OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

January 15, 2025

HCAI

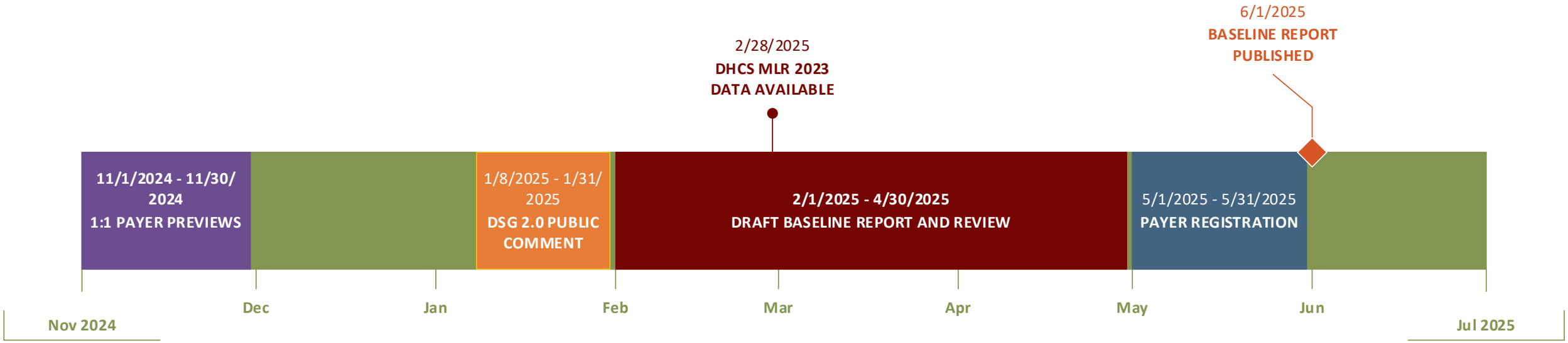
Department of Health Care Access and Information

Agenda

1. Baseline Report Update
2. 2025 Data Collection Timeline
3. Alternative Payment Model File Allocation
4. Primary Care Payment Allocation Methodology
5. Submitter Round Table
6. Next Steps

Baseline Report Update

Baseline Report Update



OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

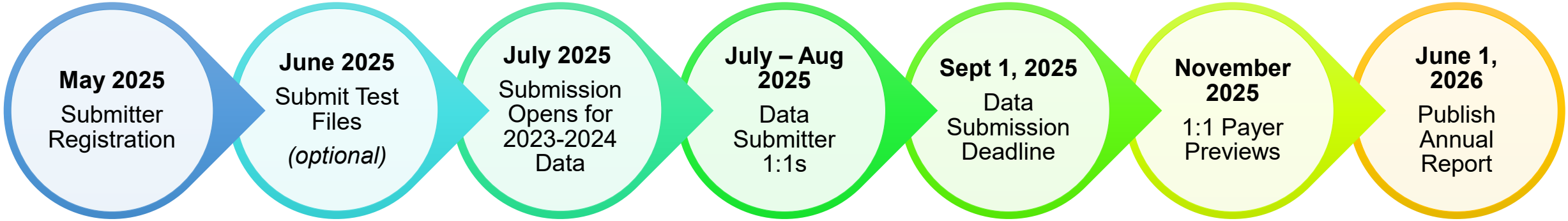
2025 Data Collection Timeline

2025 Data Collection Timeline

- Draft updates to regulations and DSG 2.0 released for public comment on January 8
- Comments due to OHCA@HCAI.ca.gov by **January 31, 2025**
- Anticipated submission to Office of Administrative Law in April

- Drafts available for review on HCAI's website: https://hcai.ca.gov/about/laws-regulations/

2025 Data Collection Timeline



Alternative Payment Model File Allocation

Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
1	APM001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	APM002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	APM003	Market Category	Integer	1	Use this field to report the market category code. Refer to Market Categories for more information. Valid values include: • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care • 4 = Medicare Advantage • 5 = Dual Eligibles (Medi-Cal Expenses Only) • 6 = Dual Eligibles (Medicare Expenses Only) • 7 = Dual Eligibles (Medi-Cal and Medicare Expenses)
4	APM004	Product Type	Integer	1	Use this field to designate the product type. Refer to Market Categories for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For other Market Categories, valid value includes: • 0 = Not applicable

Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
5	APM005	Payment Category	Text	1	Use this field to report the payment category. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include: • A = Population health and practice infrastructure payments • B = Performance payments • C = Shared savings payments and recoupments • D = Capitation and full risk payments • E = Other non-claims payments • X = Fee-for-service **Note**: This field shall correspond to a Payment Subcategory (APM006) that begins with the same character.

Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
6	APM006	Payment Subcategory	Text	2	Use this field to report the payment subcategory based on the initial character in Payment Category (APM005). Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include: • A1 = Care management/care coordination/population health/medication reconciliation • A2 = Primary care and behavioral health integration • A3 = Social care integration • A4 = Practice transformation payments • A5 = EHR/HIT infrastructure payments • B1 = Retrospective/prospective incentive payments: pay-for-reporting • B2 = Retrospective/prospective incentive payments: pay-for-performance • C1 = Procedure-related, episode-based payments with shared savings • C2 = Procedure-related, episode-based payments with risk of recoupments • C3 = Condition-related, episode-based payments with shared savings • C4 = Condition-related, episode-based payments with risk of recoupments • C5 = Risk for total cost of care (*e.g.*, ACO) with shared savings • C6 = Risk for total cost of care (*e.g.*, ACO) with risk of recoupments • D1 = Primary care capitation • D2 = Professional capitation • D3 = Facility capitation • D4 = Behavioral health capitation • D5 = Global capitation • D6 = Payment to integrated, comprehensive payment and delivery systems • E1 = Other non-claims payments • X9 = Claims: Total

Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
7	APM007	Quality Indicator	Integer	1	This field indicates when a payment arrangement is linked to quality. Submitters will provide data on arrangements linked to quality and those that are not for each Payment Subcategory in APM006. A payment arrangement is "linked to quality" if any component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings or capitation payment, then the payment would be considered "linked to quality". Refer to APM File Payment Allocation for more information. Valid values are: • 0 = No • 1 = Yes
8	APM008	Total Amount Paid/Allowed	Integer	12	Report the total of all payments made across billing providers during the reporting year. For non-claims payments, this is the amount paid by the payer or fully integrated delivery system across providers. For fee-for-service claims, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). Refer to APM File Payment Allocation for more information. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
9	APM009	Member Months	Integer	12	Report the total number of months of coverage for members in the arrangement indicated in Payment Category (APM005) and Payment Subcategory (APM006). All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows. **Note**: This field reported as an integer. When Payment Subcategory (APM006) is 'A4', 'A5', or 'E1', Member Months should be 0.

APM Allocation

- Data collected for payment arrangements linked to quality and those not linked to quality separately at the market category and product type level
- Payments and member months are mutually exclusive across payment subcategories
- Total medical expense and member months for members to be reported in the payment subcategory furthest along the continuum of provider clinical and financial risk
  - Claims and non-claims payments for the member shall be allocated based on the subcategory where the provider is most at risk for some or all of the payment made on behalf of the member
  - E.g., If the data submitter pays for care management (Payment Subcategory A1) on behalf of a member who is in a professional capitation arrangement (Payment Subcategory D2), then all claims and non-claims payments and member cost share will be reported in the row for the professional capitation arrangement.

Primary Care Payment Allocation Methodology

Primary Care File Layout

Col. #	Field ID	Field Name	Type	Max	Description
1	PRC001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	PRC002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	PRC003	Market Category	Integer	1	Use this field to report the market category code. Refer to Market Categories for more information. Valid values include: • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care • 4 = Medicare Advantage • 5 = Dual Eligibles (Medi-Cal Expenses Only) • 6 = Dual Eligibles (Medicare Expenses Only) • 7 = Dual Eligibles (Medi-Cal and Medicare Expenses)
4	PRC004	Product Type	Integer	1	Use this field to designate the product type. Refer to Market Categories for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For other Market Categories, valid value includes: • 0 = Not applicable

Primary Care File Layout

Col. #	Field ID	Field Name	Type	Max	Description
5	PRC005	Payment Category	Text	1	Use this field to report the payment category. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include: • A = Population health and practice infrastructure payments • B = Performance payments • C = Shared savings payments and recoupments • D = Capitation and full risk payments • E = Other non-claims payments • X = Fee-for-service **Note**: This field shall correspond to a Payment Subcategory (PRC006) that begins with the same character.

