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OFFICE OF HEALTH CARE AFFORDABILITY
FINDING OF EMERGENCY OF PROPOSED EMERGENCY REGULATIONS

HEALTH CARE SPENDING TARGETS;
TOTAL HEALTH CARE EXPENDITURES (THCE) DATA COLLECTION

SUBJECT MATTER OF PROPOSED REGULATIONS

This rulemaking updates total health care expenditures (THCE) data collection pursuant to Health and Safety Code sections 127501 *et seq.* (spending targets program), in the California Code of Regulations (CCR) at Title 22, Division 7, Article 2, sections 97445 and 97449.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

The Office of Health Care Affordability (OHCA or the Office) within the Department of Health Care Access and Information (HCAI) is statutorily required to increase cost transparency through public reporting of per capita total health care spending and factors contributing to cost growth. (Health & Saf. Code, § 127501, subd. (c)(1).) OHCA is also statutorily required to advance standards for promoting the adoption of alternative payment models and to measure and promote systemwide investment in primary care. (Health & Saf. Code, § 127501, subds. (c)(8), and (c)(9).) OHCA is required to adopt emergency regulations to carry out these functions and the adoption of these regulations is statutorily deemed to be an emergency for purposes of administrative rulemaking. (Health & Saf. Code, § 127501.2, subd. (a).)

As directed by statute, OHCA specifically finds these emergency regulations necessary for the immediate preservation of public health and safety, and general welfare of the citizens of California. (*Id.*)

OHCA previously adopted emergency regulations, effective March 4, 2024, implementing THCE data collection (hereinafter, the "THCE data collection regulations"). (Cal. Code Regs., tit. 22, § 97445, *et seq*.) The THCE data collection regulations require specified payers and fully integrated delivery systems (collectively hereinafter, "submitters") to annually register and submit health care spending data to OHCA on an ongoing basis. (Cal. Code Regs., tit. 22, § 97449, subds. (e) through (h).) The THCE data collection regulations also incorporate two documents by reference: the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.1)*, dated June 2024 ("THCE Data Submission Guide" or the "Guide"); and the *OHCA Attribution Addendum*, dated June 2024 ("OHCA Attribution Addendum" or "Attribution Addendum"). Submitters use the instructions in the Guide and Attribution

Addendum to extract and aggregate THCE data in a standardized format before submission to OHCA.

Since adoption of the THCE data collection regulations, OHCA has determined certain clarifying amendments to the regulations and updates to the documents incorporated by reference are necessary. Among other things, this regulatory proposal makes necessary changes to the submitter registration process and streamlines attribution of member-level total medical expenses. This regulatory proposal also adds two new files to THCE data collection related to *OHCA's Alternative Payment Model (APM) Adoption Goals* and *OHCA's Primary Care Investment Benchmark*, approved by the Health Care Affordability Board (Board) in June 2024 and October 2024, respectively.[1] The new APM and Primary Care files will enable OHCA to meet its statutory mandate to measure and report on alternative payment model adoption and primary care spending and growth in its first annual report. (Health & Saf. Code, §§ 127504, subds. (a) and (c); and 127505, subds. (a) and (b).)

Pursuant to Health and Safety Code section 127501.4(k), OHCA must engage relevant stakeholders, hold a public meeting to solicit input, and "provide a response to input received" prior to adopting data collection regulations. The Board is also required to discuss proposed emergency regulations during at least one Board meeting prior to OHCA's adoption. (Health & Saf. Code, § 127501.2, subd. (c).)

For purposes of this regulatory proposal, OHCA held regularly scheduled meetings with its THCE Data Submitter workgroup to solicit feedback and inform regulation development, on the following dates:

- March 13, 2024
- April 17, 2024
- May 15, 2024
- June 18, 2024
- July 17, 2024
- October 9, 2024[2]
- January 15, 2025
- January 22, 2025 (Medi-Cal payer focus)

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[1] *See* Memo Re: OHCA's Alternative Payment Model (APM) Standards and Adoption Goals, available at: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/, last accessed January 27, 2025; and Memo Re: OHCA's Primary Care Investment Benchmark, available at: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/primary-care-investment-benchmark/, last accessed March 6, 2025.

[2] In lieu of holding THCE Data Submitter Workgroup Meetings in August and September 2024, OHCA met one-on-one with each required submitter to address technical questions related to THCE submission and to solicit additional feedback on ways to improve the data submission process.

- February 26, 2025
- March 26, 2025

Additionally, the specifications for the new APM and Primary Care files were informed by OHCA's Investment and Payment Workgroup, which consists of stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans. OHCA's Investment and Payment Workgroup began regularly scheduled monthly meetings in June 2023.

OHCA posted a draft of these proposed revisions on its public website on January 8, 2025, with a 23-day window for submission of written comments. OHCA received one email with substantive comments from a health plan and one letter with substantive comments from an industry lobby group. Additionally, during the aforementioned comment period, OHCA discussed the proposed revisions at the January 28, 2025 Board meeting (in-person and virtual). There were zero public comments regarding the revisions at the Board meeting.

OHCA provided a summary of the public comments regarding the January 2025 draft of these regulations to the Board at its February 25, 2025 meeting. Following thorough consideration of input received from all stakeholders, OHCA made responsive changes to these proposed revisions and provided an update to the Board at its March 25, 2025 meeting.

OHCA collects THCE data annually by September 1. Because payers and fully integrated delivery systems need sufficient time to extract and aggregate THCE data in accordance with the requirements outlined in this rulemaking prior to September 1, 2025, OHCA must adopt these regulations as soon as possible. (Health & Saf. Code, § 127501.4, subd. (d)(2); Cal. Code Regs., tit. 22, § 97449, subd. (h)(2).)

AUTHORITY AND REFERENCE

Pursuant to Health and Safety Code sections 127501(c)(16), 127501.2, and 127501.4(k), OHCA shall adopt, amend, or repeal, in accordance with the Administrative Procedure Act, rules and regulations as may be necessary to enable it to carry out the laws relating to the collection of data and other information from health care entities under the California Health Care Quality and Affordability Act (Health and Safety Code, section 127500, *et seq*. (Act).)

These regulations implement, interpret, or make specific Health and Safety Code sections 127500.2, 127500.5, 127501.4, 127504, and 127505.

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INFORMATIVE DIGEST

Existing Law

OHCA's existing THCE data collection regulations:

- Define terms used in the regulations. (Section 97445.)
- Specify who is a required submitter and how voluntary submitters may request to participate. (Section 97449(a) through (c).)
- Outline how submitters should coordinate data submission with their subcontracted health plans and affiliates. (Section 97449(d).)
- Set deadlines for submitter registration and data file submission. (Section 97449(e) through (h).)
- Describe other requirements related to data file specifications, test files, data acceptance and correction, and variance requests. (Section 97449(i) through (l).)

