OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

June 25, 2025

HCAI

Department of Health Care Access and Information

Agenda

1. Attributing Total Medical Expense
2. Overview of Onpoint CDM & Data Submission Best Practices
   - Reviewing submission errors in Onpoint CDM
   - Requesting a variance
3. Primary Care payment allocation
4. Submitter Round Table
5. Next Steps
   - Scheduling 1:1 Technical Assistance meetings

Attributing Total Medical Expense to Provider Orgs

Changes for 2025

- Attribution Addendum reduced to 145 organizations based on number of attributed lives received in 2024 submissions
- OHCA asked POs with the most attributed lives to confirm TINs and NPIs and added the information to the Attribution Addendum where possible
  - Commercial market POs with 50,000+ lives across all payers
  - Medicare Advantage market POs with 20,000+ lives across all payers

Reminder: Medi-Cal Managed Care market category data is not required in the Attributed TME file in 2025.

Changes for 2025

- When possible, submitters should match their data to both the **Organization Name and TIN** listed in the Attribution Addendum.
- Otherwise, continue to match on the **Organization Name only** and report the TIN used by the submitter to identify the organization in the Organization Taxpayer Identification Number field (ATT005) in the Attributed TME file.
- NPIs in the Attribution Addendum are provided as a secondary confirmation source, if necessary.

Attribution Methods

Attribution shall be performed in the following order of operations:

1. First, identify members in a **Capitated, Delegated Arrangement**
2. Next, attribute remaining members to an **Accountable Care Organization (ACO) Arrangement**
3. Use a **Payer-Developed Attribution** approach to attribute remaining members to any organization
4. Report any remaining members as **Not Attributed**

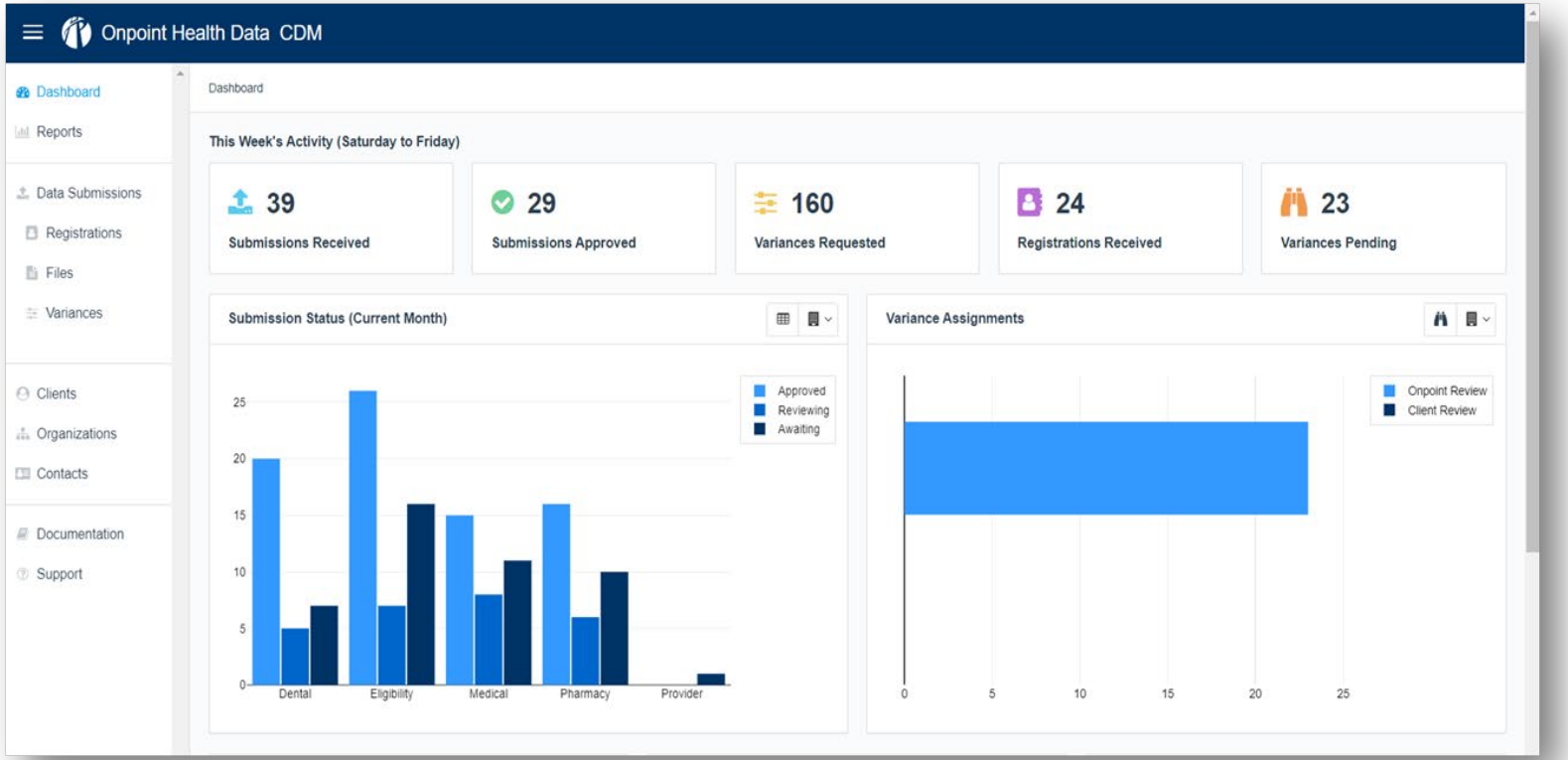
Attribution Reminders

- Members and their TME must only be attributed to one organization for any given month.
- Attributed TME must include all payments for the attributed members regardless of provider.
- Organizations not listed on the Attribution Addendum with at least 1,000 attributable members as of the last day of the reporting period (December 31, 2024) may be added using the Organization Code 7777.