Primary Care File Layout

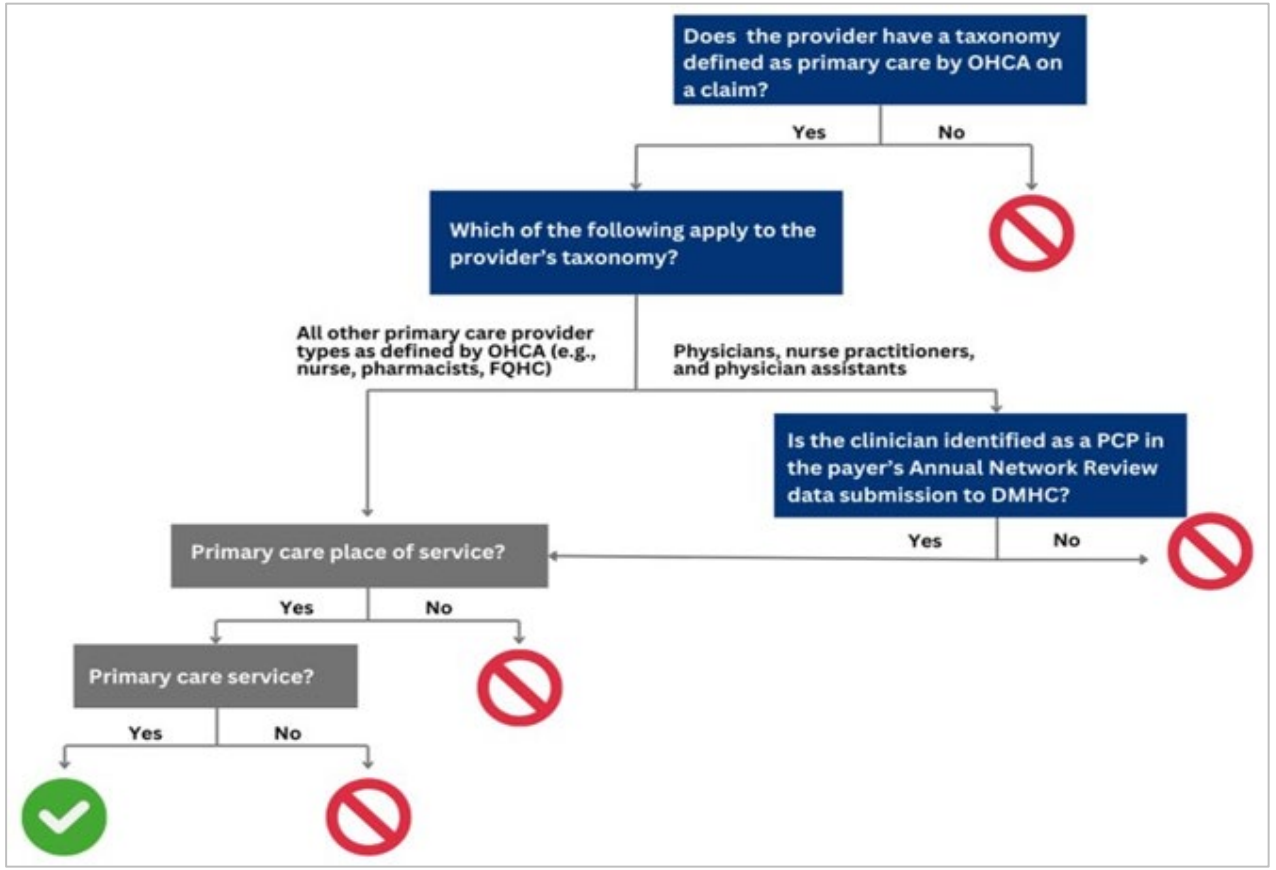
Col. #	Field ID	Field Name	Type	Max	Description
6	PRC006	Payment Subcategory	Text	2	Use this field to report the payment subcategory based on the initial character in the Payment Category (PRC005). Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include: • A1 = Care management/care coordination/population health/medication reconciliation • A2 = Primary care and behavioral health integration • A3 = Social care integration • A4 = Practice transformation payments • A5 = EHR/HIT infrastructure payments • B1 = Retrospective/prospective incentive payments: pay-for-reporting • B2 = Retrospective/prospective incentive payments: pay-for-performance • C1 = Procedure-related, episode-based payments with shared savings • C2 = Procedure-related, episode-based payments with risk of recoupments • C3 = Condition-related, episode-based payments with shared savings • C4 = Condition-related, episode-based payments with risk of recoupments • C5 = Risk for total cost of care (*e.g.*, ACO) with shared savings • C6 = Risk for total cost of care (*e.g.*, ACO) with risk of recoupments • D1 = Primary care capitation • D2 = Professional capitation • D3 = Facility capitation • D4 = Behavioral health capitation • D5 = Global capitation • D6 = Payment to integrated, comprehensive payment and delivery systems • E1 = Other non-claims payments • X9 = Claims: Total