OHCA's existing THCE data collection regulations also incorporate by reference:

- The *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.1),* dated June 2024 ("THCE Data Submission Guide" or the "Guide"). The Guide contains requirements related to the extraction and aggregation of data for submission to OHCA. The Guide also provides technical specifications, file layouts, reporting schedules, and other instructions to ensure submission of accurate THCE data in a standardized format. The Guide is available on, and may be downloaded from, the HCAI website.

- The *Office of Health Care Affordability: Attribution Addendum*, dated June 2024 ("OHCA Attribution Addendum" or "Attribution Addendum"). The Attribution Addendum contains a list of physician organizations with unique identifiers submitters must use when attributing total medical expenses. OHCA periodically updates the names and identifying information in the Attribution Addendum as physician organizations reorganize, enter, and exit the health care market. The Attribution Addendum is available on, and may be downloaded from, the HCAI website.

General Policy Statement

In 2022, the Act (Senate Bill (SB) 184, Chapter 47, Statutes of 2022) established OHCA within HCAI. Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, the Legislature expressed its intent to:

> …have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care, with the goal of improving affordability, access, and

equity of health care for Californians. (Health & Saf. Code, § 127500.5, subd. (b).)

In enacting SB 184, the Legislature charged OHCA with doing all of the following:

(1) Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs.
(2) Addressing cost increases in excess of health care cost targets through public transparency, opportunities for remediation, and other progressive enforcement actions to achieve cost targets that optimize value in health care spending.
(3) Referring transactions that may reduce market competition or increase costs to the Attorney General for further review. (Health & Saf. Code, § 127500.5, subds. (o)(1) through (o)(3).)

When fully implemented in 2028, OHCA's spending targets program will collect, analyze, and publicly report THCE data and progressively enforce health care spending targets set by the Board. (Health & Saf. Code, § 127501, subd. (b).)

This rulemaking amends regulations contained in Title 22 of the CCR that implement SB 184 with regard to collecting data and measuring total health care spending.

This proposal will:

- Amend section 97445 to clarify terms defined for purposes of Article 2 of Chapter 11.5 of Division 7 of Title 22 of the CCR.
- Amend section 97445 to update version numbers and dates of documents incorporated by reference through this regulatory action.
- Amend section 97449 to remove language that is no longer applicable following completion of the first annual THCE data submission in September 2024.
- Amend section 97449 to require submitters to submit remediated files within five business days of notification by OHCA that a previously accepted file contains initially unidentified errors.
- Amend section 97449 to clarify variance requests granted by OHCA will not carry over to future data submission years.

This proposal also incorporates by reference:

- An updated version of the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0)*, dated April 2025 (hereinafter, "Guide Version 2.0"). The Guide Version 2.0 contains requirements

related to the extraction and aggregation of data for submission to OHCA. The Guide Version 2.0 also provides technical specifications, file layouts, reporting schedules, and other instructions to ensure submission of accurate THCE data in a standardized format. Each update to the Guide Version 2.0 is described in the *Total Health Care Expenditures Data Submission Guide (Version 2.0)* section of this Finding of Emergency, below.

The Guide Version 2.0 will be available on, and may be downloaded from, the HCAI website.

- An updated version of the *Office of Health Care Affordability: Attribution Addendum*, dated April 2025 ("OHCA Attribution Addendum" or "Attribution Addendum"). This document contains a list of physician organizations with unique identifiers submitters must use when attributing total medical expenses. Each update to the Attribution Addendum is described in the *OHCA Attribution Addendum* section of this Finding of Emergency, below.

  The updated Attribution Addendum will be available on, and may be downloaded from, the HCAI website.

SPECIFIC PURPOSE AND NECESSITY FOR EACH REGULATION

Amend section 97445 of Division 7 of Title 22, Definitions.

Subsection (a)

OHCA amends the term "affiliation" to "affiliated" to align the term with how it is actually used in the regulations in subsection 97449(d) for consistency. OHCA also adds a cross-reference to the regulations where the term is used for clarity. This avoids confusion regarding its application because "affiliation" is defined in 22 CCR 97431 (Article 1, regarding transaction reviews) in a different context.

OHCA strikes "affiliate" in parentheses because the regulation text is sufficiently clear without the parenthetical.

Subsections (m) and (u)

OHCA strikes "to the System" and adds "through the Data Portal" to better align with how data submitters actually experience the data submission process. Data submitters do not interact with the Total Health Care Expenditures Data System ("THCE System" or "System"), defined in regulations in subsection 97445(q), which is used internally by OHCA to receive and process THCE data. Instead, data submitters interact with the "THCE Data Portal" or "Data Portal," defined in regulations in subsection 97445(r), and available via the Department's website, hcai.ca.gov.

Through these amendments, OHCA also intends to reduce the number of references to "System" to avoid any potential confusion over how that term is used in the context of data submission versus how it is used as part of the industry and statutory term "Fully integrated delivery system," defined in regulations in subsection 97445(f).

Subsection (s)

OHCA amends the version number of the Guide to "2.0" and the version date of the Guide to "April 2025." As explained above, required submitters use the Guide to extract and aggregate THCE data in a standardized format. These amendments ensure required submitters use the most recent version of the Guide when submitting data to OHCA. The specific changes to the Guide are discussed below.

Subsection (t)

OHCA amends the version date of the Attribution Addendum to "April 2025." As explained above, required submitters will use the Attribution Addendum to extract and aggregate THCE data in a standardized format. This amendment ensures required submitters use the most recent version of the Attribution Addendum when submitting data to OHCA. The specific changes to the Attribution Addendum are discussed below.

Reference

OHCA adds a reference citation to Health and Safety Code section 127504 [Promotion of alternative payment models and development of standards], because this regulatory proposal adds a required file type OHCA will use to measure alternative payment model adoption, implementing this statute.

Similarly, OHCA adds a reference citation to Health and Safety Code section 127505 [Spending benchmarks and promotion of improved outcomes], because this regulatory proposal adds a required filed type OHCA will use to measure primary care spending and growth, implementing this statute.

Amend section 97449 of Division 7 of Title 22, Total Health Care Expenditures Data Submission.

Subsection (a)(1)

OHCA strikes: "This subsection (a)(1) is effective beginning with the first annual data file submission as described in subsections (e)(2) and (h)(2)." This revision removes language that is no longer applicable following completion of the first annual data file submission in September 2024.

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Subsection (d)(1)

OHCA strikes “to the System” and adds “through the Data Portal” for the same reasons explained in reference to the proposed revisions to subsections 97445(m) and (u).