Overview of Onpoint CDM & Data Submission Best Practices

Using Onpoint CDM – Functionality & Features

- Access provided to registered submitters
- Submit data
- Review quality and completeness
- Request variances
- Keep record of submission schedule
- Update your contacts
- Get 24x7 support / documentation



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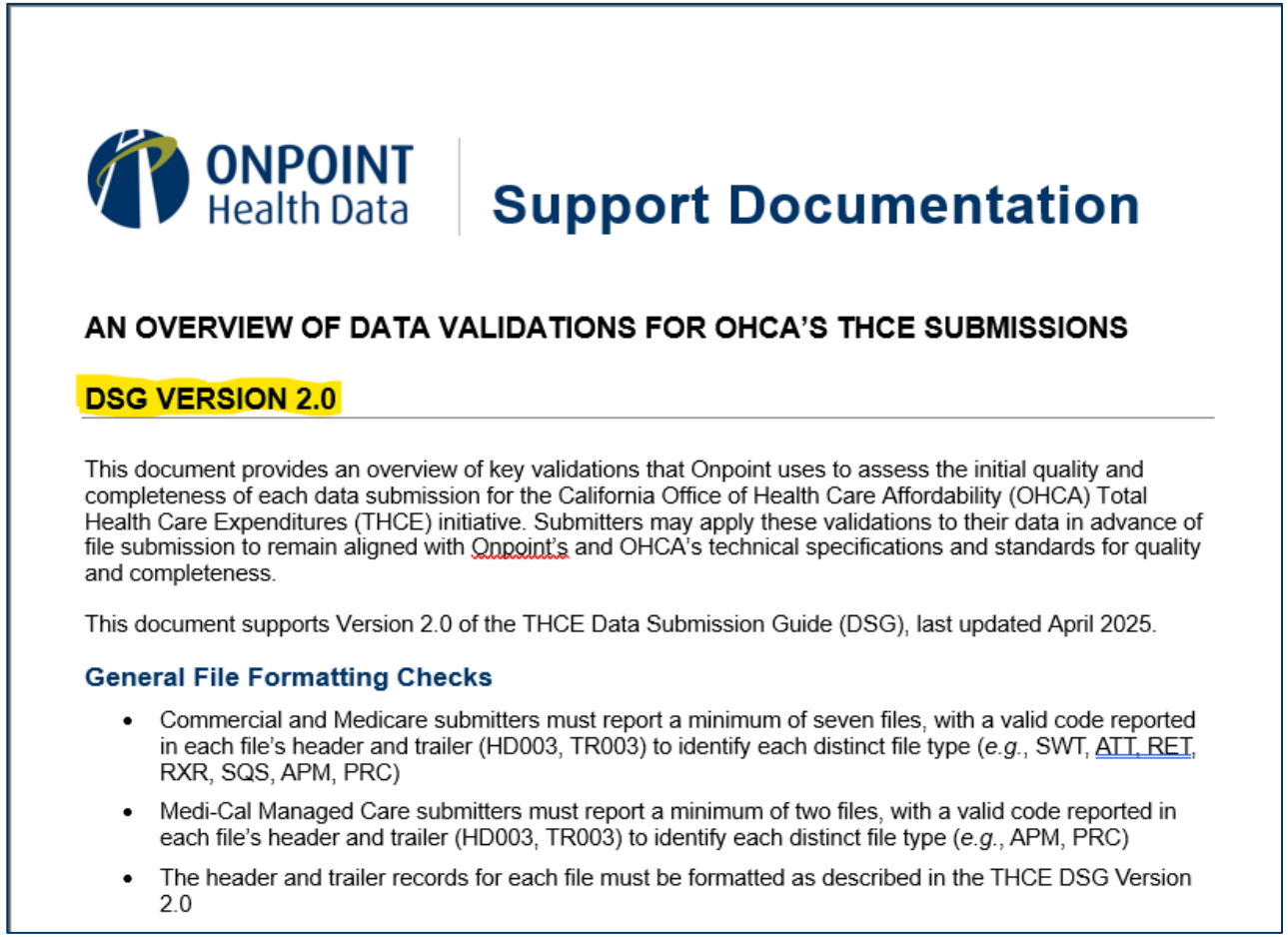
Gaining Onpoint CDM Access & Submitting Files

- To gain access to Onpoint CDM and submit files, the following items are required
  - Completed and approved submitter registration(s)
  - Submitter code(s) received and incorporated into submissions
  - Successful sign-in to Onpoint CDM (Claims Data Manager)
  - Public PGP key sent to Onpoint for data encryption
  - If submitter will be sending data via SFTP:
    - Public SSH key sent to Onpoint for SFTP connectivity
    - Confirmation from Onpoint of SFTP account creation

Data Validations

- Data submitted must comply with specifications outlined in the THCE DSG
- Validations documentation available in CDM details data quality checks performed on submitted data
- Two tier validation process:
  1) CDM validations
  2) Post data collection cross-file validation checks



ONPOINT Health Data | **Support Documentation**

AN OVERVIEW OF DATA VALIDATIONS FOR OHCA'S THCE SUBMISSIONS

DSG VERSION 2.0

This document provides an overview of key validations that Onpoint uses to assess the initial quality and completeness of each data submission for the California Office of Health Care Affordability (OHCA) Total Health Care Expenditures (THCE) initiative. Submitters may apply these validations to their data in advance of file submission to remain aligned with Onpoint's and OHCA's technical specifications and standards for quality and completeness.

This document supports Version 2.0 of the THCE Data Submission Guide (DSG), last updated April 2025.

General File Formatting Checks

- Commercial and Medicare submitters must report a minimum of seven files, with a valid code reported in each file's header and trailer (HD003, TR003) to identify each distinct file type (*e.g.*, SWT, ATT, RET, RXR, SQS, APM, PRC)
- Medi-Cal Managed Care submitters must report a minimum of two files, with a valid code reported in each file's header and trailer (HD003, TR003) to identify each distinct file type (*e.g.*, APM, PRC)
- The header and trailer records for each file must be formatted as described in the THCE DSG Version 2.0

Submitting Data Quality Variances

Element Description		Record Counts				Thresholds				Variance Information		
Code	Name	Total	Valid	Invalid	Null	Expected	Last Month Adjusted	Adjusted	Achieved	Status	Request Variance	Request Status
SWT014	Capitation and Full Risk Payments	33	25	0	8	100.00%	N/A		75.76%	FAIL	Request Variance	N/A

Variance Request Form

Please complete the form below to define your variance request. If you have any questions, please contact the Onpoint Administrator.

No prior variance found for this validation.

*** Adjusted Lower Threshold %**

75.51

Lower thresholds cannot be adjusted to be greater than the expected threshold.

*** Adjusted Upper Threshold %**

100.00

Upper thresholds cannot be adjusted for this validation.

*** Period Begin**

01/01/2021

Start dates will default to the first day of the selected month.

