OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

May 21, 2025

HCAI

Department of Health Care Access and Information

Agenda

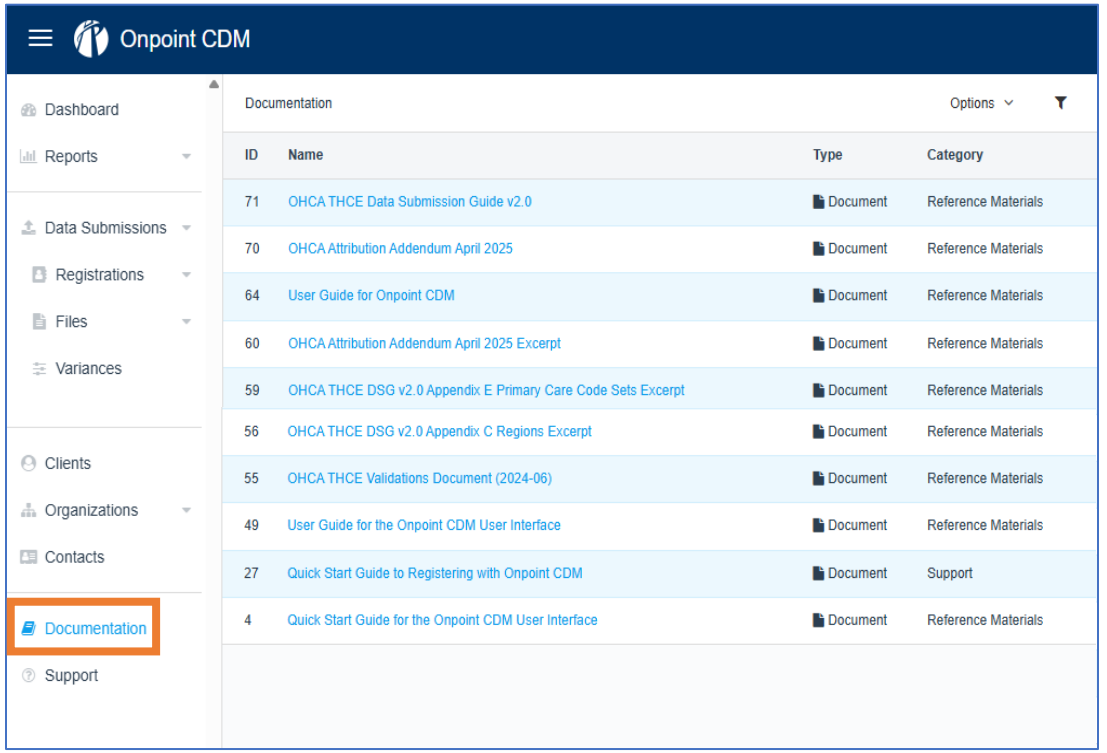
1. OHCA Updates and DSG Files Overview
2. Reporting Payments Across Files for Claims and Non-Claims Payments
3. Attributing Total Medical Expense
4. Submitter Round Table
5. Next Steps

OHCA Updates and DSG Files Overview

OHCA Updates

- Reminder: Annual submitter registration due **May 30, 2025**.