Subsection (e)

OHCA amends subsection 97449(e) to add the word “[a]nnual” to the subsection title and adds the following sentence: “All required submitters and approved voluntary submitters shall register in the Data Portal annually by the last business day of May.” The amendment to the subsection title emphasizes the existing requirement that required submitters and approved voluntary submitters re-register every year. The amendment of the registration deadline from May 31st to the last business day of May avoids potential confusion when May 31st falls on a weekend (as it does in 2025).

OHCA strikes subsection 97449(e)(1) because the language is no longer applicable following completion of the first annual data file submission in September 2024. OHCA strikes subsection 97449(e)(2) because the proposed amendments relocate ongoing registration requirements to subsection 97449(e).

Subsection (h)

OHCA amends subsection 97449(h) to add the word “[a]nnual” to the subsection title. This amendment to the subsection title emphasizes the existing requirement that registered submitters submit data every year.

OHCA also amends subsection 97559(h) to add the following sentence: “All registered submitters shall submit data files through the Data Portal annually by September 1 of the year following each reporting year as specified in the Guide.” This amendment relocates language establishing the annual submission deadline from existing subsection 97449(h)(2).

OHCA strikes subsection 97449(h)(1) because the language is no longer applicable following completion of the first annual data file submission in September 2024. OHCA strikes subsection 97449(h)(2) because the proposed amendments relocate this requirement to subsection 97449(h).

Subsection (k)(1)

OHCA strikes “to the System” and adds “through the Data Portal” for the same reasons explained in reference to the proposed revisions to subsections 97445(m) and (u).

Subsection (k)(2)

OHCA strikes “through the Data Portal” and replaces it with “by the Office” because OHCA plans to notify registered submitters directly by email if a data file contains errors

identified by OHCA after submission. During the registration process, OHCA collects the email addresses for three separate contacts from each registered submitter (a regulatory contact, business contact, and technical contact). Based on OHCA's experience with the data file submission in September 2024, registered submitters prefer to be contacted directly via these email addresses to quickly resolve any data issues and to keep all relevant parties apprised of progress in real time.

OHCA strikes "respond" and replaces it with "submit remediated files." OHCA also strikes "three" and replaces it with "five" in reference to business days. Together, these revisions require a submitter to remediate and re-submit a data file within five business days of a notification from OHCA that an accepted file contains previously unidentified errors. Under the existing regulations, submitters are only required to "respond" to a notification within three business days.

These clarifications of OHCA's expectations during the resubmission process are necessary to ensure submitters act expediently to prioritize and address errors in their data submission. Based on OHCA's experience with the September 2024 data file submission, five business days is a reasonable timeframe for remediation and prevents data errors from impacting OHCA's ability to timely process and report THCE data.

Subsection (l)

OHCA adds the sentence: "Variance requests granted by the Office will be limited in duration and will not carry over to future data submission years." This requirement already appears in the existing Guide in Section 4.2, "Data Variance Requests." OHCA elevates it from the incorporated document to the printed regulatory text of subsection 97449(l) due to its general application and regulatory importance.

Total Health Care Expenditures Data Submission Guide (Version 2.0)

OHCA's existing THCE data collection regulations incorporate by reference the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.1)*, dated June 2024 (the "THCE Data Submission Guide" or the "Guide"). OHCA proposes through this regulatory action to replace this version of the Guide with an updated version, the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0)*, dated April 2025 (hereinafter, "Guide Version 2.0"). For purposes of this regulatory proposal, OHCA identifies the updates from the existing Guide to Guide Version 2.0 using green underline text for additions and red strikethrough text for deletions. If this regulatory proposal is approved, the final Guide Version 2.0 will include the identified updates and appear as a "clean" unmarked document.

Proposed subsection 97445(s) incorporates the Guide Version 2.0 by reference. Like the existing Guide, Guide Version 2.0 provides submitters with detailed technical specifications for the extraction, aggregation, and submission of THCE data in a standardized format. The proposed updates to Guide Version 2.0 are informed by

OHCA's experience with the initial September 2024 THCE data submission, including feedback received from submitters during and after the data submission process.

As described more fully below, in addition to updates to existing required files, Guide Version 2.0 adds two new required files: the Alternative Payment Model (APM) file and the Primary Care (PC) file. These additional files were developed after extensive consultation with OHCA's contracted experts in APM adoption and primary care investment measurement. The specifications for the APM and PC files were also informed by input from OHCA's Investment and Payment Workgroup, which began monthly meetings in June 2023, and brings together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans.

The Guide Version 2.0 will be available on, and may be downloaded from HCAI's website, located at: https://hcai.ca.gov/about/laws-regulations/#total-health-care-expenditures-thce-data-submission.

The following descriptions provide the specific purpose and necessity of updates to Guide Version 2.0, incorporated by reference in this regulatory proposal.

Cover Page, Footers, "Table of Contents," and "Version History"

OHCA updates the version number of the Guide to "Version 2.0" and the date of the Guide to "April 2025" throughout the document, including on the cover page and in all headers.

OHCA updates the "Table of Contents" to reflect revised section titles, new sections, new appendices, and accurate page numbers.

OHCA adds a row for Version 2.0 in the "Version History" table. This new row includes a bulleted summary of changes reflected in Guide Version 2.0.

Each of these updates is necessary for accuracy and to ensure users can effectively navigate the Guide Version 2.0.

Section 1.2, "Data Submission Deadlines."

OHCA strikes text in the first paragraph of this section because the information it contains will no longer be relevant to users in April 2025, which is OHCA's proposed date for release of the Guide Version 2.0. OHCA adds new text in the first paragraph of this section to highlight dates that will be "upcoming" for users starting in April 2025. Namely, the September 1, 2025 deadline for submission of 2023 and 2024 THCE data and June 1, 2026 release date for OHCA's second report on health care spending.

These revisions do not change any requirements for submitters and are consistent with OHCA's established reporting schedule.

OHCA adds the following sentence to this section: "Files may be submitted individually as they are ready; however, a submission will not be deemed complete until all required files are received." During the initial September 2024 data submission, several submitters asked if required files could be submitted on a rolling basis as each file was finalized. Submission on a rolling basis is mutually beneficial for submitters and OHCA. For submitters, it is an opportunity to "test" the ability to submit a complete file meeting OHCA's specifications before finalizing multiple files. For OHCA, it provides earlier access to data, and if errors are identified, more time to work with a submitter to resolve issues that could impact multiple files.

This amendment is necessary to clarify that rolling file submission is permitted, but submission of THCE data is not deemed complete until all required files are received. The language is consistent with proposed Section 3.1 of the Guide Version 2.0, which specifies a "complete" submission contains all required file types.[3]

Section 2, "Submitter Registration."

