OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

March 26, 2025

HCAI

Department of Health Care Access and Information

Agenda

1. Regulations and Data Submission Guide Updates
2. Annual Submitter Registration Overview
3. Submitter Round Table
4. Next Steps

Regulations and Data Submission Guide Updates

Regulations Recap

- Public comment period closed January 31, 2025
- Summary of comments and OHCA responses presented at February Health Care Affordability Board meeting
  - Excerpt of slides shared in appendix

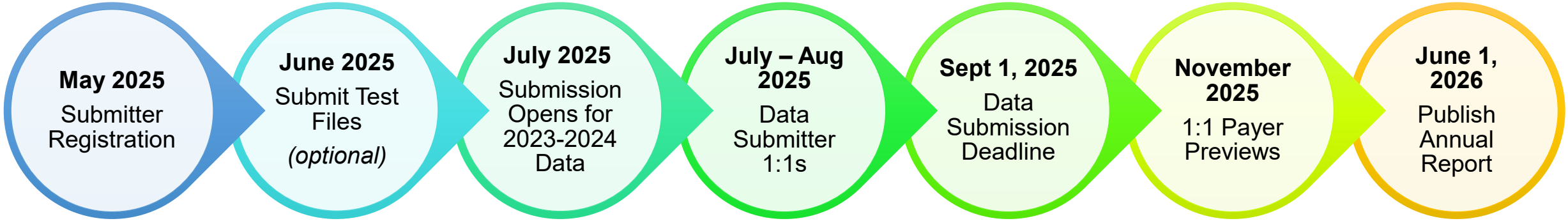
DSG changes based on public comment

- Updated exclusions list in Section 4.3.1
- Added guidance for determining the non-claims payment subcategory with the highest clinical and financial risk in Section 4.8
- Clarified APM payment allocation instructions in Section 4.8.1
- Restored Member Responsibility fields on Statewide TME file
- Added HCP-LAN categories 3N and 4N to Appendix B
- Added additional provider taxonomies and primary care service codes to Appendix E

Next Steps

- Final proposed Regulations and Data Submission Guide will be posted by the end of March at https://hcai.ca.gov/about/laws-regulations/
  - To be notified when updates are posted, subscribe to the **Health Care Affordability (OHCA) – Data Reporting** mailing list under Notice of Regulatory Actions at https://hcai.ca.gov/mailing-list/
- Anticipated submission to OAL in April 2025
- Annual submitter registration opens in May 2025

2025 Data Collection Timeline



Annual Submitter Registration Overview

Who is Required to Register?

- Payers and fully integrated delivery systems that insure at least 40,000 covered lives in any market (commercial, Medi-Cal, Medicare)
  - Payers and fully integrated delivery systems that qualify based on one market's coverage must report data on behalf of all markets
  - If a payer or FIDS operates under multiple licenses (*i.e.*, DMHC, CDI, Medi-Cal) they must register each license separately
- Submitter registration occurs in the Onpoint Claims Data Manager (CDM) portal

Health Plans Meeting Threshold

- As of December 2023, based on the best available public data, the following entities meet the 40,000 lives threshold in the **Commercial** market category:
  - Aetna Health of California Inc.
  - Aetna Life Ins. Co.
  - Anthem Blue Cross Life And Health Ins. Co.
  - Blue Cross of California
  - Blue Shield of California
  - Cigna Health And Life Ins. Co.
  - Cigna HealthCare of California, Inc.
  - Health Net of California, Inc.
  - Kaiser Foundation Health Plan, Inc.
  - Local Initiative Health Authority for L.A. County
  - Molina Healthcare of California
  - Santa Clara County
  - Sharp Health Plan
  - Sutter Health Plan
  - UHC of California
  - UnitedHealthcare Benefits Plan of California
  - Unitedhealthcare Ins. Co.
  - Western Health Advantage

Source: California Health Insurers, Enrollment Almanac – 2025 Edition
https://www.chcf.org/publication/california-health-insurers-enrollment-almanac/

Health Plans Meeting Threshold

- As of December 2023, based on the best available public data, the following entities meet the 40,000 lives threshold in the **Medicare Advantage** market category:
  - Aetna Life Ins. Co.
  - Alignment Health Plan
  - Anthem Insurance Companies, Inc.
  - Arcadian Health Plan, Inc.
  - Blue Cross of California
  - Blue Cross of California Partnership Plan, Inc.
  - Blue Shield of California
  - Central Health Plan of California, Inc.
  - Health Net of California, Inc.
  - Kaiser Foundation Health Plan, Inc.
  - Scan Health Plan
  - Sierra Health And Life Ins. Co., Inc.
  - UHC of California
  - Universal Care, Inc.
  - WellCare of California, Inc.

