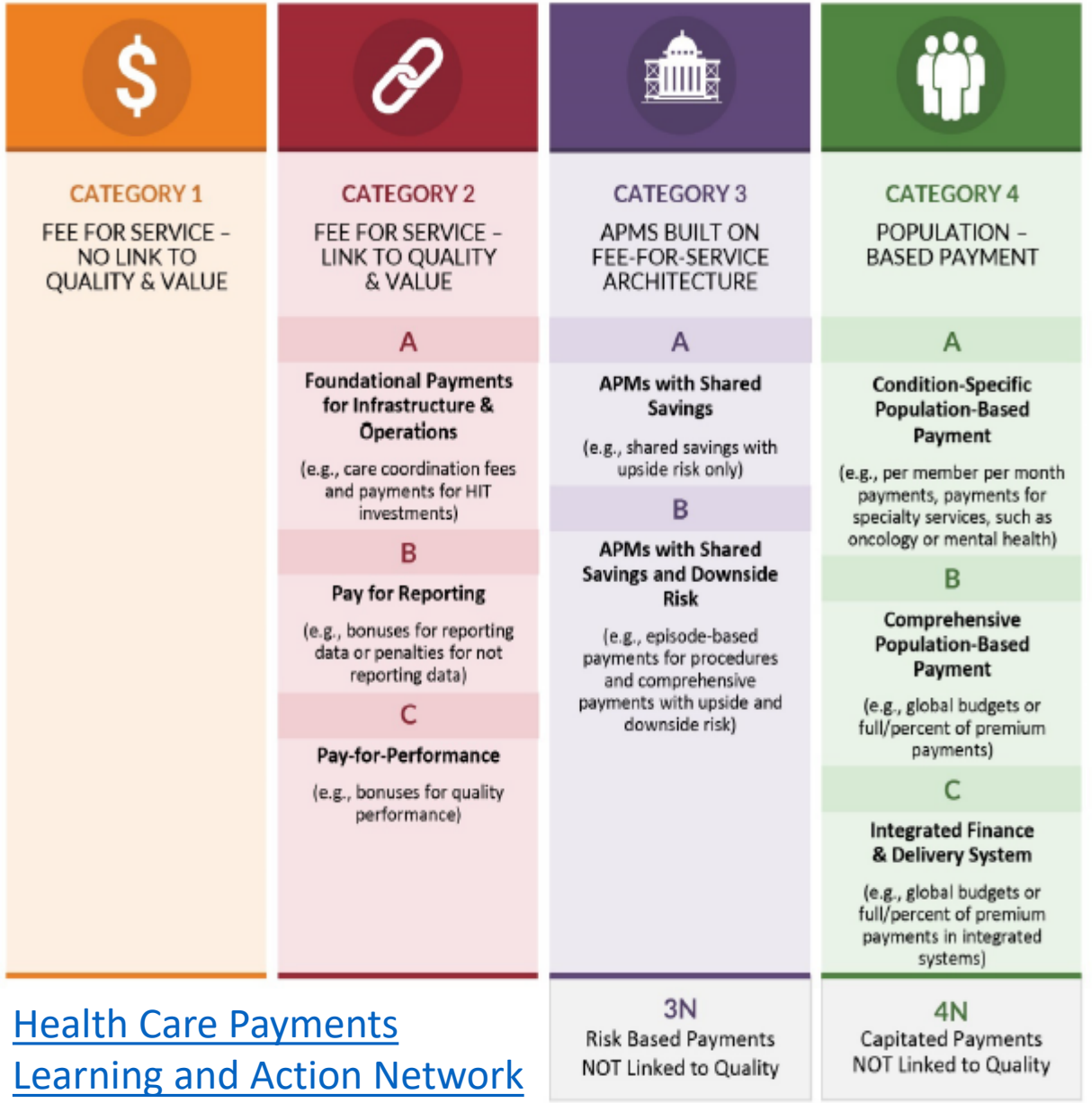
- set statewide goals for the adoption of alternative payment models, such as:
  - increasing share of total expenditures delivered through APMs
  - increasing share of membership covered by APMs
- measure the state's progress toward those goals.

OHCA reporting on APMs includes:

- types of payment models
- adoption by line of business
- number of members covered by APMs
- percent of budget dedicated to alternative payments, or cost and quality performance measures tied to those payment models

APM Payment Framework

- Created by the Health Care Payments Learning and Action Network (HCP-LAN)
- Describes the continuum of clinical responsibility and financial risk - “volume to value”
- Conceptual model – plans generally don’t pay providers exactly as represented here
- Not a perfect fit for California, e.g., capitation for professional services and primary care
- Adopted by Covered California for 2023 contract and by DHCS for 2024 contract
  - Plans required to report on APMs and primary care payment using HCP-LAN



Health Care Payments Learning and Action Network

Public Comment

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