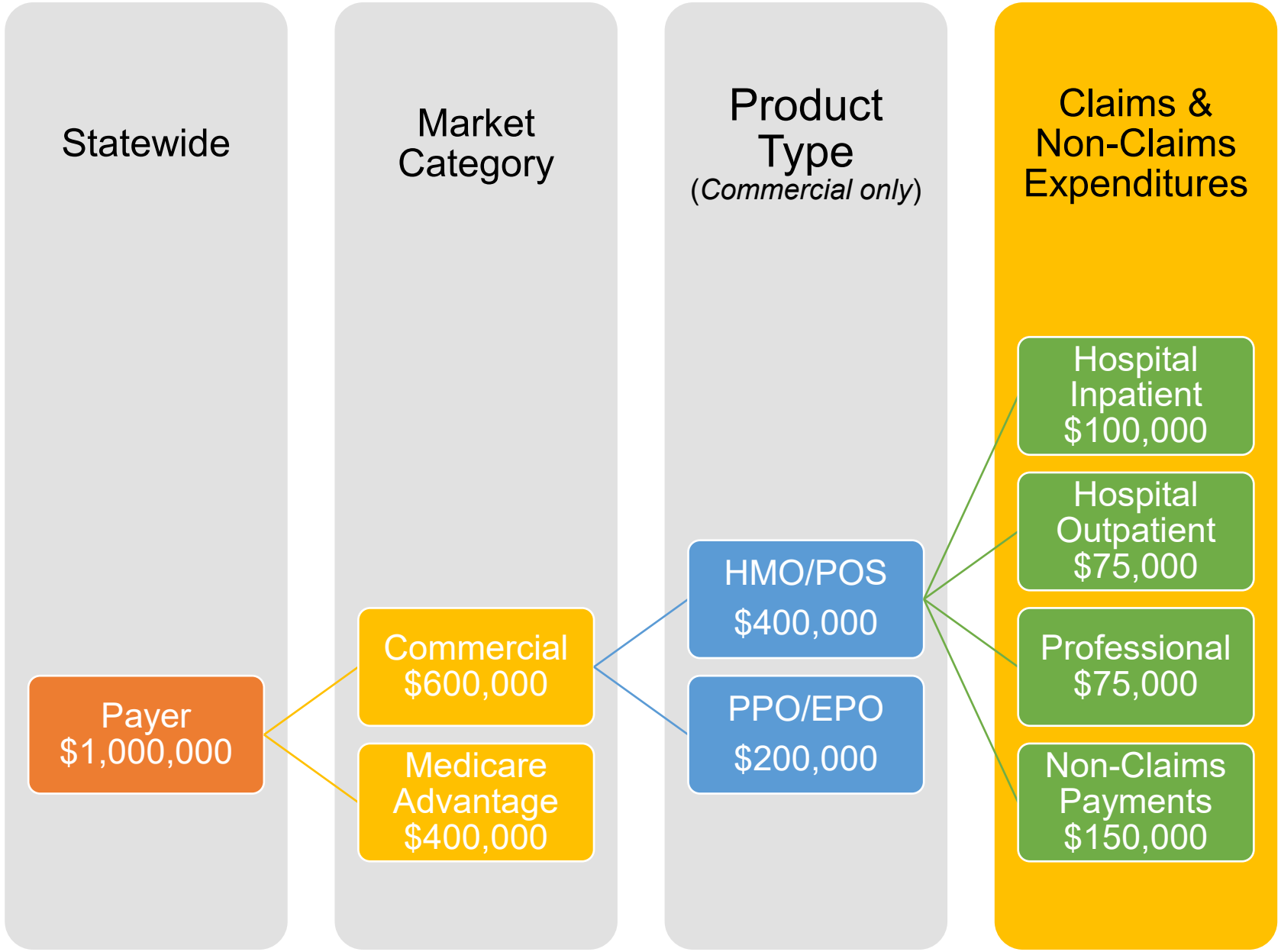
- Excel excerpts of DSG tables posted on **Documentation** page in CDM:
  - OHCA Attribution Addendum
  - Appendix C: Regions
  - Appendix E: Primary Care Code Sets



DSG Files Overview

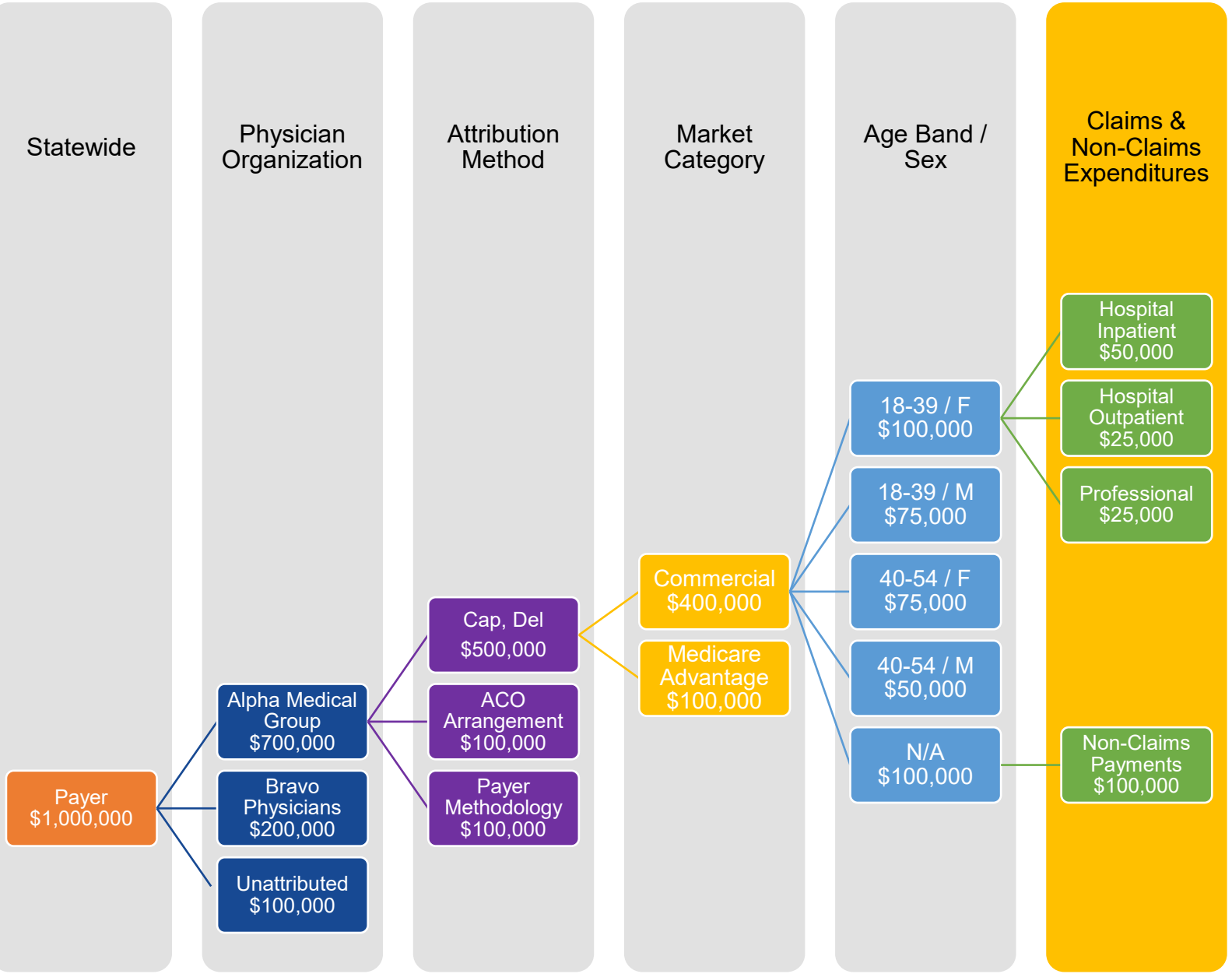
- For 2025, there are seven files described in the THCE Data Submission Guide (DSG) version 2.0
  - Commercial and Medicare Advantage data is required in all seven files
  - Medi-Cal data is required in only two files
- Six files contain aggregated total medical expense (TME) data; the seventh file is a submission questionnaire
- The following slides illustrate how TME is reported in each file, and which market categories are required to report TME data in each file