*** Period End**

12/31/2021

End date must not be later than the end of the reporting year.

*** Comments**

Add your comment here...

Onpoint Claims Data Manager (CDM) Demo

Data Submission Reminders & Best Practices

- Test PGP encryption early to avoid obstacles that may delay file submission
  - CDM opens for production submissions 7/1/2025
  - Production submissions are due 9/1/2025
- When submitting test files, populate 'T' in the "Test File Flag" (HD006) in each file's header
- If transferring data via SFTP: transfer files to your SFTP account's "TEST" directory
- Review the data validations documentation in CDM and reach out to OHCA/Onpoint with any questions
- Use CDM self-service functionality to track your file submission progress, review validation errors, and submit variances (if needed)
- For technical assistance or questions related to data specifications, mapping, or submission results: ohca-support@onpointhealthdata.org

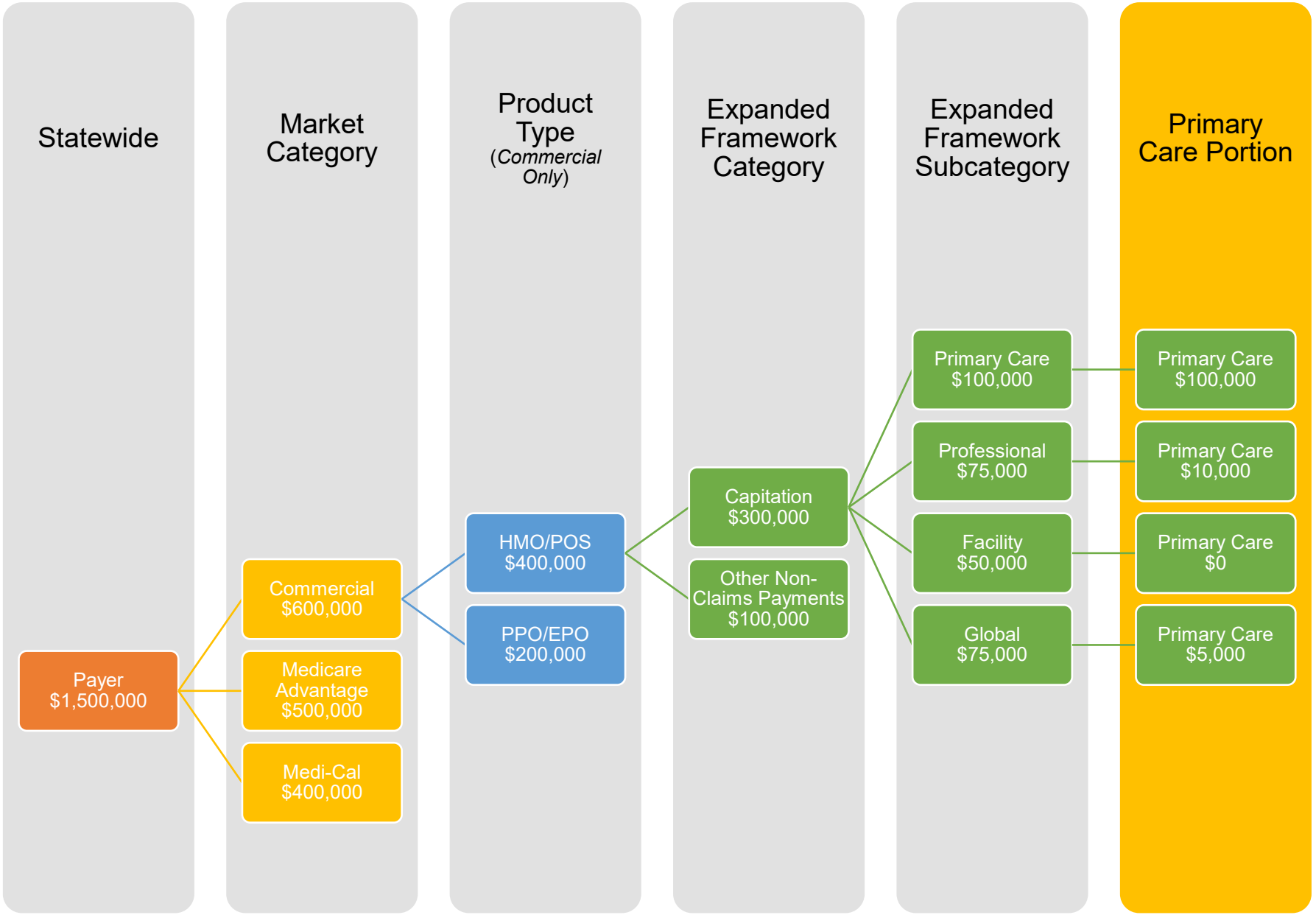
Primary Care Payment Allocation

Follow-up from May APM File Discussions

- Capitation for lab services should be included in the Payment Subcategory D2 “Professional Capitation”, not D3 “Facility Capitation”.
- Members in multiple APM arrangements:
  - If the arrangement in the Payment Subcategory furthest along the continuum for the member is not linked to quality, but another arrangement the member is in is linked to quality, then the Quality Indicator should be yes (1)
  - Example: If a member is in a Primary Care Capitation arrangement (Payment Subcategory D1), which is linked to quality, and a Behavioral Health Capitation arrangement (Payment Subcategory D4), which is not linked to quality, then all of their total medical expense and member months go to Payment Subcategory D4 with a Quality Indicator of yes (1) as payment for the member is adjusted based on predefined quality goals