Source: California Health Insurers, Enrollment Almanac – 2025 Edition
https://www.chcf.org/publication/california-health-insurers-enrollment-almanac/

Health Plans Meeting Threshold

- As of December 2023, based on the best available public data, the following entities meet the 40,000 lives threshold in the **Medi-Cal Managed Care** market category:

  - Aetna Better Health of California Inc.
  - Alameda Alliance For Health
  - Blue Cross of California Partnership Plan, Inc.
  - Blue Shield of California Promise Health Plan
  - California Health and Wellness Plan
  - CHG Foundation
  - Contra Costa County Medical Services
  - Fresno-Kings-Madera Regional Health Authority
  - Health Net Community Solutions, Inc.
  - Inland Empire Health Plan
  - Kaiser Foundation Health Plan, Inc.
  - Kern Health Systems
  - Local Initiative Health Authority for L.A. County
  - Molina Healthcare of California
  - Orange County Health Authority
  - Partnership HealthPlan of California
  - San Francisco Health Authority
  - San Joaquin County Health Commission
  - San Mateo Health Commission
  - Santa Barbara San Luis Obispo Regional Health Authority
  - Santa Clara County Health Authority
  - Santa Cruz-Monterey-Merced Managed Medical Care Commission

Source: California Health Insurers, Enrollment Almanac – 2025 Edition
https://www.chcf.org/publication/california-health-insurers-enrollment-almanac/

Overview of Submitter Registration

- Required by California Code of Regulations Title 22 § 97449
- Registration helps us identify:
  - Key contacts from each submitter
  - Market categories and enrollment for which data will be submitted
  - Plan license type and number
  - Parent company affiliation (if applicable)
- Registration opens May 1st and must be complete by May 31st

Submitter Registration FAQs

Q: I just completed CDM registration in January. Do I need to re-register in May?

A: Yes. The January registration was for the Healthcare Payments Data (HPD) program, not OHCA.

Q: I registered last year to submit data. Do I need to re-register in May?

A: Yes. Registration is an annual requirement for all submitters, as outlined in the Data Submission Guide.

Submitter Registration FAQs

Q: I represent a health plan licensed by the DMHC and a health insurer licensed by CDI. Can I register them together?

A: No. Separate registrations must be completed for each licensed health plan and/or insurer. Each will receive a distinct Submitter Code after registration, and each will be required to submit their required files separately.

Submitter Registration FAQs

Q: My plan is a subcontracted plan in a plan-to-plan contract to provide benefits. Should I include the members from other plans in my number of covered lives?

A: No. Only include members for whom the submitter is directly contracted with a group purchaser, individual subscriber, or public agency to arrange for the provision of health care services.

Submitter Registration FAQs

Q: My plan has over 40,000 Medi-Cal lives and less than 40,000 Commercial lives. Will I have to submit all seven files?

A: Yes. Commercial market data is required in all seven files. Medi-Cal data must be reported in the APM and Primary Care files.

Preparing for Submitter Registration

- Coordinate with technical teams who will be supporting the process to comply with the OHCA submission requirements
- Identify your organization's:
  - License type (*e.g.*, DMHC, CDI) and license number
  - Market categories (commercial, Medi-Cal, Medicare Advantage) and enrollment as of December 31, 2024
  - NAIC number, if applicable
- Send any registration or submission requirement questions you may have to OHCA@HCAI.ca.gov

Submitter Round Table

Next Steps

Next Steps

- Next workgroup meeting – April 23, 2025
- Topics
  - Submitter Registration demo
  - PGP encryption and SFTP overview
- Send questions to OHCA@HCAI.ca.gov