Statewide TME File



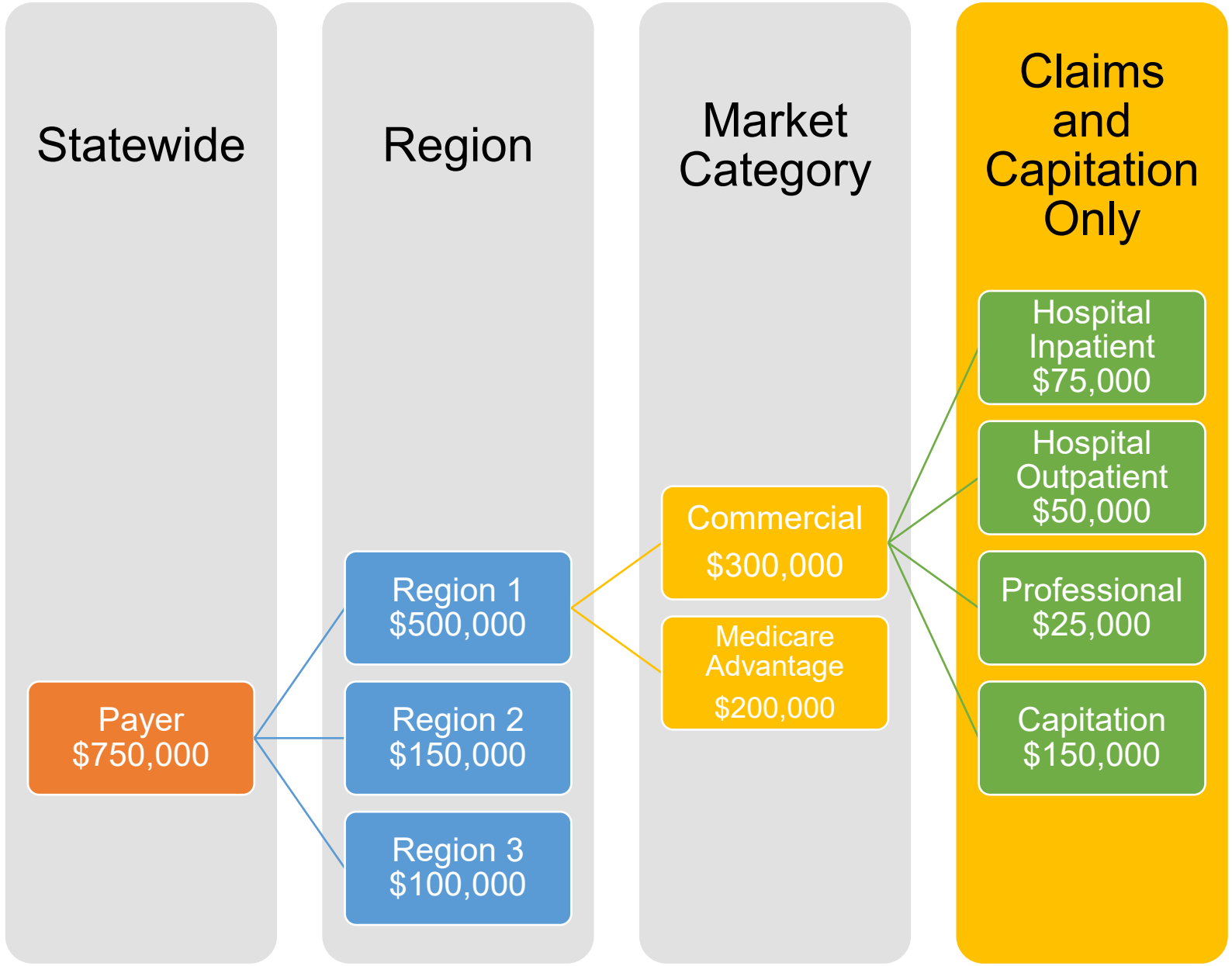
Required for Market Categories:
1. Commercial (Full Benefits)
2. Commercial (Partial Benefits)
3. Medi-Cal Managed Care
4. Medicare Advantage
5. Dual Eligibles (Medi-Cal Expenses Only)
6. Dual Eligibles (Medicare Expenses Only)
7. Dual Eligibles (Medi-Cal and Medicare Expenses)