Paragraph 1

OHCA replaces "[a]ll" with "[e]ach year, all" in paragraph one of this section for clarity and consistency with 22 CCR 97449(e). This amendment is necessary to ensure submitters complete a new registration each year with accurate, up-to-date identifying information. A submitter's market presence can change year to year, and the number of market categories applicable to a submitter's data dictates the number of rows that will be in each of the required file types comprising a complete data submission. A submitter with covered lives in multiple market categories will have more rows in each required file than a submitter with covered lives in a single market category. Accordingly, OHCA uses the information on applicable market categories obtained during registration to help confirm that the files in a submitter's data submission are complete. Additionally, because OHCA collects and reports on historical data, OHCA needs a verifiable point-in-time snapshot of each submitter's registration information that aligns with the applicable reporting year.

Paragraph 2

OHCA amends paragraph two of this section to strike language referring to the initial September 2024 data submission because it is no longer applicable. OHCA adds the sentence: "Submitters shall complete separate registrations for each health plan, health insurer, or other payer as defined in 22 CCR 97445, for which they will report THCE data."

[3] This requirement in proposed Section 3.1 is not new to the Guide Version 2.0. It is relocated from the existing Guide Section 3.

Presently, submitters are only required to complete one registration in which they identify all the licensed health plans, health insurers, or other payers for which they will report THCE data (hereinafter, "parent" registration). Submitters then submit one set of files detailing total medical expenses for covered health benefits during the reporting period aggregated across all their lines of business, regardless of how each line of business is licensed. Based on feedback received from submitters and OHCA's experience with the initial September 2024 data submission, requiring a single registration and set of files from a "parent" entity creates challenges for submitters and OHCA. Most significantly, 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 two state departments – the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) – submitters are accustomed to storing and reporting data for these license types separately, at the license-level. Indeed, many submitters informed OHCA that the existing "parent" registration required novel coordination between licensed entities with distinct regulatory staff and data systems.

Additionally, the existing "parent" registration is not aligned with the registration process for HCAI's Health Care Payments Data (HPD) program. In OHCA's experience, the submitter contacts for the HPD program and THCE data submission overlap because the data submissions involve similar data sources, extracted and aggregated differently. Accordingly, the existing "parent" registration is a source of confusion for submitters who also register annually at the license-level with the HPD. The lack of alignment between how entities register with the HPD program and OHCA (and consequently, how entities' data flows into each program) may also make it more difficult for OHCA to utilize HPD program data for future reporting. For these reasons, OHCA's proposed language requiring submitters to complete separate registrations for health plans, health insurers, and other payers, is necessary to reduce submitters' administrative burden and ensure consistency across HCAI's data collection programs.

OHCA replaces "end" in the last sentence of paragraph two of this section with "last business day" for consistency with the proposed revisions to 22 CCR 97449(e). OHCA incorporates the reasons it provides for the proposed revisions to 22 CCR 97449(e) here.

Paragraph 3

OHCA makes multiple revisions to the list of required information provided during registration in the THCE Data Portal for clarity and consistency with the proposal to require submitter registration at the license-level, discussed under *Paragraph 2*, above.

First, OHCA relocates the items "License Type and License Number" and "National Association of Insurance Commissioners (NAIC) Code(s)…" up the list of required items from existing numbers 6 and 7 to proposed numbers 2 and 3 for clarity because it is logical for fields containing identifying information to be grouped together

at the beginning of the registration process. This is a non-substantive change, as no obligation is changed.

Second, OHCA adds the item "Parent company name" because the information is necessary for OHCA to determine how to aggregate or "roll up" spending data submitted at the license-level to the "parent" level. The term "parent" in this context is widely understood in the industry. Requiring this detail allows OHCA to compare spending data submitted at the "parent" level during the September 2024 data submission with spending data OHCA proposes to receive at the license-level in September 2025.

Third, OHCA adds a reference to Section 4.4, "Market Categories" for clarity because this is the first reference to Market Categories in the Guide Version 2.0. This reference is intended to direct a user of the Guide Version 2.0 to Section 4.4 for more information on the types of spending included in each Market Category.

Fourth, OHCA makes clarifying changes to the names of the existing "Medi-Cal Expenses for Dual-Eligibles," "Medicare Expenses for Dual-Eligibles," and "Special Needs Plans (D-SNPs)" Market Categories. OHCA incorporates the reasons it provides for the proposed revisions to Section 4.4, "Market Categories" here.

Fifth, OHCA adds the following item: "For Each Market Category selected above, the number of members as of December 31st of the most recent reporting year." The addition of this item is necessary for OHCA to confirm each submitter meets the minimum enrollment thresholds in 22 CCR 97449(a). Currently, OHCA utilizes enrollment data published by the California Health Care Foundation (CHCF) to establish submitter enrollment. CHCF's annual analysis makes use of data from DMHC and CDI databases.[4] However, registered submitters are the most accurate source of this data broken out by market category. Collecting this information directly from registered submitters also ensures agreement between OHCA and each entity regarding enrollment calculations.

Finally, OHCA strikes the requirement submitters provide a list of organizations for which the submitter can attribute total medical expenses for California members. OHCA strikes this requirement to reduce submitter administrative burden. OHCA incorporates the reasons it provides for the proposed revisions to the "OHCA Attribution Addendum" here.

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[4] *See* Wilson, Katherine. 2025 Edition – California Health Insurers, Enrollment (February 24, 2025), California Health Care Foundation, available at: https://www.chcf.org/publication/california-health-insurers-enrollment-almanac/#related-links-and-downloads, last accessed March 5, 2025.

Section 2.1, “Test File Submission.”

OHCA replaces “may opt” with “are strongly encouraged” in reference to test file submission to encourage submitters to avail themselves of the option to submit test files. Based on OHCA’s experience with the September 2024 data submission, the test file process provides submitters with a valuable opportunity to confirm their submission protocols are in working order ahead of the data submission deadline. For this same reason, OHCA also adds a sentence explaining why test files are useful.

Section 3, “File Intake Requirements.”

Subsection 97449(i) provides data files submitted to OHCA must comply with the file format, field specifications, and other standards in the Guide. Currently, Section 3 of the Guide identifies the files that comprise a complete data submission and instructs submitters how to format text entered into each data field across all files.

OHCA proposes dividing Section 3 into three subsections for clarity and to improve the Guide Version 2.0’s ease of use. Consistent with this proposed change, OHCA revises the title of Section 3 to “File Intake Requirements” because this title is more specific and more accurately reflects the contents of this section. OHCA also replaces the phrase “specifications shall” with “requirements” in the text introducing this section because it better aligns with the new section title and subsection titles.

Each proposed new subsection in Section 3 is discussed in turn, below.

Section 3.1, “Required Files.”