Primary Care Payment Allocation Methodology

Primary Care File



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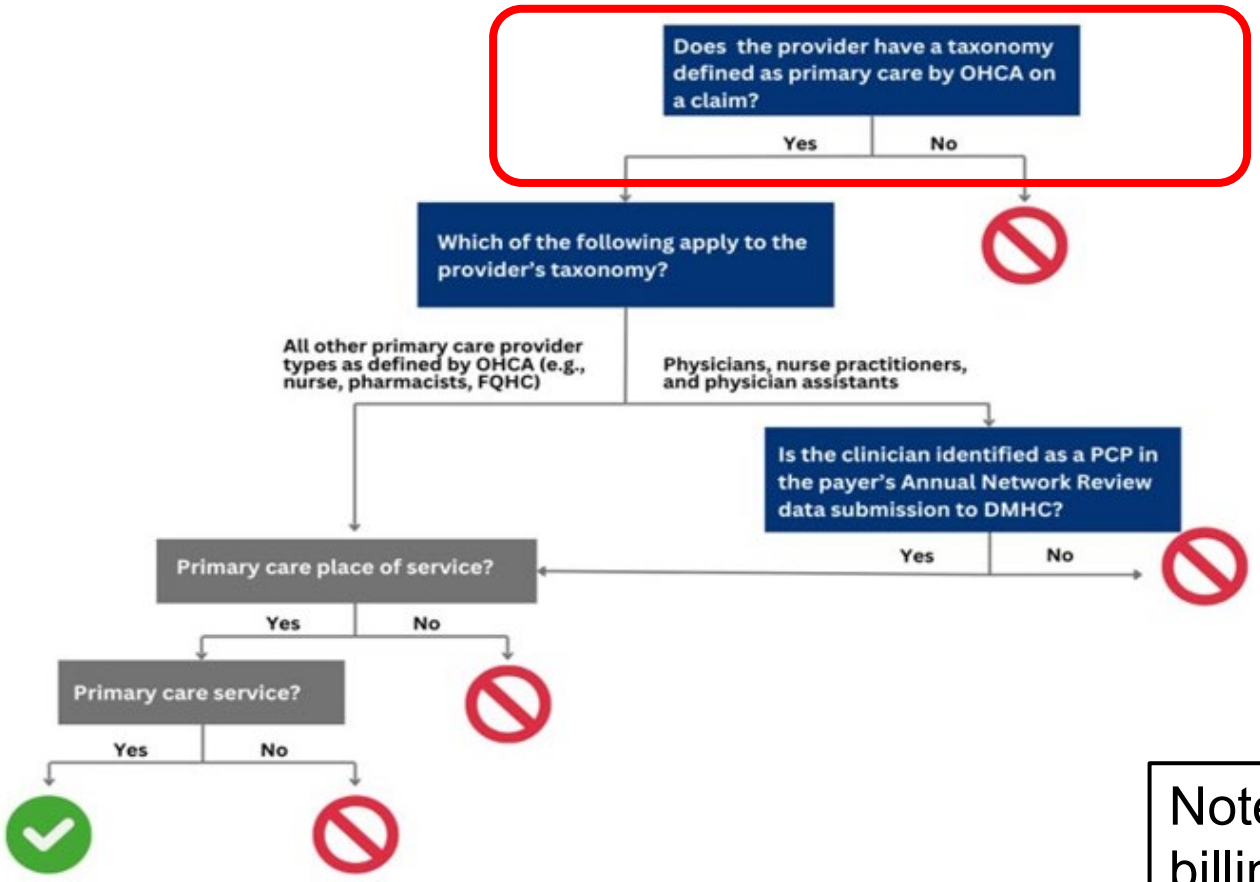
Primary Care Paid via Claims

Primary care claims payments are a subset of all professional claims (*i.e.*, the subgroup of professional claims that meet OHCA's primary care definition). The code set defines what spending shall be identified as primary care based on the provider taxonomy, place of service, and service codes included on the claim.

Primary Care Paid via Claims Decision Tree: Step 1



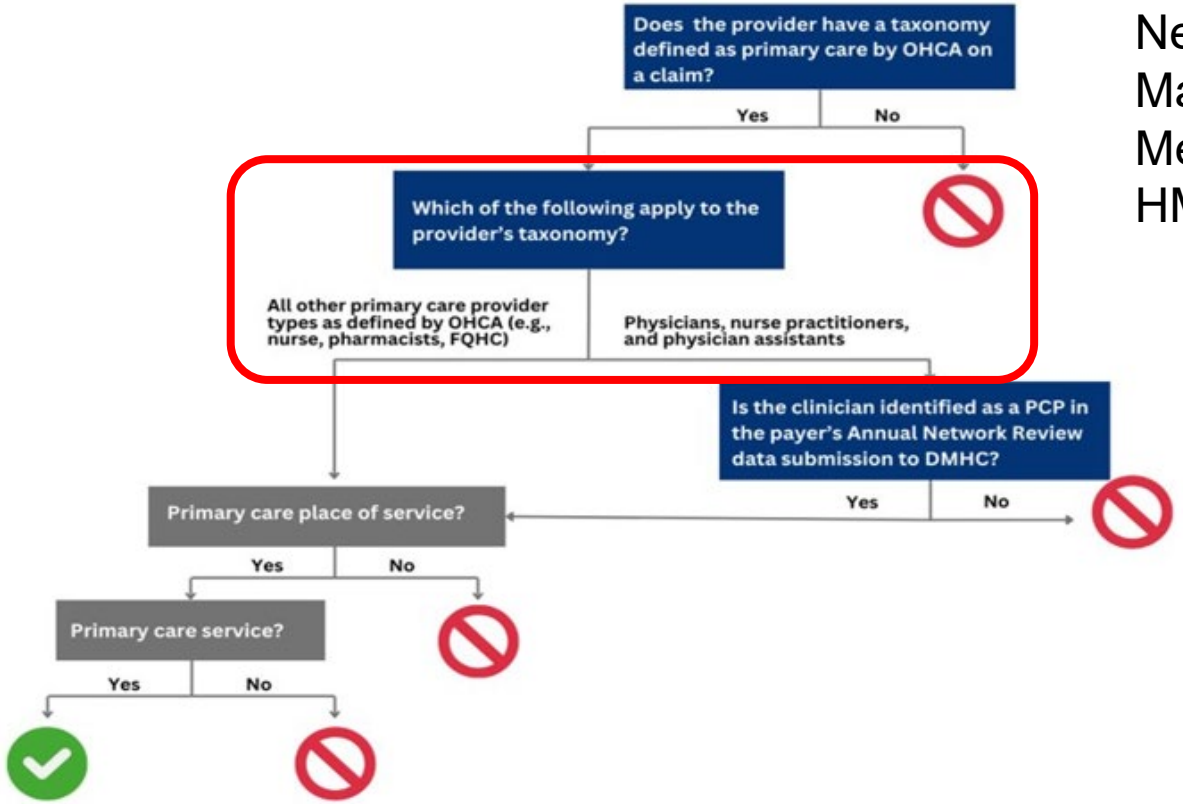
Determine whether the claim was rendered by a provider with a taxonomy defined as primary care by OHCA in the Primary Care (PC) Providers Taxonomy List (Appendix 1). If the claim was not rendered by a provider with a taxonomy on the list, then the claim shall not be included as primary care spending. If the rendering provider has a taxonomy included in the list, proceed to the second step.