Attributed TME File



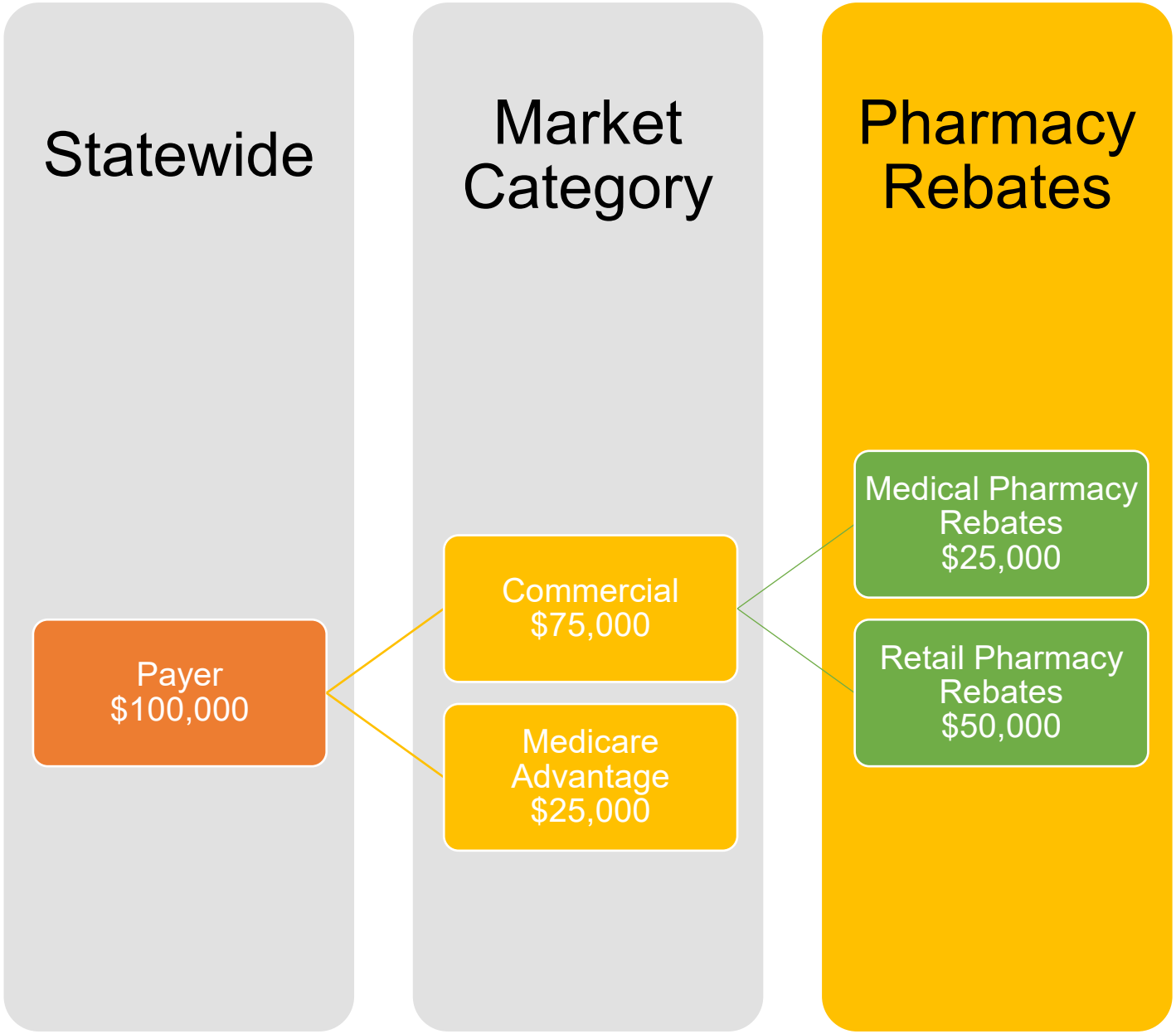
Required for Market Categories:
1. Commercial (Full Benefits)
2. Commercial (Partial Benefits)
3. Medi-Cal Managed Care
4. Medicare Advantage
5. Dual Eligibles (Medi-Cal Expenses Only)
6. Dual Eligibles (Medicare Expenses Only)
7. Dual Eligibles (Medi-Cal and Medicare Expenses)