OHCA relocates the list of file types from Section 3 of the existing Guide into a new Section 3.1, titled “Required Files.” OHCA proposes this title for clarity and to emphasize submission of each file type is required for a THCE data submission to be deemed complete. OHCA relocates the sentence beginning with “A complete submission contains the following…” from existing Section 3 and revises the “five” to “seven” in reference to the number of required files. This revision reflects the proposed addition of two new file types, as follows:

…

6. Alternative Payment Model (APM) – total medical expenses for covered health benefits during the reporting period broken out by Expanded Non-Claims Payments Framework category and subcategory.
7. Primary Care – primary care portions of total medical expenses for covered health benefits during the reporting period broken out by market category and, where applicable, product type.

The purpose of listing the APM and Primary Care files in this section is to identify these new files as required files in a complete THCE data submission. The APM and Primary Care files are necessary to collect THCE data at the level of granularity required for

OHCA to measure and report on alternative payment model adoption and primary care spending and growth in its annual report. (Health & Saf. Code, §§ 127504, subds. (a) and (c); and 127505, subds. (a) through (b).)

OHCA replaces “contracting arrangement” with “where applicable, product type” in the brief description of the Statewide Total Medical Expenses (TME) file for consistency and accuracy. With regards to the removal of contracting arrangement, OHCA incorporates the reasons it provides in reference to removal of the payment arrangement data field in Section 4.4 here. OHCA’s inclusion of product type does not reference a new requirement. The existing Statewide TME file includes a data field for product type (SWT004).

Under the list of file types, OHCA adds an instruction and illustrative example applicable to “parent” entities with multiple registered submitters, as follows:

> Submitters reporting data for more than one health plan and/or health insurer shall complete separate file submissions for each registered entity. The total medical expenses reported for each registered entity shall be mutually exclusive.
>
> For example, Payer A separately registers two entities: a health plan, licensed by the Department of Managed Health Care, and a health insurer, licensed by the Department of Insurance. Payer A receives a unique Submitter Code for each registered entity. Payer A submits a complete set of files reflecting total medical expenses for the health plan’s lines of business using the health plan’s Submitter Code. Payer A separately submits a complete set of files reflecting total medical expenses for the health insurer’s lines of business using the health insurer’s Submitter Code.

The purpose of this instruction is to avoid potential confusion related to OHCA’s proposed change from “parent” registration to license-level registration, described in Section 2, “Submitter Registration,” *Paragraph 2*, above. This instruction is necessary because the change to license-level registration requires each registered submitter to submit a set of files reflecting spending for the registered submitter only, mutually exclusive of spending by other registered submitters. The spending in each set of files must be mutually exclusive to ensure OHCA’s THCE calculations are accurate and do not double count any spending by registered submitters who share a “parent” entity.

Section 3.1.1, “Special Requirements for Medi-Cal Data Submission in 2025.”

Proposed Section 3.1.1 informs submitters of special requirements for Medi-Cal data submission in 2025.

Pursuant to 22 CCR 97449(a)(1), Medi-Cal managed care plans are not required to submit THCE data until September 1, 2025. This effectively delayed implementation of the THCE data collection regulations *apropos* of all spending in the “Medi-Cal Managed Care” and “Medi-Cal Expenses for Dual Eligibles” market categories for one year. As a

result, for the September 2024 data submission, OHCA collected data for these market categories directly from the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). The one-year delay gave OHCA the opportunity to explore whether existing data sources were comprehensive enough to meet OHCA's reporting needs. The one-year delay was also consistent with the legislature's directive that "to the greatest extent possible," OHCA use existing data sources "to minimize administrative burdens and duplicative reporting…" (Health & Saf. Code, § 127501.4, subd. (a)(1).)

OHCA's analysis of September 2024 data is currently ongoing. However, based on receipt of the DHCS and CMS data currently available, it is unlikely the existing state and federal data sources will allow OHCA to conduct analysis at a level comparable to its analysis of commercial and Medicare Advantage data obtained directly from submitters. As a result, OHCA cannot rely exclusively on existing data sources for these market categories and does not propose to extend the implementation delay through this regulatory action.

Instead, for the data submission in 2025, OHCA proposes a phased in approach. In 2025, submitters are only required to report spending in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories in the proposed new APM and Primary Care files. For all other file types (*i.e.*, the existing five file types), submitters may choose to voluntarily report spending in the in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories. Beginning with the data submission in 2026, OHCA plans to collect data for all market categories in all files.

OHCA includes a table denoting required (R) and voluntary (v) files for each market category for clarity.

Section 3.2, "Required Format."

OHCA relocates formatting specifications from Section 3 of the existing Guide into proposed Section 3.2, titled "Required Format." OHCA chose this title for clarity and to emphasize submission of each file type using a standardized format is required.

OHCA revises "[s]ubmission format" to "[f]ile format" for accuracy. "File format" is more accurate because the specifications require submitters to produce pipe delimited files, not pipe delimited submissions.

OHCA adds language requiring submitters to encrypt all files using the OpenPGP encryption standard and explaining how submitters will interact with Onpoint, OHCA's data management vendor (introduced in Section 1.1), when securely transferring encrypted files. During the September 2024 data submission, submitters successfully encrypted all data files using the OpenPGP encryption standard to be compliant with other laws and/or consistent with their own internal practices. Although the existing

Guide does not include an express encryption requirement. OHCA seeks to remedy its oversight through this regulatory proposal.

Encryption is necessary to ensure spending data is exchanged securely and in compliance with state and federal law. OpenPGP encryption allows for the secure exchange of data between two parties using a public and private key pair to encrypt sensitive data. OHCA selected OpenPGP encryption because it is a widely utilized industry standard, and it aligns with how HCAI receives claims data for the HPD program. Additionally, submitters can meet the OpenPGP encryption standard without incurring any additional cost. In the unlikely event that submitters do not already have access to OpenPGP encryption software, it is publicly available for download at https://openpgp.org, which OHCA references in footnote 5 of the Guide Version 2.0 for the convenience of submitters. Therefore, using OpenPGP is the most effective and least burdensome method of providing this sensitive data securely to OHCA.

OHCA adds the following sentence to this section referencing how to indicate missing data: "Note: Any amount field with no reportable dollars shall be reported as 0 and not null or missing." OHCA adds this sentence in response to questions it received from submitters during the September 2024 data submission. Specifically, submitters were unsure whether fields without reportable dollars should be left blank. This sentence is necessary to clarify submitters should not leave fields blank. In OHCA's experience, blank fields can lead to data errors because it is unclear whether omissions are intentional or due to an oversight.

Section 4, "Data Submission Information."

OHCA revises the title of Section 4 from "General Information" to "Data Submission Information" for clarity. The latter title is more descriptive and is intended to improve the Guide Version 2.0's ease of use.

Section 4.1.1, "Claims Payments."