Primary Care File Layout

Col. #	Field ID	Field Name	Type	Max	Description
7	PRC007	Total Amount Paid/Allowed	Integer	12	Report the total of all payments made across billing providers during the reporting year. For non-claims payments, this is the amount paid by the payer or fully integrated delivery system across providers. For fee-for-service claims, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
8	PRC008	Amount Paid for Primary Care	Integer	12	Report the total of all payments made across billing providers for primary care during the reporting year. For fee-for-service payments follow the instructions in Primary Care Paid via Claims to determine the portion allocated to primary care. For non-claims payments follow the instructions specific to each payment subcategory outlined in Primary Care Paid via Non-Claims. **Note**: This is a money field reported in whole dollars. This field may contain a negative value. When Payment Subcategory (PRC006) is 'C1', 'C2', 'D3', 'D4', or 'E1', Amount Paid for Primary Care should be 0.
9	PRC009	Member Months	Integer	12	Report the total number of months of coverage for members in the payment reported in Total Amount Paid/Allowed (PRC007). All months where a member had at least 1 day of coverage are counted. Member months shall **not** be mutually exclusive across all rows. **Note**: This field reported as an integer. When Payment Subcategory (PRC006) is 'A4', 'A5', or 'E1', Member Months should be 0.
10	PRC010	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format.
11	PRC899	Record Type	Text	2	Use this field to report the value of 'PRC' to indicate primary care reporting at the submitter level.

Primary Care Claims Payments Allocation Methodology

- All primary care claims payments are a subset of professional claims
- Appendix E: Primary Care Code Sets defines the primary care provider taxonomies, the places of service, and the services that must be present on a claim for inclusion in primary care spending
- Physicians, nurse practitioners, and physician assistants must be identified as primary care physicians or primary care non-physician medical practitioners in the payer's Annual Network Review data submission to the Department of Managed Health Care



Primary Care Non-Claims Payment Allocation Methodology

Expanded Framework Category		Allocation to Primary Care Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments when paid to primary care provider, care team, or organization and for primary care programs such as care management, care coordination, population health, health promotion, behavioral health, or social care integration.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Include payments when paid to primary care provider, care team, or organization. Limit the portion of practice transformation and IT infrastructure payments that are allocated to primary care spending to 1 percent of total medical expense.
A5	EHR/HIT infrastructure and other data analytics payments	

*Include all Primary care and behavioral health integration payments when made to any provider organization.

Primary Care Non-Claims Payment Allocation Methodology

Expanded Framework Category		Allocation to Primary Care Spending
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include payments when paid to primary care provider, care team, or organization. Include performance incentives in recognition of reporting, quality, and outcomes of patients attributed to primary care providers in multi-specialty organizations.
B2	Retrospective/prospective incentive payments: pay-for-performance	

Primary Care Non-Claims Payment Allocation Methodology

Expanded Framework Category		Allocation to Primary Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not applicable.
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Limit the portion of risk settlement payments that are allocated to primary care spending to the same proportion that claims-based professional spending represents as a percent of claims-based professional and hospital spending.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments (Linked to quality)	

Shared Savings Primary Care Allocation Methodology

Subcategories C3-C6

Σ Shared Savings Payments

x

$$\frac{\text{Claims: Professional}}{\text{Claims: Professional + Claims: Hospital Inpatient + Claims: Hospital Outpatient}}$$