Regional TME File



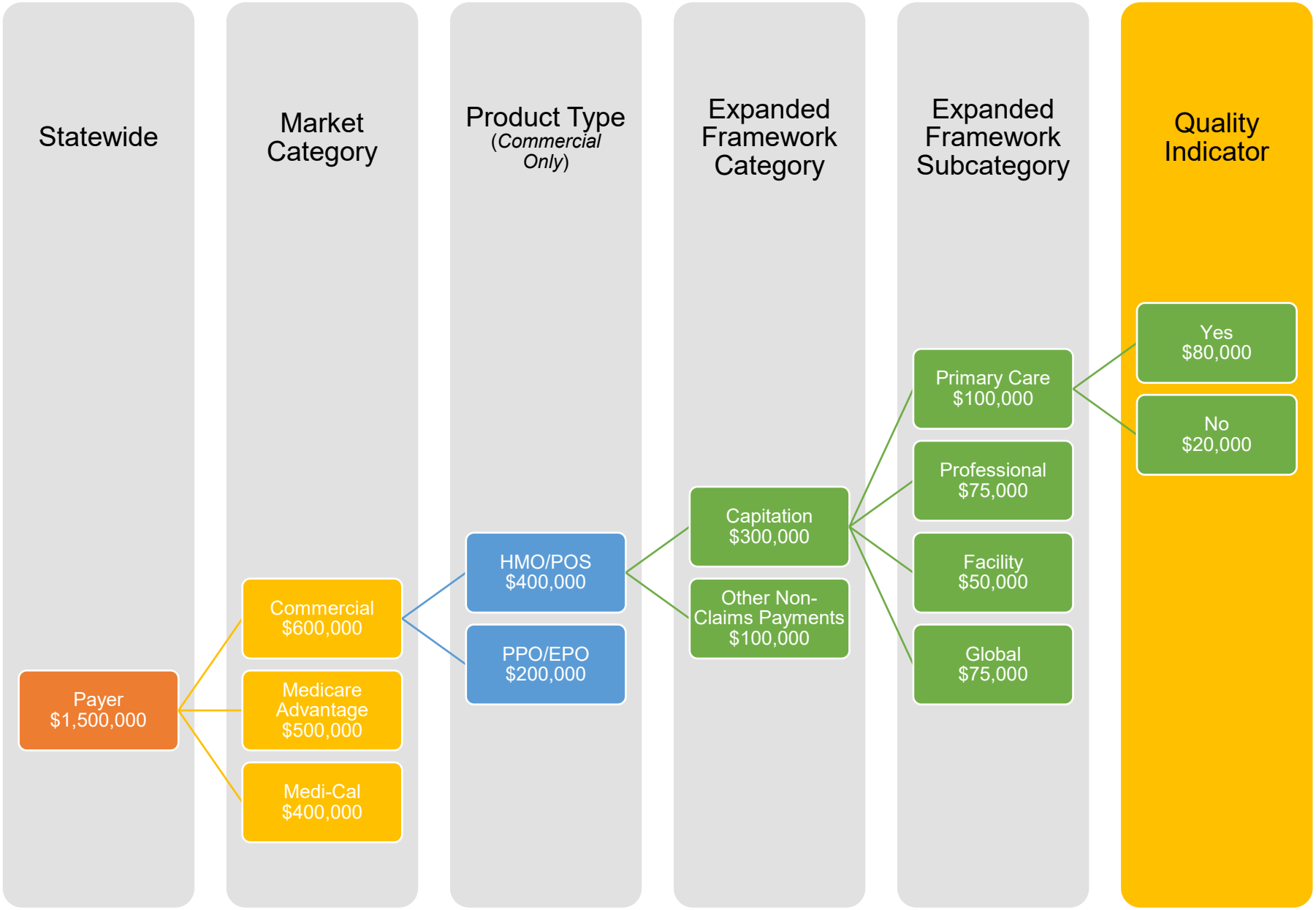
Required for Market Categories:
1. Commercial (Full Benefits)
2. Commercial (Partial Benefits)
3. Medi-Cal Managed Care
4. Medicare Advantage
5. Dual Eligibles (Medi-Cal Expenses Only)
6. Dual Eligibles (Medicare Expenses Only)
7. Dual Eligibles (Medi-Cal and Medicare Expenses)

Pharmacy Rebates File



Required for Market Categories:
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)

