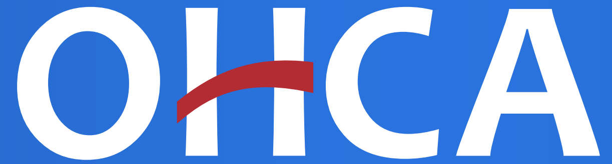
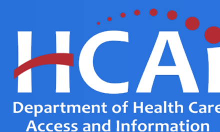


Total Health Care Expenditures (THCE) Data Submitter Workgroup

October 9, 2024



Agenda

1. Data Submission Guide 2.0 Proposed Changes
2. Alternative Payment Model (APM) and Primary Care data collection
3. Payer Previews
4. Submitter Round Table
5. Next Steps

Data Submission Guide 2.0

Data Submission Guide 2.0

- DSG 2.0 outlines requirements for submission of 2023-2024 data in 2025
- Draft will be shared for public comment in early 2025
- Annual registration due by May 31, 2025
- Data submission due by September 1, 2025

DSG 2.0 Proposed Changes

- Require licensed health plans and insurers to register and submit data separately
- Remove PO/TIN list requirement from 2025 registration
- Remove Los Angeles SPAs from Regional file; use two Covered CA rating regions for Los Angeles members
- Remove standalone Pharmacy Rebates file
  - Retail and Medical Pharmacy Rebates fields added to Statewide TME file
- Remove some duplicative fields in response to submitter feedback (e.g., drop Member Responsibility from Attributed and Regional files)
- Add two new files for Alternative Payment Model and Primary Care data

DSG 2.0 Proposed Changes

- Currently, OHCA sources administrative costs and profits data from other federal and state filings (such as MLR reports).
- OHCA is considering adding a field for payers to report their net administrative costs and profits by market category as part of TME data submission.
- DSG 2.0 would include formulas to use and references to specific line items as shown on the next slides.

DSG 2.0 Proposed Changes

To calculate administrative costs and profits for the Commercial Fully-Insured* market using the CCIIO MLR report:

Premiums Earned (Pt.1, Line 1.1)

– Adjusted Incurred Claims (Pt.3, Line 1.2)

– Quality Improvement Expenses (Pt.3, Line 1.3)

– MLR Rebates (Pt.3, Line 5.4)

= Amount Reported

*Sum of Individual, Small Group, Large Group, and Student columns on MLR report.

DSG 2.0 Proposed Changes

To calculate administrative costs and profits for the Medicare Advantage market using the CCIIO MLR report:

Premiums Earned (Pt.1, Line 1.1)

– Total Incurred Claims (Pt.1, Line 2.1)

– Quality Improvement Expenses (Pt.1, Line 4.6)

+ Fraud Expenditures (Pt.2, Line 2.18a)

= Amount Reported

If the payer does not submit an MLR report to CCIIO for the Medicare Advantage market, use the following amounts from the California DMHC Schedule L form:

Premium amount from Title XVIII Medicare column

– Total Medical and Hospital amount from Title XVIII Medicare column

= Amount Reported

Alternative Payment Model Data Collection

Focus Areas for Promoting High Value

Focus Area	Activities
Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Alternative Payment Models

Statutory Requirements

- Promote the shift of payments based on fee-for-service (FFS) to alternative payment models (APMs) that provide financial incentive for equitable high-quality and cost-efficient care.
- Convene health care entities and organize an APM workgroup, **set statewide goals** for the adoption of APMs, **measure the state's progress** toward those goals, and **adopt contracting standards** healthcare entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.

Health and Safety Code 127504(a-d)

APM Standards and Goals Adopted

At the June 2024 meeting, the Board adopted the proposed APM Standards and Adoption Goals.

Baseline established on 2024 data collected in 2025, to be categorized via Expanded Framework. Data on 2026 goal collected in 2027, reported in 2028.

	APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type			
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

See OHCA website for APM Standards and Goals: https://hcai.ca.gov/affordability/ohca/#laws-and-regulations

HCAI Non-Claims Data Collection

Data Collection Consideration	APM	TME/ Primary Care	HPD
Reporting Expanded Framework subcategory?	Yes	No	Yes
Reporting payments in categories/subcategories	All member TME in one category	Actual non-claims payments	Actual non-claims payments
Frequency of data collection	Annual	Annual	Annual; monthly capitation

Expanded Non-Claims Payment Framework, Categories 1-3

	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

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Expanded Non-Claims Payment Framework, Categories 4-6

	Expanded Non-Claims Payment 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**	

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network. https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

Draft Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
1	APM001	Data 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 = Medi-Cal Expenses for Dual Eligibles • 6 = Medicare Expenses for Dual Eligibles • 7 = Dual Eligible Special Needs Plans (D-SNPs)
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
5	APM005	Payment Category	Text	1	A = Population health and practice infrastructure payments B = Performance payments C = Payments with shared savings and recoupments D = Capitation and full risk payments E = Other non-claims payments X = Fee for service Select a corresponding Payment Subcategory based on the initial character in the Payment Category.