Note: If rendering provider field is incomplete, use billing provider's taxonomy.

Figure 2. Identifying Primary Care Paid via Claims

See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set (Appendix 1), dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Primary Care Paid via Claims Decision Tree: Step 2



For physicians, nurse practitioners, and physician assistants, crosswalk the provider from the claim with the payer's Annual Network Review data submission to the California Department of Managed Health Care (DMHC) for the respective market (*e.g.*, Medicare, Commercial, Medi-Cal) and product type (*e.g.*, PPO, HMO).

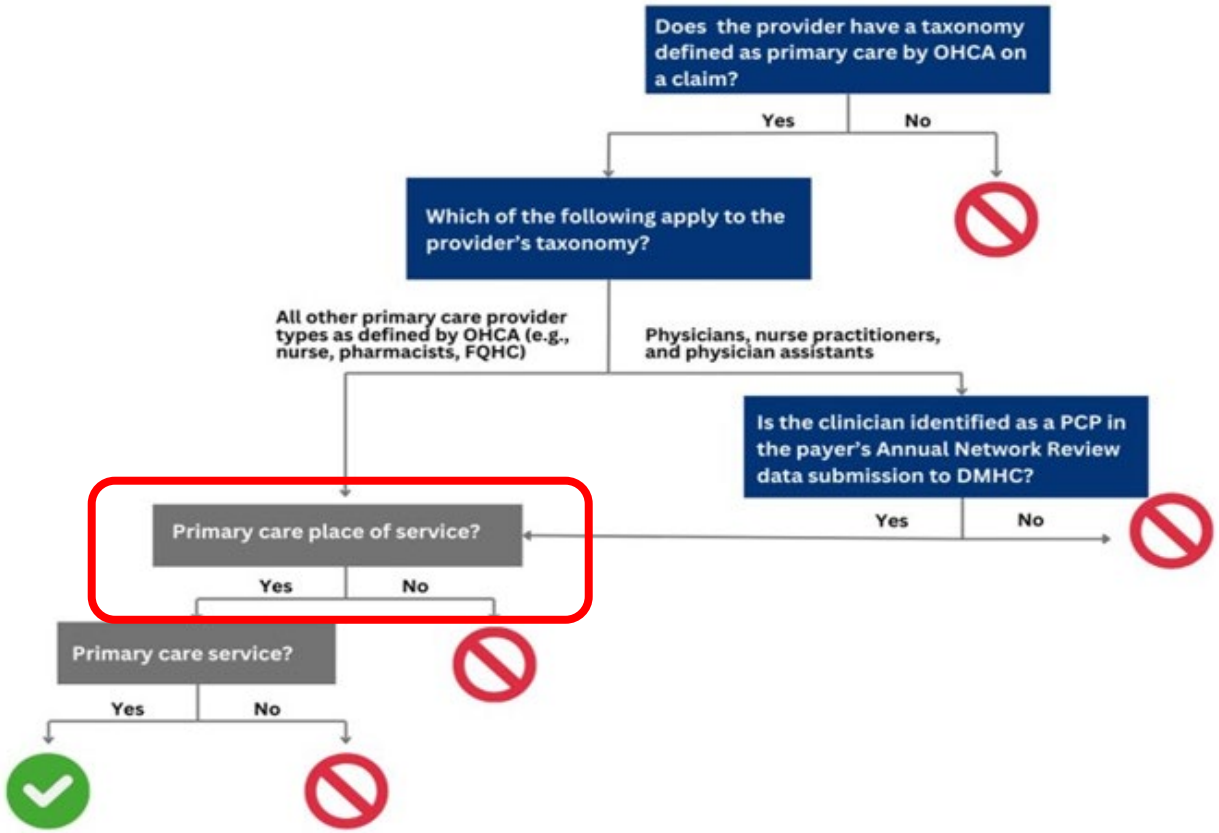
- If the payer does not have an Annual Network Review submission to DMHC, proceed to Step 3.
- If the provider on the claim is identified as a primary care physician or primary care non-physician medical practitioner (NPMP) in the Annual Network Review data submission, proceed to Step 3.
- If the provider on the claim is not identified as a primary care physician or practitioner, the claim shall not be included as primary care spending.

For all other primary care provider types as defined by OHCA (*e.g.*, nurses, pharmacists, Federally Qualified Health Center), proceed to Step 3.

Figure 2. Identifying Primary Care Paid via Claims

See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Primary Care Paid via Claims Decision Tree: Step 3



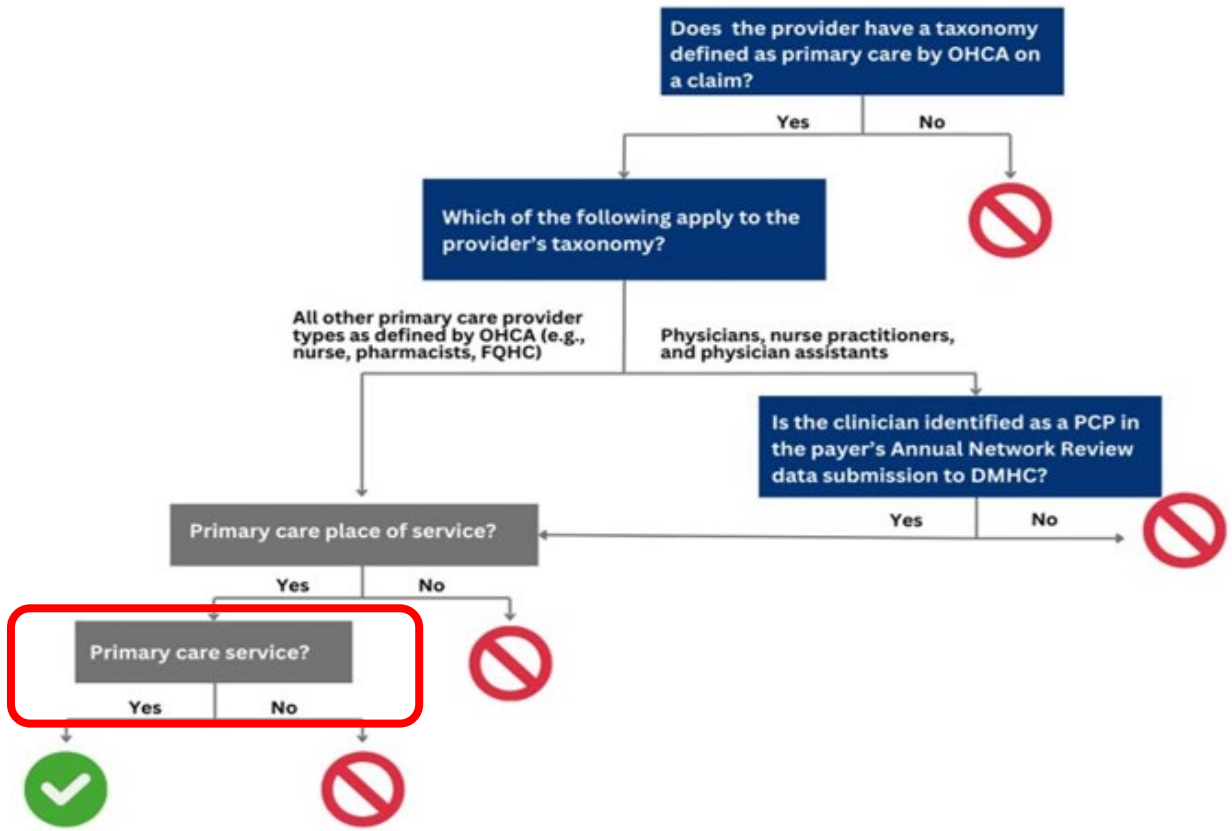
The third step is to determine whether the claim represents a service provided at a care setting that OHCA defines as primary care. The list of Centers for Medicare and Medicaid (CMS) Place of Service codes that OHCA defines as primary care settings can be found in Primary Care CMS Places of Service (Appendix 2).