APM File



Required for Market Categories:
1. Commercial (Full Benefits)
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3. Medi-Cal Managed Care
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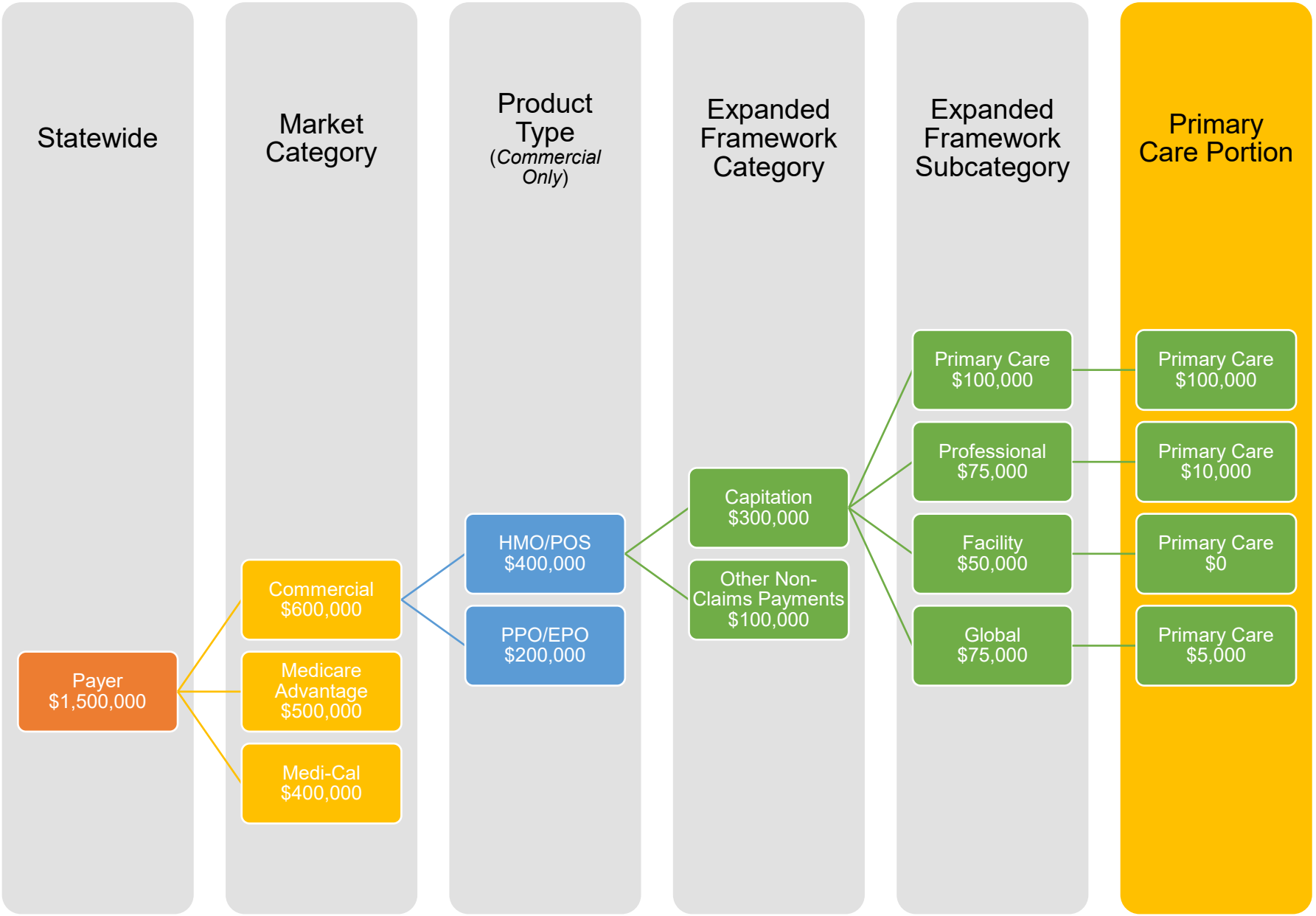
6. Dual Eligibles (Medicare Expenses Only)
7. Dual Eligibles (Medi-Cal and Medicare Expenses)

Primary Care File



Required for Market Categories:
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)

Reporting Payments Across Files for Claims and Non-Claims Payments

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.