OHCA updates the dates in the parenthetical example included in this section for the convenience of users of the Guide Version 2.0. For the September 2024 data submission, the claims reconciliation period for 2022 and 2023 service dates was June 30, 2024. For the upcoming September 2025 data submission, the claims reconciliation period for 2023 and 2024 service dates is June 30, 2025.

Section 4.1.2, "Non-Claims Payments."

OHCA updates the dates in the parenthetical example included in this section for the convenience of users of the Guide Version 2.0. For the September 2024 data submission, the non-claims reconciliation period for 2022 and 2023 service dates was June 30, 2024. For the upcoming September 2025 data submission, the non-claims reconciliation period for 2023 and 2024 service dates is June 30, 2025.

OHCA strikes "…including incentives, capitation, risk settlements, and other non-claims-based payments" for consistency and accuracy. The existing language in this section of the Guide already refers submitters to "Appendix B" for more information on non-claims payments categories. Because "Appendix B" provides more comprehensive descriptions of non-claims payments, it is the best source of information on the types of payments submitters should include in their data submissions as non-claims payments.

OHCA revises the title of "Appendix B," referenced in this section from "Appendix B: Non-Claims Payments Framework" to "Appendix B: Expanded Non-Claims Payments Framework" for consistency and accuracy. As explained more fully in the "Appendix B, Expanded Non-Claims Payments Framework" section of this Finding of Emergency, OHCA updates the title of "Appendix B" because it is an expanded, updated iteration of the existing appendix with instructive non-claims payments subcategories.

Section 4.1.3, "Pharmacy Rebates."

OHCA relocates the first sentence of this section to a new second paragraph and adds the qualifying introductory phrase "[f]or most members." OHCA then adds the following language:

> If pharmacy benefits are carved-out, submitters shall create a reasonable estimate of pharmacy rebates for members in the Commercial (Partial Benefits) market category. Refer to Market Categories for more information.

OHCA makes these clarifying changes in response to questions received from submitters about how to reconcile the existing specifications for the Commercial (Partial Benefits) market category in Section 4.4, "Market Categories," with the current language in this section. These changes address any potential confusion and refer submitters to the related information in Section 4.4 for more information.

Section 4.3, "Included Population."

OHCA relocates the following two sentences from this section to a proposed new Section 4.3.1, "Exclusions" for consistency and clarity:

> …
> Claims paid for residents of states other than California who receive care from California providers shall not be included.
> …
> Total medical expenses and member months for members with whom the submitter is not directly contracted (*i.e.*, members "from other plans") shall not be included.

While non-substantive, these proposed changes ensure this section instructs submitters on how to identify the included member population, consistent with the section title. As described more fully in reference to proposed Section 4.3.1, OHCA proposes

consolidating all instructions on how to identify excluded spending into a new, more comprehensive section for clarity.

Section 4.3.1, "Exclusions."

OHCA proposes adding this section in response to questions received from submitters asking OHCA to confirm whether certain lines of business should be excluded from data submissions. Because many submitters also participate in the spending target program in Oregon and are familiar with the "Excluded LOBs" section in Oregon's technical specifications manual, OHCA decided to add a similar section to the Guide Version 2.0 for consistency and clarity. Like the "Excluded LOBs" section in Oregon's manual, proposed Section 4.3.1 contains a bulleted list of excluded lines of business along with other excluded items.[5] This section is necessary to ensure the types of spending excluded from data submissions are consistent across submitters and promotes consistency and standardization in submitted data. This section is also necessary to ensure the lines of business included in data submissions are consistent with the law. For example, dental-only insurance and vision-only insurance are excluded from the "line of business" definition in OHCA's enabling statute. (*See* Health & Saf. Code, § 127500.2, subd. (m).) The inclusion of certain types of spending could also lead to double counting and impact the accuracy of data. For example, Medicare supplemental insurance (Medigap) generally reimburses all or a portion of the member responsibility amounts for Medicare beneficiaries. As specified in Section 4 of the existing Guide, these member responsibility amounts are already captured as part of the "allowed amount" for covered health care benefits.

OHCA notes that during the informal comment period for this regulatory proposal, stakeholders questioned whether the intent of the listed exclusions was to exclude spending on mandatory supplemental benefits in Medicare Advantage plans. To avoid any confusion regarding the intent of this section, OHCA deleted a proposed exclusion specific to gym memberships (an optional supplemental benefit in some Medicare Advantage plans). OHCA does not intend to exclude spending for any specific covered health care benefits. Instead, OHCA excludes the bulleted items from total medical expense calculations to ensure the amounts reported reflect the actual cost of care provided without adjustments for post-reporting financial reconciliations.

Section 4.4, "Market Categories."

OHCA adds the phrase "..., and the estimated amounts must be reported in the Submission Questionnaire file" to the final sentence describing the "Commercial (Partial Benefits)" market category to provide OHCA insight into the proportion of commercial spending estimated by each submitter. Consistent with this new requirement, OHCA

[5] *See* Oregon's Health Care Cost Growth Target Program Data Specification Manual (CGT-2) at p. 17, available at: https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/CGT-2-Data-Specification-Manual.pdf, last accessed January 20, 2025.

adds the following fields to the Submission Questionnaire file: Estimated Pharmacy Spending (SQS018), Estimated Behavioral Health Spending (SQS019), and Estimated Other Spending (SQS020). This new requirement and the corresponding fields are necessary for OHCA to assess the overall comparability of data, and to evaluate the impacts of "carve-outs" (an industry term of art referring to special types of services, *e.g.* behavioral health benefits and pharmacy benefits) on health care spending growth.

OHCA adds the proposed APM and Primary Care files to the list of file types that disaggregate data by product type. Categorizing commercial spending in the APM and Primary Care files by product type is necessary for OHCA to assess the potential relationship between product type, APM adoption, and primary care spending.

OHCA strikes "and payment arrangement (capitated/delegated or non-capitated/direct)" for clarity and to reduce submitter administrative burden. Based on OHCA's experience with the September 2024 data submission, the payment arrangement field added an unnecessary level of complexity to the Statewide TME file and was a source of confusion for submitters. Specifically, disaggregation by payment arrangement is challenging in scenarios where some of a member's benefits are capitated/delegated and others are non-capitated/direct. Additionally, payment arrangement does not always align with a particular product type. A health maintenance organization (HMO) product may or may not be capitated/delegated or it may be both capitated/delegated and non-capitated/direct. The same is true for preferred provider organization (PPO) products. OHCA does not currently plan to report spending in the commercial market disaggregated by payment arrangement, so the payment arrangement field is no longer necessary.

OHCA strikes existing footnotes 5 and 6 because each refers to the delayed implementation of the THCE data collection regulations apropos of all spending in the "Medi-Cal Managed Care" and "Dual-Eligibles (Medi-Cal Expenses Only)" market categories. These footnotes provide information that is no longer applicable following completion of the first annual data file submission in September 2024.