- If the place of service code is on the list, proceed to the fourth and final step.
- If the place of service code is not on the list, the claim shall not be included as primary care spending.

Figure 2. Identifying Primary Care Paid via Claims

See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set (Appendix 2), dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Primary Care Paid via Claims Decision Tree: Step 4



The final decision confirms whether the service on the claim provided by a primary care provider at a primary care place of service is for a primary care service as defined by OHCA.

If the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code on the claim is included in the list of service codes in HCPCS/CPT Primary Care Services (Appendix 3), the claim shall be included in Amount Paid for Primary Care (PRC008).

If the claim has a service not included in the list, then the claim shall not be included in Amount Paid for Primary Care (PRC008).

Note: UB-04 payments with the facility type code 73 (Freestanding Clinic) that meet the primary care provider taxonomy and HCPCS/CPT service code requirements shall be included in Amount Paid for Primary Care (PRC008).

Figure 2. Identifying Primary Care Paid via Claims
See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set (Appendix 3), dated April 2025:
https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Expanded Non-Claims Payment Framework

	Expanded Non-Claims Payment Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N

Primary Care Allocation Required

Expanded Non-Claims Payment Framework

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A, 4N
D2	Professional capitation	4A, 4N
D3	Facility capitation	4A, 4N
D4	Behavioral Health capitation	4A, 4N
D5	Global capitation	4B, 4N
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C, 4N
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

Category A: Population Health and Practice Infrastructure Payments

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 information technology systems or other internal payer expenses.

Category A Subcategories:

- 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 and other data analytics payments

Payment Subcategory A1

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

Identify payments with 'A' in Payment Category (PRC005) and 'A1' in Payment Subcategory (PRC006)

- 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 payments to **multi-specialty practices and 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.

Payment Subcategory A2

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

Identify payments with ‘A’ in Payment Category (PRC005) and ‘A2’ in Payment Subcategory (PRC006).

- **Allocate all subcategory A2 payments** as primary care spending in Amount Paid for Primary Care (PRC008).

Payment Subcategory A3

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

Identify payments with 'A' in Payment Category (PRC005) and 'A3' in Payment Subcategory (PRC006)

- 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 A3 payments to **multi-specialty practices and 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.

Payment Subcategory A4

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

Identify payments with ‘A’ in Payment Category (PRC005) and ‘A4’ in Payment Subcategory (PRC006).

- Include all subcategory A4 payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to a primary care provider**, care team, or provider organization.
- Allocate only a portion of these payments **when paid to multi-specialty practices and health systems** as primary care spending in Amount Paid for Primary Care (PRC008).
- Limit the portion of practice transformation payments allocated to primary care to a **maximum of 1% of total medical expenses** as determined by summing all Total Amount Allowed (PRC007) in the file.

Payment Subcategory A5

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

Identify payments with 'A' in Payment Category (PRC005) and 'A5' in Payment Subcategory (PRC006)

- Include all subcategory A5 payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to a primary care provider**, care team, or provider organization.
- Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to multi-specialty practices and health systems**.
- Limit the portion of EHR/HIT infrastructure and other data analytics payments allocated to primary care to a **maximum of 1% of total medical expenses** as determined by summing all Total Amount Allowed (PRC007) in the file.

Category B: Performance Payments

Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.

Category B Subcategories:

- B1 - Pay-for-reporting payments
- B2 - Pay-for-performance payments

Payment Subcategory B1

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B: Pay for Reporting: Bonuses for reporting data or penalties for not reporting data

Identify payments with ‘B’ in Payment Category (PRC005) and ‘B1’ in Payment Subcategory (PRC006).

- Include all subcategory B1 payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to a primary care provider**, care team, or provider organization.
- Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to multi-specialty practices and health systems**. Limit the portion of pay-for-reporting payments included to only those for **patients attributed to primary care providers**.

Payment Subcategory B2

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C: Pay for Performance: Bonuses for quality performance

Identify payments with ‘B’ in Payment Category (PRC005) and ‘B2’ in Payment Subcategory (PRC006).

- Include all subcategory B2 payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to a primary care provider**, care team, or provider organization.
- Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) **when paid to multi-specialty practices and health systems**. Limit the portion of pay-for-performance payments included to only those for **patients attributed to primary care providers**.

Category C: Shared Savings Payments and Recoupments

Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category shall reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars shall be reported as a negative value. Payments in this category may be considered "linked to quality" if the shared savings payment or any other 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 payment, then the shared savings payment would be considered "linked to quality." Payments in this category may not be "linked to quality".

Category C Subcategories:

- C1 – C4 - Procedure-related or condition-related, episode-based payments with shared savings/with risk of recoupments
- C5 – C6 - Risk for total cost of care (e.g., ACO) with shared savings/with risk for recoupments

Payment Subcategory C1-C2

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality
Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality

Do not allocate payments in subcategories C1 or C2 to primary care spending.