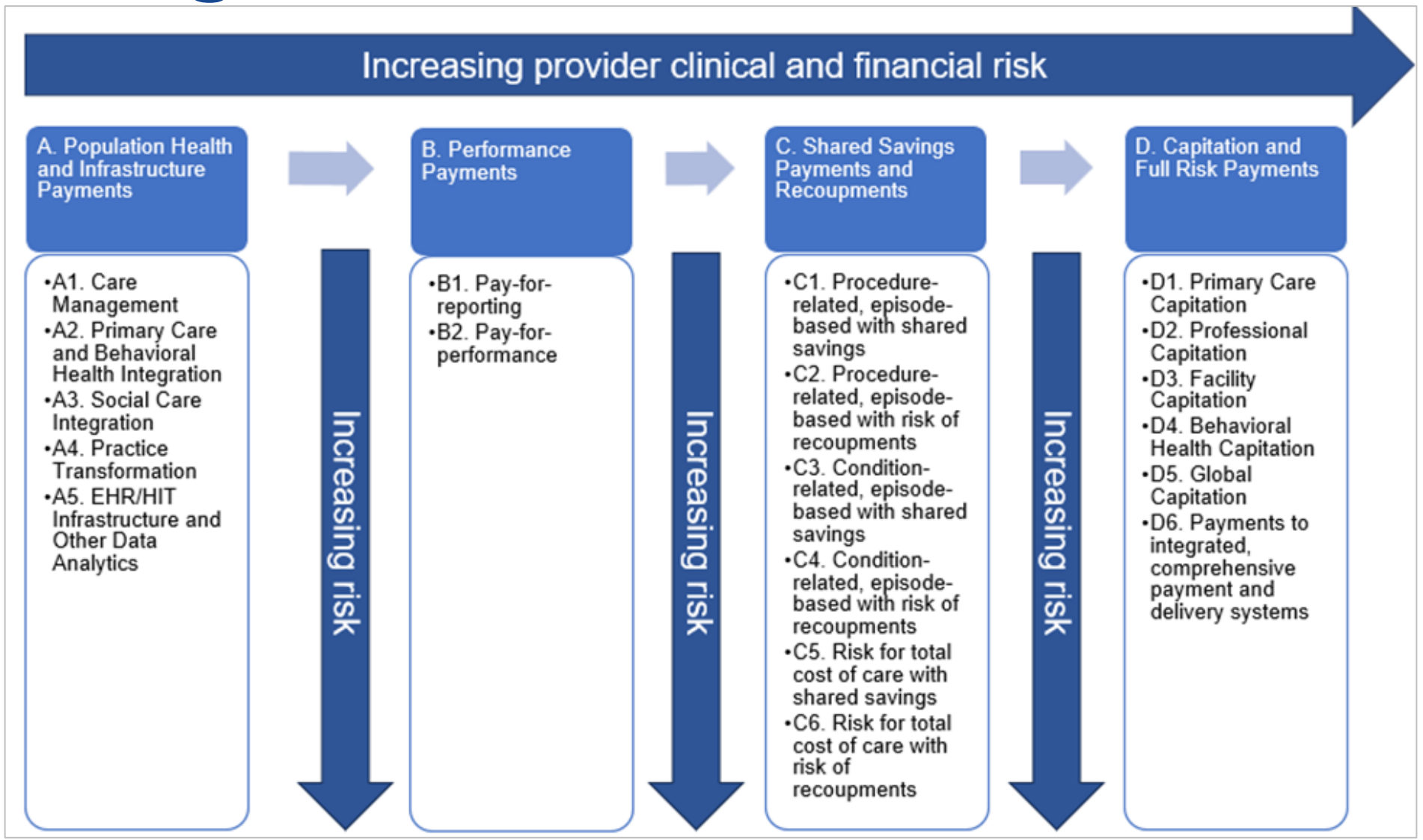
Reporting Claims Payments

Data Collection Consideration	APM File	Primary Care File	TME Files*
Where do claims dollars get reported?	In each Payment Subcategory that the submitter has a payment arrangement	Only in Payment Subcategory X9	In the corresponding service category claims fields (e.g. hospital inpatient)
Where are claims payments in FFS only arrangements reported?	Only in Payment Subcategory X9	Only in Payment Subcategory X9	In the corresponding service category claims fields
Where are claims in arrangements with non-claims reported?	In the non-claims Payment Subcategory furthest along the continuum	Only in Payment Subcategory X9	In the corresponding service category claims fields

*TME files are not required for Medi-Cal MCO submitters

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

Reporting Non-Claims in the APM File



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**	

Non-Claims Payment Category A: Population Health And Practice Infrastructure

Description	Corresponding HCP-LAN Categories

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.
• 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
	• 2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

See THCE Data Submission Guide (Version 2.0) for Appendix B Expanded Non-Claims Payments Framework, dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Non-Claims Payment Category A: Population Health And Practice Infrastructure

Data Collection Consideration	APM File	Primary Care File	TME Files*
Where are A1-A5 non-claims payments reported?	In the corresponding Payment Subcategory (A1-A5) for members who are not in Category B, C, or D arrangements.	In the corresponding Payment Subcategory (A1-A5)	In "Non-Claims: Population Health and Practice Infrastructure Payments"
Are any claims payments reported in this category/subcategory?	Yes, all claims for members in the arrangement (A1-A5), who are not in a Category B, C, or D arrangement.	No, claims are only reported in Payment Subcategory X9	No, only in the service category claims fields (e.g. professional)

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Non-Claims Payment Category B: Performance Payments

Description	Corresponding HCP-LAN Categories
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. Subcategories: • B1 - Pay-for-reporting payments • B2 - Pay-for-performance payments	• 2B: Pay for Reporting: Bonuses for reporting data or penalties for not reporting data • 2C: Pay for Performance: Bonuses for quality performance

See THCE Data Submission Guide (Version 2.0) for Appendix B Expanded Non-Claims Payments Framework, dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Non-Claims Payment Category B: Performance Payments

Data Collection Consideration	APM File	Primary Care File	TME Files*
Where are performance payments reported?	In the corresponding Payment Subcategory (B1-B2) for members who are not in Category C or D arrangements.	In the corresponding Payment Subcategory (B1-B2)	In "Non-Claims: Performance Payments" field
Are any claims payments reported in this category/subcategory?	Yes, all claims for members in the arrangement (B1-B2), who are not in a Category C or D arrangement.	No, claims are only reported in Payment Subcategory X9	No, only in the service category claims fields (e.g. long-term care)
How are claims payments to providers who did not meet the performance threshold reported?	If a non-claims payment is not made, in Payment Subcategory X9.	Claims are only reported in Payment Subcategory X9	Only in the service category claims fields