Appendix: Summary of Public Comments

Health Care Affordability Board Meeting – February 25, 2025

Theme	Comment/Question Summary	OHCA Response
Data Collection	Request to clarify scope of proposed definition of "affiliated" in 22 CCR 97445(a).	OHCA amends the term "affiliation" to "affiliated" for consistency with how the term is used in the regulations in 22 CCR 97449(d). OHCA also adds a cross-reference to the regulations where the term is used for clarity. The proposed changes are only for consistency and clarity and do not change the scope of the term in any way.
	Concern payments from the State for Medi-Cal providers (*i.e.*, directed payments) are not yet settled by the annual September 1 submission deadline.	OHCA acknowledges that for some claims, run-out may exceed the minimum 180-day claims run-out period. This is one of the reasons why Section 4.1 of the Data Submission Guide (DSG) requires data submission for the previous two calendar years (CY) with each annual data submission. Because the 180-day claims run-out period is calculated from December 31 of the most recent reporting year, updated CY data submitted to OHCA will reflect a claims run-out period of at least 540 days. OHCA intends to use the initial data submissions received in 2024 and 2025 to develop further insight into the impact of the 180-day minimum claims run-out period on overall data completeness.

Theme	Comment/Question Summary	OHCA Response
Data Collection	Concern proposed requirement for payers and FIDS to complete separate data submissions for each licensed health plan and/or health insurer will have significant implications for the data.	The existing “parent” registration is inconsistent with how many submitters operate their businesses in California. Because health plans and health insurers in California are separately licensed and regulated at the state-level by DMHC and CDI, respectively, most submitters are accustomed to reporting data for these license types separately, at the license-level. Additionally, OHCA’s existing “parent” registration is not aligned with the registration process for the Health Care Payments Data (HPD) program, which already requires annual registration at the license-level. The current lack of alignment impacts how entities’ data flows into each program and may make it more difficult for OHCA to utilize HPD program data for future analysis and reporting.
	Request to align how member responsibility amounts are reported across the Statewide TME, Attributed TME, and Regional TME files.	OHCA plans to restore the member responsibility data field in the Statewide TME file.

Theme	Comment/Question Summary	OHCA Response
Data Collection	Recommendation to revisit approach to how submitters report spending in the Commercial (Partial Benefits) market category.	The methodology for estimating expenses in the Commercial (Partial Benefits) market category has not changed from the existing, approved DSG. The proposed DSG includes new data fields in the Submission Questionnaire file to capture the type and amount of estimated expenses for more accurate analysis and reporting.
	Request to clarify whether/how MCO data would be categorized in Commercial (Partial Benefits) given carve-outs for many MH/SUD services and pharmacy.	MCO data would not be reported or otherwise categorized in the Commercial (Partial Benefits) market category because this market category only applies to the commercial market.
	Recommendation to adjust the data submission timeline or revise instructions so submitters can estimate Medicare shared savings amounts for the prior benefit year.	Section 4.1.2 of the DSG instructs submitters to “apply reasonable and appropriate estimations of non-claims liability for each provider (including payments expected to be made to providers not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period.”

Theme	Comment/Question Summary	OHCA Response
Data Exclusions	Request to clarify whether proposed exclusion of spending on “discounts and other member perks” in Section 4.3.1 of the DSG intends to exclude spending on mandatory supplemental benefits in Medicare Advantage plans.	OHCA plans to revise the DSG to clarify this exclusion. OHCA does not intend to exclude the cost of mandatory supplemental benefits in Medicare Advantage plans, as these are part of plan-required coverage beyond traditional Medicare.
	Request to clarify proposed exclusion of CMS reconciliation payments (such as Medicare sweep payments or Part D premiums).	OHCA plans to revise the DSG to clarify this exclusion. Since revenue is not reported in the THCE files, the exclusion of CMS reconciliation payments (such as Medicare sweep payments or Part D premiums) ensures that TME reflects the actual cost of care provided, without adjustments for post-reporting financial reconciliations.