Draft Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
6	APM006	Payment Subcategory	Text	2	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

Draft 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 may 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". Valid values are: • 0 = No • 1 = Yes
8	APM008	Total Amount Paid/Allowed	Integer	12	Total of all payments made across billing providers during the Reporting Year. For non-fee-for-service payments, this is the amount paid across providers by the data submitter. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
9	APM009	Member Months	Integer	12	Report the total number of months of coverage for members associated with the arrangement indicated in APM005 and APM006. All months where a member had at least 1 day of coverage are counted. If APM006 is A4, A5, C1, C2, C3, C4, or E1 valid value includes: 0 = Not applicable **Note**: This field reported as an integer.

Draft Alternative Payment Model File Layout

Col. #	Field ID	Field Name	Type	Max	Description
10	APM010	Number of Episodes	Integer	12	Report the total number of episodes when APM006 is populated C1, C2, C3, or C4. When APM006 is not C1, C2, C3, or C4, valid value includes: 0 = Not applicable **Note:** This field reported as an integer.
11	APM011	Condition/Procedure Type	Integer	2	Use this field to report the condition/procedure type code for all entries populated with C1-C4 in APM006. Refer to Condition and Procedure Types for more information. Valid values when APM006 is C1 and C2 include: • 1 = Cardiovascular Procedures • 2 = Gastrointestinal Procedures • 3 = Orthopedic Procedures • 4 = Transplant Procedures • 5 = Other Procedures Valid values when APM006 is C3 and C4 include: • 7 = Chronic/Outpatient-Based Conditions • 8 = Acute/Hospitalization-Based Conditions • 8 = Oncology Conditions • 9 = Pregnancy • 10 = Other Conditions **Note:** When APM006 is not C1, C2, C3, or C4, the valid value is: • 0 = Not Applicable
12	APM012	Record Type	Text	3	Use this field to report the value of ‘APM’ to indicate APM reporting at the data submitter level.

Interest in Collecting Risk Scores of APM Members

- The Health Care Affordability Board is interested in knowing whether APMs serve high acuity Californians and has asked OHCA to collect data on the health of members in APMs*.
- Example data collection:

Col. #	Field ID	Field Name	Type	Max	Description
3	HD003	File Type	Text	3	Use this field to report the code that indicates the type of data being submitted. The only valid codes for this field are: • SWT = Statewide TME • ATT = Attributed TME • RET = Regional TME • SQS = Submission Questionnaire • APM = Alternative Payment Model • PRC = Primary Care
9	HD009	Risk Score (FFS Only)	Decimal	1,5	This field is used only when HD003 is "APM". Report the risk score of all members who are in fee-for-service only arrangements (i.e. they are not in any type of alternative payment model arrangement).
10	HD010	Risk Score (APM Arrangements)	Decimal	1,5	This field is used only when HD003 is "APM". Report the risk score of all members who are in APM arrangements with any non-claims payment as defined by the Expanded Non-Claims Payment Framework in Appendix X.

Note: Risk scores will not be used to adjust payments or compared across data submitters as risk adjustment tools may vary.

Primary Care Data Collection

Focus Areas for Promoting High Value

Focus Area	Activities
Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Primary Care Investment

Statutory Requirements

- Measure the **percentage of total health care expenditures allocated to primary care** and **set spending benchmarks** that consider current and historic underfunding of primary care services.
- Determine the categories of providers, specific procedure codes, and non-claims payments that should be considered when determining the total amount spent on primary care.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Promote improved outcomes for primary care and sustained systemwide investment in primary care.
- Include an analysis of **primary care spending and growth in the annual report.**
- Consult with state departments, external organizations promoting investment in primary care, and other entities and individuals with expertise in primary care.