OHCA revises the name of the existing "Medi-Cal Expenses for Dual Eligibles" market category to "Dual Eligibles (Medi-Cal Expenses Only)." OHCA also strikes the existing description of this market category and replaces it with the following: "Use this market category to report total medical expenses for dual eligible members when the submitter is only administering Medi-Cal benefits." OHCA makes these changes for clarity. During the September 2024 data submission, the existing name and description of this market category was confusing for some submitters. These proposed changes, in combination with the additional changes to the other dual-eligibles market categories, clearly identify three distinct "buckets" for dual-eligibles spending: one for submitters only administering a member's Medi-Cal benefits, one for submitters only administering a member's Medicare benefits, and one for submitters administering a member's Medicare and Medi-Cal benefits. These proposed changes are necessary to avoid submission of inaccurate or inconsistent spending data for dual-eligible members.

OHCA revises the name of the existing “Medicare Expenses for Dual Eligibles” market category to “Dual Eligibles (Medicare Expenses Only).” OHCA also strikes the existing description of this market category and replaces it with the following: “Use this market category to report total medical expenses for dual eligible members when the submitter is only administering Medicare benefits.” OHCA incorporates the reasons it provided in reference to the proposed changes to the “Medi-Cal Expenses for Dual Eligibles” market category here.

OHCA revises the name of the existing “Dual Eligible Special Needs Plans (D-SNPs)” market category to “Dual Eligibles (Medi-Cal and Medicare Expenses).” OHCA also strikes the existing description of this market category and replaces it with the following: “Use this market category to report total medical expenses for dual eligible members when the submitter is administering both Medicare and Medi-Cal benefits (*e.g.*, Medicare Medi-Cal (Medi-Medi) Plans).” Based on OHCA’s experience with the September 2024 data submission, the existing name and description of this market category was confusing for some submitters because it was unclear whether the term D-SNP was inclusive of all types of D-SNPs (*e.g.*, Fully Integrated D-SNPs (FIDE SNPs), Highly Integrated D-SNPs (HIDE SNPs), and Coordination-only (CO) D-SNPs.) By replacing the reference to D-SNPs with broader language focused on the types of benefits administered by the submitter, OHCA intends to include all spending for dual-eligible members when the submitter is administering both Medicare and Medi-Cal benefits, regardless of whether the member is in a special needs plan. OHCA also incorporates the reasons it provided in reference to the proposed changes to the “Medi-Cal Expenses for Dual Eligibles” market category here.

OHCA strikes the existing “Note for Medi-Cal Expenses for Dual Eligibles and Medicare Expenses for Dual Eligibles categories” and replaces it with “Note for Dual Eligibles market categories.” OHCA also replaces the text in this note with the following:

> Member months for dual eligibles should be mutually exclusive across the three market categories. A member’s total medical expenses shall only be reported in one market category for any given month based on the benefits administered by the submitter.

OHCA makes these changes to the note for accuracy and consistency with the proposed changes to the names and descriptions of the above-referenced market categories. The existing language in the note is no longer accurate because the proposed changes to the dual-eligibles market categories prohibit reporting a member’s total medical expenses in multiple market categories in any given month.

Section 4.5, “Member Attribution.”

Member-level attribution enables measurement of total medical expenses at the physician organization level. This section provides an order of operations for attributing member-level expenses to physician organizations, including those listed in the OHCA Attribution Addendum, incorporated by reference pursuant to subsection (t) of 97445.

Under the existing attribution approach, step three in the order of operations specified in this section requires submitters to identify physician organizations not listed on the OHCA Attribution Addendum (referred to in the existing Guide as the "Attributed to Other Organizations" attribution method) and then report data for those organizations. However, based on OHCA's experience with the September 2024 data submission, existing step three adds unnecessary complexity to the Attributed TME file. Accordingly, OHCA proposes striking existing step three and adding new data fields to the Attributed TME file to capture physician organization identifying information. OHCA proposes these consolidating revisions to the member attribution order of operations for clarity and to reduce submitter administrative burden.

First, OHCA adds the following language to this section:

> In addition, submitters shall report the identifier(s) (*i.e.*, Taxpayer Identification Number (TIN) and/or National Provider Identifier (NPI)) used to identify the organization on the OHCA Attribution Addendum within their data.

Consistent with this language, OHCA adds data fields for TIN (ATT005) and NPI (ATT006) to the Attributed TME file. These changes are necessary for OHCA to make continued updates to physician organization identifying information in OHCA's Attribution Addendum. These changes are also necessary to improve the overall accuracy of OHCA's future reporting on spending attributed to physician organizations by payers and fully integrated delivery systems.

Second, for the reasons previously stated, OHCA strikes existing step 3 in its entirety and updates numbering in this section consistent with this change. OHCA relocates language in existing step 3 related to identification of physician organizations to a new "Note" section offset by a text box. Moving this language into a visual call-out box is a non-substantive change for the convenience of the user.

Third, OHCA strikes the phrase "or other organization" and item "a." from existing step 4 (proposed step 3) for consistency with the proposed removal of existing step 3. OHCA strikes item "b." referencing Organization Code '8888' because the code number is no longer necessary. Consistent with OHCA's efforts to simplify and refine the order of operations for member-level attribution, OHCA will no longer require submitters to identify physician organizations with 1-999 attributed members in a single record if those physician organizations do not appear on OHCA's Attribution Addendum. Instead, spending for these members will be reported as "Not Attributed" using existing step 5 (proposed step 4). OHCA removes this requirement, and revises existing step 5 accordingly, to reduce submitter administrative burden. As discussed more fully in the "OHCA Attribution Addendum" section of this document, OHCA intends to initially focus on larger physician organizations as it continues to refine its member attribution approach.

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Section 4.6, “Self-Insured Plans.”

OHCA revises “cost and profit” to “costs and profits” in this section for accuracy and consistency with the term “administrative costs and profits,” defined in Health and Safety Code section 127500.2(a)(1). OHCA adds “payer-submitted” and strikes “submitted by self-insured payers” in this section for clarity and accuracy. Here, OHCA intends to refer to payers operating self-insured lines of business. The existing language incorrectly suggests OHCA intends to refer to payers who are participants in a self-insured plan.

OHCA updates the field name and number “Self-Insured Business” (SQS021) to “Administrative Costs and Profits for Self-Insured Plans” (SQS023) in this section. OHCA proposes the field name update for consistency with the existing field name in Section 5.7 of the Guide. The update to the field number is necessary to accommodate new and removed fields throughout the Submission Questionnaire file.

Sections 4.7 through 4.7.2, “Standard Deviation.”