Other Shared Savings Payments Subcategories: C3-C6

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality
Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality

Identify payments with ‘C’ in Payment Category (PRC005) and ‘C3’, ‘C4’, ‘C5’, or ‘C6’ in Payment Subcategory (PRC006).

- Allocate **only a portion of these payments** as primary care spending in Amount Paid for Primary Care (PRC008). Limit the portion of the shared savings (or recoupment) to the **ratio of Claims: Professional to the sum of Claims: Professional, Claims: Hospital Inpatient, and Claims: Hospital Outpatient, multiplied by the shared savings payment**

Other Shared Savings Payments Subcategories: C3-C6

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality
Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.”	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality

Identify payments with ‘C’ in Payment Category (PRC005) and ‘C3’, ‘C4’, ‘C5’, or ‘C6’ in Payment Subcategory (PRC006).

- Allocate **only a portion of these payments** as primary care spending in Amount Paid for Primary Care (PRC008). Limit the portion of the shared savings (or recoupment) to the **ratio of Claims: Professional to the sum of Claims: Professional, Claims: Hospital Inpatient, and Claims: Hospital Outpatient, multiplied by the shared savings payment**

Equation for Allocating Shared Savings and Recoupments to Primary Care Subcategories: C3-C6

$$\underbrace{\Sigma \text{ Shared Savings Payments}}_{\text{Subcategories C3-C6}} \times \frac{\text{Claims: Professional}}{\text{Claims: Professional + Claims: Hospital Inpatient + Claims: Hospital Outpatient}} = \text{Category C Primary Care Spend via Non-Claims}$$

Figure 3. Equation for Allocating Shared Savings and Recoupments to Primary Care
See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Category D: Capitation and Full Risk Payments

Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period. Payments in this category may be considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality." Payments in this category may not be "linked to quality".

Category D Subcategories:

- D1 – Primary care capitation
- D2 – Professional capitation
- D3 – Facility capitation
- D4 – Behavioral health capitation
- D5 – Global capitation
- D6 - Payments to integrated, comprehensive payment and delivery systems

Payment Subcategory D1

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Primary care capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period. Services are restricted to primary care services performed by primary care teams.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality

Identify payments with ‘D’ in Payment Category (PRC005) and ‘D1’ in Payment Subcategory (PRC006).

- **Allocate all subcategory D1 payments as primary care** spending in Amount Paid for Primary Care (PRC008).

Payment Subcategory D2, D5, & D6

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Professional capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
Global capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B: Comprehensive Population-based Payment: Global budgets or full/percent of premium payments; 4N: Capitated payments not linked to quality
Payments to integrated, comprehensive payment and delivery systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C: Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems; 4N: Capitated payments not linked to quality

Identify payments with ‘D’ in Payment Category (PRC005) and ‘D2’, ‘D5’, or ‘D6’ in Payment Subcategory (PRC006)

- For subcategories D2, D5, and D6**, allocate only a portion of these payments as primary care** spending in Amount Paid for Primary Care (PRC008). Take the ratio of (a) the sum of primary care encounters multiplied by their fee-for-service equivalent fee over (b) the sum of all encounters multiplied by their fee-for-service equivalent fee.
- Next, multiply this ration by the capitation amount for each respective type of capitation arrangement as shown

Medicare Physician Fee Schedule can be found at https://www.cms.gov/medicare/physician-fee-schedule/search
Medi-Cal rates can be found at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates

Professional and Global Capitation (D2 & D5) Payments to Integrated Comprehensive Payment and Delivery Systems (D6)

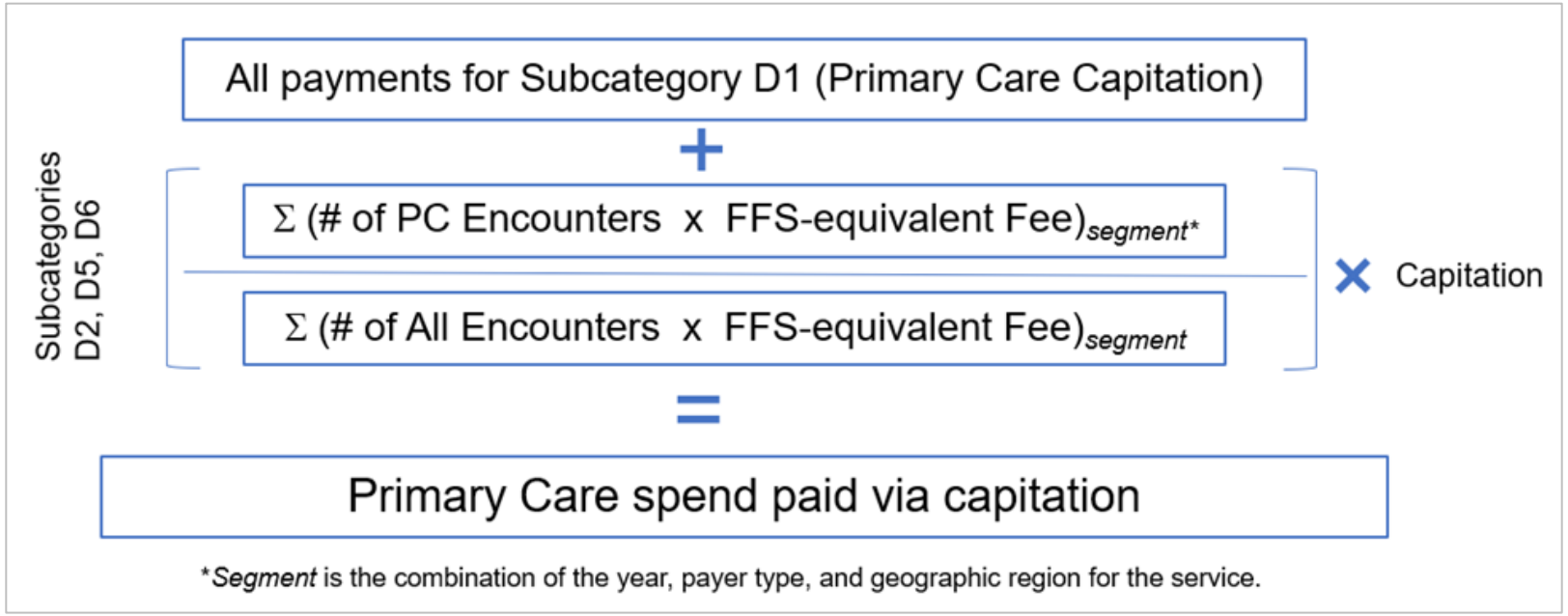


Figure 4. Equation for Allocating Capitation and Full Risk Payments to Primary Care
See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Payment Subcategory D3-D4

Non-Claims Payment Subcategory	Description	Corresponding HCP-LAN Category
Facility capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
Behavioral health capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period. May include professional, facility, and/or residential services.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality

Do not allocate payments in Subcategory D3 or D4 to primary care spending.