Health and Safety Code § 127505 (a) – (c)

Primary Care Investment Benchmark (OHCA Recommendation)

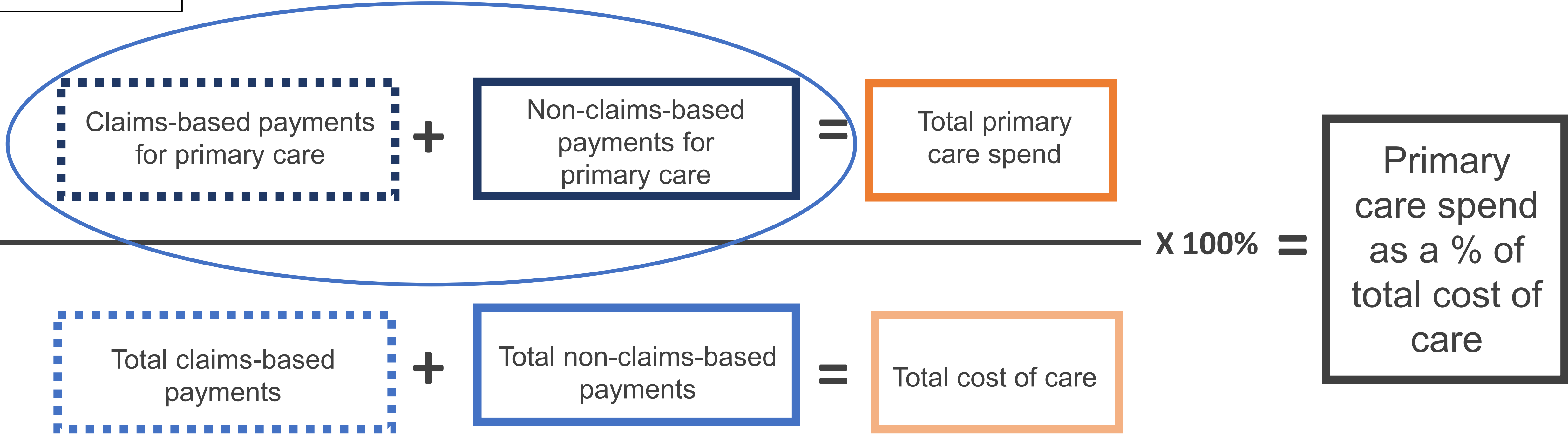
Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% per year for each payer by line of business and product type
Performance Year	**Investment Benchmark**
2034	15% statewide across all payers, lines of business, and product types

Data Collection Considerations:

- Motion to approve this stakeholder-endorsed OHCA recommendation pending at October Board meeting.
- If approved, progress towards first annual improvement benchmark will be assessed for performance year 2025 on data collected in 2026.
- Baseline for 0.5-1% increase **per year for each payer** established on **2024** data collected in 2025.
- Numerator includes primary care claims, a subset of Claims: Professional, and primary care non-claims, a subset of specific **Expanded Framework subcategories**.
- Denominator is **total medical expense**.

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

Measuring Primary Care Spending



Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021

Required for Primary Care

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

Required for Primary Care

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**	

*OHCA is discussing whether there are Medi-Cal Other Non-Claims Payments that may be apportioned to primary care with DHCS.

Primary Care File Layout

Col. #	Field ID	Field Name	Type	Max	Description
1	PRC001	Data 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 = Medi-Cal Expenses for Dual Eligibles • 6 = Medicare Expenses for Dual Eligibles • 7 = Dual Eligible Special Needs Plans (D-SNPs)
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
5	PRC005	Payment Category	Text	1	A = Population health and practice infrastructure payments B = Performance payments C = Payments with shared savings and recoupments D = Capitation and full risk payments E = Other non-claims payments X = Fee for service Select a corresponding Payment Subcategory based on the initial character in the Payment Category.

Primary Care File Layout

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Primary Care File Layout

Col. #	Field ID	Field Name	Type	Max	Description
7	PRC007	Total Amount Paid/Allowed	Integer	12	Total of all payments made across billing providers during the Reporting Year. For non-claims payments, this is the amount paid across providers by the data submitter. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
8	PRC008	Amount Paid for Primary Care	Integer	12	Total of all payments made across billing providers for primary care during the Reporting Year. For fee-for-service payments follow the OHCA primary care claims definition provided in Appendix X to determine the portion allocated to primary care. For non-claims payments follow the OHCA primary care non-claims allocation methodology specific to each payment subcategory outlined in Appendix X. If PRC006 is C1, C2, D3 or D4 valid value includes: 0 = Not applicable
9	PRC009	Member Months	Integer	12	Report the total number of months of coverage for members associated with the payment reported in PRC007. All months where a member had at least 1 day of coverage are counted. If PRC006 is A4, A5, C1, C2, C3, C4, or E1 valid value includes: 0 = Not applicable **Note**: This field reported as an integer.
10	PRC010	Record Type	Text	2	Use this field to report the value of 'PC' to indicate primary care reporting at the data submitter level.