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Non-Claims Payment Category C: Shared Savings Payments and Recoupments

Description	Corresponding HCP-LAN Categories
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". 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	• 3A: Shared Savings: Shared savings with upside risk only • 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

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Non-Claims Payment Category C: Shared Savings and Recoupments

Data Collection Consideration	APM File	Primary Care File	TME Files*
Where are shared savings or recoupment payments reported?	In the corresponding Payment Subcategory (C1-C6) for members who are not in Category D arrangements.	In the corresponding Payment Subcategory (C1-C6)	In "Non-Claims: Shared Savings Payments and Recoupments" field
Are any claims payments reported in this category/subcategory?	Yes, all claims for members in the arrangement (C1-C6), who are not in a Category D arrangement.	No, claims are only reported in Payment Subcategory X9	No, only in the service category claims fields (e.g., hospital outpatient)
How are members' episode-based payments reported (C1-4)?	In the relevant Payment Subcategory (C1-4) if the member is not in a C5, C6, or Category D arrangement.	Only in Payment Subcategories C1-4	In the corresponding non-claims category field

*TME files are not required for Medi-Cal MCO submitters

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Non-Claims Payment Category D: Capitation and Full Risk

Description	Corresponding HCP-LAN Categories
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 of time. 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". 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	• 4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health • 4B: Comprehensive Population-based Payment: Global budgets or full/percent of premium payments • 4C: Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems • 4N: Capitated payments not linked to quality

See THCE Data Submission Guide (Version 2.0) for Appendix B Expanded Non-Claims Payments Framework, dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Non-Claims Payment Category D: Capitation and Full Risk

Data Collection Consideration	APM File	Primary Care File	TME Files*
Where are capitation payments reported?	In the corresponding Payment Subcategory (D1-D6)	In the corresponding Payment Subcategory (D1-D6)	In “Capitation and Full Risk Payments” field
Are any claims payments reported in this category/subcategory?	Yes, all claims for members in the arrangement (D1-6).	No, claims are only reported in Payment Subcategory X9	No, only in the service category claims fields (e.g., retail pharmacy)

*TME files are not required for Medi-Cal MCO submitters
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Non-Claims Payment Category E: Other Non-Claims Payments

Description	Corresponding HCP-LAN Categories
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. Examples include: 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	N/A

See THCE Data Submission Guide (Version 2.0) for Appendix B Expanded Non-Claims Payments Framework, dated April 2025: https://hcai.ca.gov/wp-content/uploads/2025/04/THCE-Data-Submission-Guide-v2.0.pdf

Non-Claims Payment Category E: Other Non-Claims Payments

Data Collection Consideration	APM File	Primary Care File	TME Files*
Where are non-claims payments that are not categorized in Payment Subcategory A1-D6 reported?	In Payment Subcategory E1	In Payment Subcategory E1	In “Non-Claims: Other” field
Are any claims payments reported in this category/subcategory?	No, claims payments for members should be reported in the payment subcategory furthest along the continuum for provider clinical and financial risk	No, claims are only reported in Payment Subcategory X9	No, only in the service category claims fields (e.g., Claims: Other)

*TME files are not required for Medi-Cal MCO submitters

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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

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**

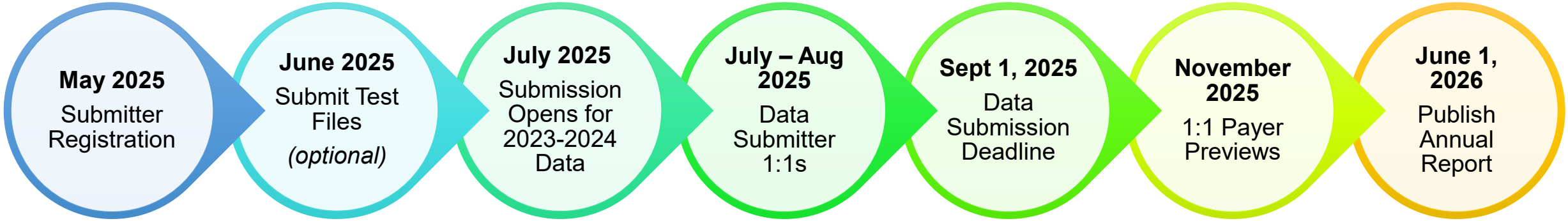
Attribution Reminders

- 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.

Submitter Round Table

Next Steps

2025 Data Collection Timeline



Next Steps

- Next workgroup meeting – June 25, 2025 1:00 – 2:30pm
- Topics
  - Data submission best practices
  - Reviewing submission errors in Onpoint CDM
  - Requesting a variance
  - Primary care payment allocation
- Send questions to OHCA@HCAI.ca.gov