Theme	Comment/Question Summary	OHCA Response
Attribution Addendum	Request to clarify why OHCA reduced the number of physician organizations listed in the Attribution Addendum.	OHCA developed the proposed version of the Attribution Addendum utilizing actual data from the Attributed TME files received from submitters during the September 2024 data submission. OHCA seeks to initially focus on larger entities, which based on analysis of reporting year 2023 data would be physician organizations with greater than 5,000 attributed members across the commercial and Medicare Advantage market categories. Combining the identified organizations' attributed members with the unattributed population (approximately 20 percent of covered lives in reporting year 2023) accounts for nearly ninety percent of covered lives across the commercial and Medicare Advantage market categories. The proposed version of the Attribution Addendum applies a 5,000 attributed member threshold and lists 145 physician organizations. This includes 122 physician organizations retained from the existing Attribution Addendum and 23 physician organizations newly identified through the September 2024 data submission. Within each annual data submission, submitters may identify organizations to which they can attribute at least 1,000 members, for potential addition to a future iteration of the Attribution Addendum. As OHCA refines its attribution approach, OHCA will revisit member thresholds.

Theme	Comment/Question Summary	OHCA Response
Data Accuracy	Recommendation to explore pathways to ensure that provider entity spending is accurately attributed, reported, and consistently aggregated across payers.	OHCA acknowledges that because there is no existing, comprehensive list of physician organizations operating in California with unique identifiers, many issues will need to be resolved with the continued involvement of stakeholders. OHCA notes that the Attribution Addendum will be periodically revised based on information received from submitters, with an ultimate objective of data completeness. All updates to the Attribution Addendum will be made in accordance with the regulatory process.
	Recommendation to 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.	OHCA conducted 1:1 sessions with each submitter in August 2024 prior to data submission, and again in November 2024 to preview total medical expenditure (TME) calculations. At the preview session, each submitter was given the opportunity to provide feedback and/or additional context for their data. OHCA also holds monthly Board meetings with multiple opportunities for public comment, including from payers.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	Recommendation OHCA and OHCA's vendor, Onpoint, explore additional methods to streamline the error-handling process during data submission.	OHCA and Onpoint are committed to continuously improving the data submitter experience. Webinars leading up to the submission deadline will include training on how to view automated validation errors on submission. Once files pass automated validation, there are additional manual validations that may require submitters to resolve discrepancies. OHCA and Onpoint are also available for technical assistance prior to and during the submission process.
	Recommendation to finalize updates to the DSG earlier than March of the submission year. Can OHCA provide more information on timing of future updates to the DSG?	Any updates to the DSG will be discussed at multiple Board meetings and proceed through a public comment process before submission to the Office of Administrative Law. Updates may occur annually as OHCA fully implements its program. For example, OHCA plans to update the DSG in 2026 to collect data necessary to report on progress towards a future behavioral health investment benchmark.