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Category C Primary Care Spend via Non-Claims

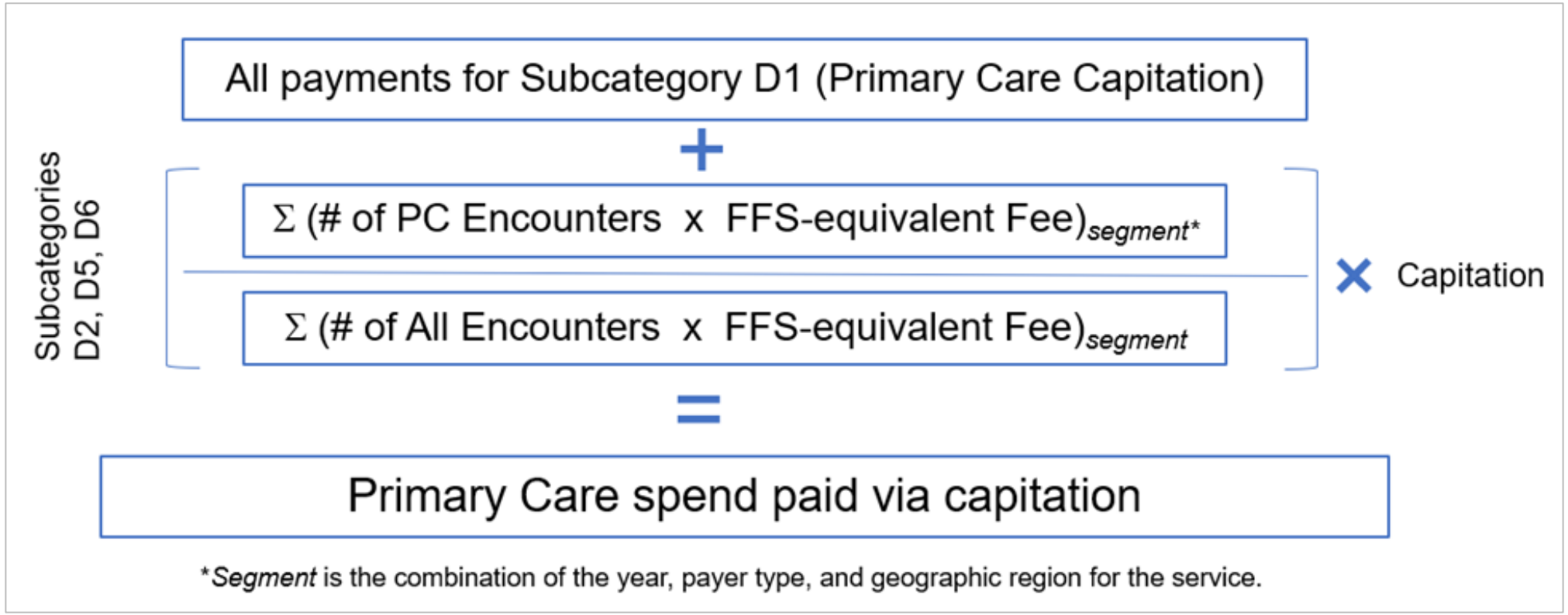
Primary Care Non-Claims Payment Allocation Methodology

Expanded Framework Category		Allocation to Primary Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Allocate full primary care capitation amount to primary care spending.
D2	Professional capitation	Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio.
D3	Facility capitation	Not applicable.
D4	Behavioral Health capitation	Not applicable.

Primary Care Non-Claims Payment Allocation Methodology

Expanded Framework Category		Allocation to Primary Care Spending
D	**Capitation and Full Risk Payments**	
D5	Global capitation	Calculate a ratio of fee-for-service equivalents for primary care services to fee-for-service equivalents for all services in the capitation. Multiply the capitation payment by the ratio.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	**Other Non-Claims Payments**	Not applicable.
F	**Pharmacy Rebates**	Not applicable.

Capitation Primary Care Allocation Methodology



Submitter Round Table

Next Steps

Next Steps

- OHCA kickoff with MCO plans – January 2025
- Next workgroup meeting – March 2025
- Topics
  - Regulations and Data Submission Guide updates
  - Annual Submitter Registration