Category E: Other Non-Claims Payments

Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit.

Examples of payments **not** to report in this category:

- Shared savings or recoupments
- Condition-specific population-based payments
- Other payments that may be categorized in Payment Subcategories A1-D6

Do not allocate payments in Category E to primary care spending.

Submitter Round Table

Next Steps

1:1 Technical Assistance Meetings

- In lieu of July and August workgroup meetings, OHCA will offer 30 minute 1:1 sessions with each submitter
- OHCA will contact the individuals identified during registration to schedule the sessions
- Submit questions in advance to facilitate a productive discussion
- Submitters are strongly encouraged to take advantage of this opportunity as they prepare data files for submission

Next Steps

- OHCA will reach out to schedule 1:1 Technical Assistance meetings
- Next workgroup meeting – Fall 2025
- Send questions to OHCA@HCAI.ca.gov

2025 Data Collection Timeline

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Appendix

HCAI

Department of Health Care Access and Information

Appendix 1: Primary Care Providers Taxonomy List

Taxonomy	NUCC Name
163W00000X	Nurse, non-practitioner
172V00000X	Community Health Worker
183500000X	Pharmacist
1835G0303X	Geriatric Pharmacist
1835P0018X	Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist
1835P0200X	Pediatric Pharmacist
207Q00000X	Family Medicine*
207QA0000X	Family Medicine, Adolescent Medicine*
207QA0505X	Family Medicine, Adult Medicine*
207QG0300X	Family Medicine- Geriatric Medicine*
207R00000X	Internal Medicine*
207RA0000X	Internal Medicine, Adolescent Medicine*
207RG0300X	Internal Medicine- Geriatric Medicine*
208000000X	Pediatrics*
2080A0000X	Pediatrics, Adolescent Medicine*
208D00000X	General Practice*
261QC0050X	Critical Access Hospital Clinic/Center
261QF0400X	Federally Qualified Health Center
261QP2300X	Clinic/Center- Primary Care
261QR1300X	Clinic/Center- Rural Health
363AM0700X	Physician Assistant, Medical*
363L00000X	Nurse Practitioner*
363LA2200X	Nurse Practitioner- Adult Health*
363LC1500X	Nurse Practitioner, Community Health*
363LF0000X	Nurse Practitioner- Family*
363LG0600X	Nurse Practitioner, Gerontology*
363LP0200X	Nurse Practitioner- Pediatrics*
363LP2300X	Nurse Practitioner- Primary Care*
363LS0200X	Nurse Practitioner, School*
364SA2200X	Certified clinical nurse specialist- adult health
364SC1501X	Certified clinical nurse specialist- community health/public health
364SC2300X	Certified clinical nurse specialist- chronic health
364SF0001X	Certified clinical nurse specialist- family health
364SG0600X	Certified clinical nurse specialist- gerontology
364SP0200X	Certified clinical nurse specialist- pediatrics

Primary care providers are defined by the National Uniform Claim Committee (NUCC) taxonomy codes on claims. The taxonomies listed, in combination with service and place of service criteria, are included in the claims-based definition of primary care. Rows with an asterisk (*) indicate taxonomies for physicians, physician assistants, and nurse practitioners.

National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy: https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40 provider-taxonomy-mainmenu-40

See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set dated April 2025: THCE Data Submission Guide v2.0.pdf

Appendix 2: Primary Care CMS Places of Service

POS Code	Place of Service
02	Telehealth Provided Other than in Patient's Home
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/ Correctional Facility
10	Telehealth Provided in Patient's Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
18	Place of Employment- Worksite
19	Off Campus- Outpatient Hospital
22	On Campus- Outpatient Hospital
26	Military Treatment Facility
27	Outreach Site/ Street
49	Independent Clinic
50	Federally Qualified Health Center
66	Programs of All-Inclusive Care for the Elderly (PACE) Center
71	Public Health Clinic
72	Rural Health Clinic

Primary care places of service are defined by the Centers for Medicare and Medicaid Services (CMS) Place of Service (POS) codes on claims. The listed POS codes, in combination with service and provider criteria, are included in the claims-based definition of primary care

CMS Place of Service Code Set: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets
See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set dated April 2025: THCE Data Submission Guide v2.0.pdf

Appendix 3: Example HCPCS/CPT Primary Care Services

HCPCS/CPT Code	Description
10040	Acne surgery
10060	Drainage Of Skin Abscess Simple
10061	Drainage Of Skin Abscess Complicated
10080	Drainage Of Pilonidal Cyst Simple
10081	Drainage of pilonidal cyst
10120	Remove Foreign Body Simple
10121	Remove Foreign Body Complicated
10140	Drainage of hematoma/fluid
10160	Puncture Drainage Of Lesion
10180	Complex drainage wound
11000	Debride Infected Skin
11055	Trim Skin Lesion Single
11056	Trim Skin Lesions 2 To 4
11102	Tangntl bx skin single les
11103	Tangntl bx skin ea sep/addl
11104	Punch bx skin single lesion
11105	Punch bx skin ea sep/addl
11106	Incal bx skn single les
11107	Incal bx skn ea sep/addl
11200	Removal Of Skin Tags <W/15
11201	Remove Skin Tags Add-On
11300	Shave Skin Lesion 05 Cm/<
11301	Shave Skin Lesion 06-10 Cm

Primary care services are defined by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes on claims. The listed service codes, in combination with provider taxonomy and place of service, are included in the claims-based definition of primary care.

Note: The codes listed here are an excerpt of the full list of primary care HCPCS/CPT codes

HCPCS and CPT codes are maintained by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA): https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system

See THCE Data Submission Guide (Version 2.0) for Primary Care Allocation Methodologies and Code Set dated April 2025: THCE Data Submission Guide v2.0.pdf