APM and Primary Care Data Submitter Feedback

1. Do data submitters have feedback on use of payment category and subcategory fields for both APM and PC files?
2. Can submitters populate member months associated with payments in the subcategories in green displayed on the right?
3. Do submitters have feedback on condition/procedure types, definitions, and associated conditions/procedures for episode-based shared savings payments? Do the options align with current models? These will be emailed out for feedback.
4. Will a submission deadline for the APM and Primary Care files after the TME files ease reporting burden or do you prefer an aligned due date? Note: Run out of claims and non-claims across all OHCA submissions will be the same.
5. Can data submitters run health status adjustment tools to develop risk scores for members in an APM and those who are in fee-for-service only arrangements?

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
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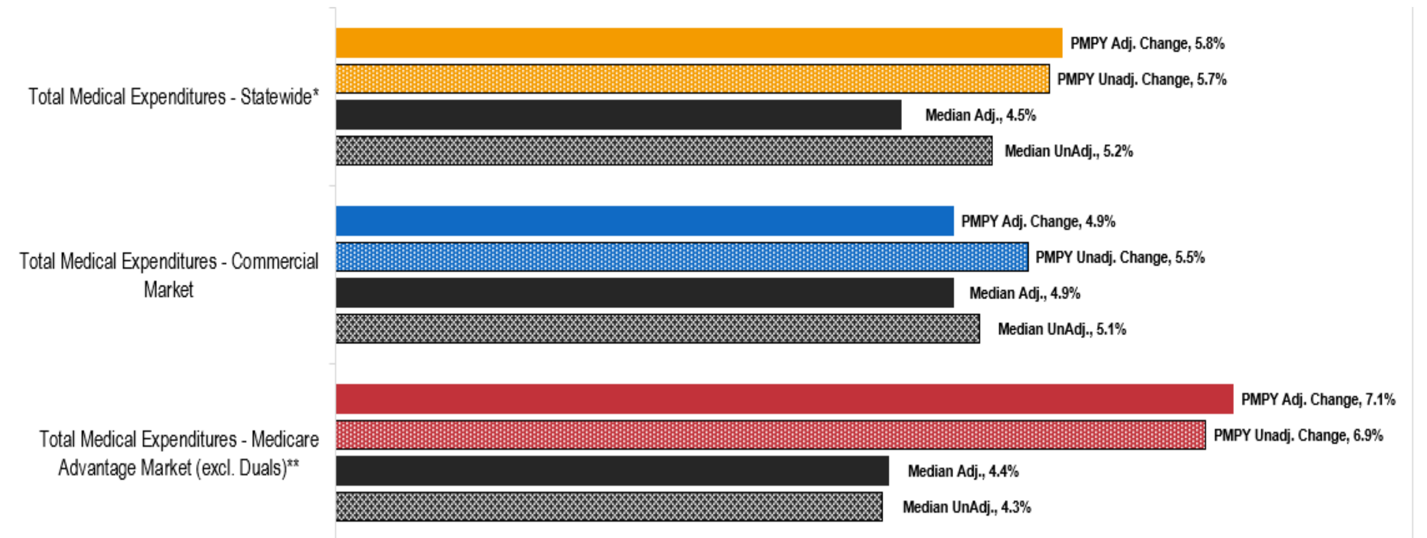
C4 = Condition-related, episode-based payments with risk of recoupments
C5 = Risk for total cost of care (e.g., ACO) with shared savings
C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments
D1 = Primary care capitation
D2 = Professional capitation
D3 = Facility capitation
D4 = Behavioral health capitation
D5 = Global capitation
D6 = Payment to integrated, comprehensive payment and delivery systems (Linked to quality)
E1 = Other non-claims payments
X9 = Claims: Total

Payer Previews

Payer Previews

1. November – December
2. 30 minutes
3. We will share a spreadsheet with descriptive statistics in advance
4. For each payer:
   - Enrollment
   - Aggregate spend
   - Absolute and relative change in PMPY
5. We will ask clarifying questions

Payer ADJ and UNADJ PMPY TME Growth, 2022 - 2023



*Statewide refers to the sum of all expenditures or total PMPY spending across the applicable markets shown (Commercial and Medicare Advantage). Note that Medi-Cal MCO is excluded from the Statewide calculation.
**Dual-eligible beneficiaries reported in Medicare Advantage plans (Market Code = '6') and D-SNP plans (Market Code = '7') are excluded from Medicare Advantage results.

Submitter Round Table

Next Steps

Next Steps

1. Please provide feedback to OHCA on information presented today by 10/16/2024 at OHCA@HCAI.ca.gov
2. Next workgroup meeting – January 2025
3. OHCA will reach out to schedule payer previews