Theme	Comment/Question Summary	OHCA Response
Miscellaneous	OHCA should work with stakeholders to develop an appropriate risk adjustment methodology prior to any enforcement actions.	OHCA will not modify its risk adjustment methodology to consider clinical risk through these proposed regulations. OHCA currently collects data at the granularity needed to perform age/sex risk adjustment. OHCA will continue to assess the issue of whether clinical risk adjustment should be introduced in future reporting. OHCA remains open to other approaches to risk adjustment and will continue to assess options going forward.
	OHCA should work with DHCS to eliminate overlapping data collection efforts.	Starting Fall 2025, Medi-Cal Managed Care Plans (MCOs) will report primary care spending and APM data to OHCA, using OHCA's methodology, and DHCS will sunset its related reporting requirements. Data submitted to OHCA will be shared between the two departments. Additionally, to minimize reporting burdens for MCOs, the proposed regulations only require MCOs to report spending in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories in the new APM and Primary Care files in 2025. For all other file types (Total Medical Expense files) OHCA will receive data directly from DHCS and the Centers for Medicare and Medicaid Services (CMS). However, MCOs may choose to voluntarily report spending in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories to help prepare for full reporting in 2026.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to change “Total Amount Paid/Allowed” to “allowed” amount in Section 4.8.1 of the DSG.	OHCA plans to revise the language in the DSG to “Total Amount Allowed” for consistency with the provided field description.
	Request to clarify how submitters should handle capitation based on risk-adjusted revenue.	Reported payments should match what the data submitter paid the provider organization without any subsequent risk adjustment. Capitation payments developed based on risk-adjusted revenue should be reported as developed and paid to the provider organization.
	Request to clarify why submitters are required to crosswalk primary care providers to the Annual Network Review file submitted to the DMHC.	OHCA proposes this requirement in response to stakeholder concerns that using only taxonomy to identify primary care providers (PCPs) would include some providers with a primary care taxonomy who may hold multiple certifications or subspecialties and do not practice primary care, therefore overinflating primary care spend measurement. OHCA’s Investment and Payment Workgroup suggested leveraging Annual Network Review submissions to accurately identify physicians, nurse practitioners, and physician assistants who practice as PCPs.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to include retail pharmacy costs related to administration of vaccines in reported primary care spending.	During discussions at OHCA's Investment and Payment Workgroup, stakeholders had concerns that care provided at retail pharmacies did not align with the Workgroup's vision for whole-person, comprehensive, coordinated primary care. As a result, OHCA's measurement methodology excludes retail pharmacies as a primary care place of service. If the retail pharmacy place of service were added, all primary care services delivered in this setting would be included in spending measurement, which would not align with the vision for primary care. If onl the administration of vaccines in retail pharmacies were added, it would require submitters to develop additional specialized logic to apply to retail pharmacies and would increase submitter administrative burden.
	Request to clarify why only administration of vaccines is considered a primary care service and not the full cost of the vaccine.	OHCA does not include the cost of the actual vaccine as part of primary care spend since this spending is not determined or controlled by primary care practices, nor does spending on the actual vaccine support primary care delivery or transformation. Additionally, the majority of states measuring primary care spending do not include the costs of the actual vaccines.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Recommendation to allow submitters to estimate care coordination fee (CCF) payments in scenarios where a practice received capitation, but CCF payments are not distinguished as primary versus specialty care.	OHCA only intends to count CCF payments as part of primary care spending if they can specifically be tied to primary care programs. If the CCF payment is embedded within a capitation payment, the formula for allocating a portion of capitation payments to primary care spending (Figure 3 in Section 4.9.2 of the proposed DSG) would apply.
	Request to clarify how submitters should account for the fact that encounter data is incomplete from providers.	OHCA appreciates that incomplete encounter data may impact both the numerator and denominator of the ratio and therefore the impact on the spending allocated to primary care may vary based on completeness of encounter data. OHCA seeks to incentivize payers to work with providers to acquire more complete encounter data to support accurate allocation of these payments.
	Request to clarify hierarchy for payment categories in Section 4.8.1 of the DSG.	OHCA plans to revise the DSG to clarify the hierarchy. Provider clinical and financial risk increases moving across the categories of the Expanded Framework from A (Population Health and Practice Infrastructure Payments) to D (Capitation and Full Risk Payments), and as you move down subcategories within categories B through D.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to clarify whether the Payment Category “X = Fee-for-service” in the APM and Primary Care files includes retail pharmacy.	Within the APM and Primary Care files, payments reported under Payment Category X (“X = Fee-for-service”) must also be reported as Payment Subcategory X9 (“X9 = Claims: Total”). Subcategory X9, total claims payments, includes retail pharmacy.
	Request to clarify why Appendix B: Population Health and Infrastructure Payments does not include payer personnel and internal expenses.	The Population Health and Infrastructure Payments category is intended to capture only those non-claims payments that are made to providers or healthcare delivery organizations that support care delivery goals. Payer personnel and internal expenses are included in OHCA’s calculation of total health care expenditures as part of administrative costs and profits.
	Request to clarify whether care coordination fee (CCF) payments should be categorized furthest along the continuum of clinical and financial risk.	OHCA’s primary care payment allocation methodology asks that non-claims payments within a payment model are reported based on the intended use of the payment and in their distinct payment subcategory to support OHCA’s understanding of the intent of the non-claims payment. The primary care methodology does not require spending be allocated to the category furthest along the continuum. That allocation is only for the APM file.

Theme	Comment/Question Summary	OHCA Response
Alternative Payment Model (APM) and Primary Care Files	Request to update the primary care code set to remove some outdated codes.	OHCA plans to remove and correct several codes to reflect most current codes in use.
	Internal and DHCS review of new codes that align with existing codes in the primary care code set.	OHCA plans to add new codes for telehealth evaluation and management, COVID vaccine administration, and pharmacist subspecialties to align with existing code set.