OHCA adds the qualifying phrases “and reporting year” and “each reporting year on” in multiple locations in this section. These qualifying phrases were incorrectly omitted from the existing Guide. This additional language clarifies that standard deviation values must be calculated and reported to OHCA for each reporting year separately and not for both reporting years collectively. Standard deviation values for each reporting year are necessary for OHCA to calculate confidence intervals and accurately evaluate the variability in THCE for each reporting year.

OHCA replaces “specialty” with “specialized” in reference to estimates for specialized or carved-out services in this section for accuracy. Generally, “specialty” is used in the health care industry as a descriptive term relating to a health care practitioner, facility, or clinic; “specialized” is used as a descriptive term relating to a type of care sometimes carved-out to specialized health plans or insurers. (*See, e.g.,* Health & Saf. Code, § 127500.2, subd. (o) [referring to “specialized mental health care service plan” and “specialized behavioral health-only policies”].) Accordingly, use of the term “specialized” is more accurate in this section.

Section 4.8, “APM File Payment Allocation.”

The purpose of this new section is to provide submitters with instructions for how to categorize their payment models for the APM file. Specifically, this section instructs submitters how to allocate payments and member months to the correct payment category and subcategory of the Expanded Non-Claims Payments Framework[6] in the APM file. This section is necessary because OHCA is required to annually report on

[6] The specific purpose and necessity of OHCA’s Expanded Non-Claims Payments Framework is discussed in the Appendix B, “Expanded Non-Claims Payments Framework” section of this Finding of Emergency.

health care entity progress toward meeting OHCA's APM Adoption Goals (hereinafter, the "APM Adoption Goals"), which were approved by the Board in June 2024. (Health & Saf. Code, § 127504.)

Figure 1 in this section was added in response to feedback from stakeholders during the informal comment period for this regulatory proposal. Specifically, stakeholders requested OHCA clarify the hierarchy of payment subcategories. The purpose of Figure 1 is to provide submitters with a clear illustration of how the payment subcategories fall along the continuum of provider clinical and financial risk in the APM file. Figure 1 is necessary because submitters are required to report member total medical expenses and member months in the payment subcategory furthest along the continuum of provider clinical and financial risk.

The purpose of the first "Note" in this section is to provide submitters with an example of how to categorize payment arrangements with multiple types of non-claims payments. Once again, OHCA's payment categorization guidance and the methodology used to categorize payment models was informed by the approach used in other states. Both Maryland and Delaware use the same guidance and similar examples in their respective data submission manuals.[7] Aligning guidance across states promotes comparability with national data and will give OHCA greater insight into California's APM performance relative to other states. Such guidance and methodology are necessary because OHCA's APM Adoption Goals focus on members in specified payment arrangements – specifically, Expanded Non-Claims Payments Framework categories C and D. Submitters must categorize payment arrangements using a standardized methodology for OHCA to accurately report health care entity year-over-year progress toward meeting the APM Adoption Goals.

The purpose of the second "Note" in this section is to provide submitters with instructions for how to differentiate between payment arrangements that are linked to quality and those that are not, and how to report on these payment arrangements separately. OHCA's approach to collecting APMs linked to quality and not linked to quality separately was informed by the approach used by Maryland's Health Care

[7] *See* Maryland Manual at Appendix H, available at: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/documents/2025_MCDB_data_submission_manual.pdf, last accessed January 31, 2025; Delaware Insurance Commissioner Affordability Standards Data Submission Manual dated February 8, 2024 (Delaware Manual) at p. 16, available at: https://insurance.delaware.gov/wp-content/uploads/sites/15/2024/03/2025-ASDS-Data-Submission-Manual.pdf, last accessed January 31, 2025. Although OHCA's payment categorization guidance is similar to other states, OHCA's guidance regarding member months is California-specific.

Commission.[8] This specification is necessary because the payment arrangements that count towards the APM Adoption Goals must be linked to quality.[9]

Section 4.8.1, "Payment Allocation for Payment Arrangements."

The purpose of this section is to provide step-by-step instructions for submitters on how to allocate payments and member months for members in alternative payment models to payment subcategory data fields in the APM file. This section is necessary so that OHCA can calculate the percentage of membership and total medical expenses included in Expanded Non-Claims Payments Framework categories C and D. OHCA also incorporates the reasons it provides for the categorization of payment arrangements in Section 4.8, "APM File Payment Allocation" here.

Section 4.9, "Primary Care Allocation Methodology."

The purpose of this section is to introduce submitters to OHCA's primary care payment allocation methodology. This section informs submitters that both the primary care claims and non-claims portions of total medical expenses will be used to calculate primary care spending. This section is necessary because OHCA is required to measure primary care spending and report on performance of health care entities against the Primary Care Investment Benchmark[10] approved by the Board in October 2024. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).) OHCA will measure primary care spending using the data reported by submitters in the Primary Care file.

Section 4.9.1, "Primary Care Paid via Claims."

The purpose of this section is to instruct payers how to identify primary care claims payments to report in the Primary Care file. Specifically, this section specifies the three components that must be present on a claim for it to count towards primary care spending: (1) a primary care provider, (2) a primary care place of service, and (3) a primary care service.

For clarity, this section includes a graphic flow chart and step-by-step instructions explaining how to identify primary care claims payments to report in the Primary Care file. OHCA developed these instructions in consultation with experts on primary care

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[8] *See* Maryland Health Care Commission 2025 Data Submission Manual (Maryland Manual) at Appendix H, available at: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/documents/2025_MCDB_data_submission_manual.pdf, last accessed January 31, 2025.

[9] *See* Memo Re: OHCA's APM Standards and Adoption Goals at p. 6, available at: https://hcai.ca.gov/wp-content/uploads/2024/07/Board-Adopted-APM-Standards-and-Adoption-Goals-Memo-Final.pdf, last accessed January 31, 2025.

[10] *See* Memo re: OHCA's Primary Care Investment Benchmark, available at: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/primary-care-investment-benchmark/, last accessed March 6, 2025.

spending measurement, using existing measurement approaches in Delaware and North Carolina as a starting point.[11] OHCA's measurement approach builds on the efforts in these states and leverages the Annual Network Review data submission most submitters already prepare for the Department of Managed Health Care (DMHC) as a primary care provider crosswalking tool.[12] OHCA notes that during informal public comment for this regulatory proposal, payer stakeholders questioned whether the crosswalking step was necessary. However, OHCA added this step in response to concerns raised by the Investment and Payment Workgroup that using only Provider Taxonomy Codes to identify primary care providers would be overinclusive and capture some providers with multiple certifications or subspecialties who do not practice primary care. Workgroup members suggested leveraging the Annual Network Review data submission to accurately identify physicians, nurse practitioners, and physician assistants who practice as primary care providers.

This section is necessary because submitters must categorize claims-based primary care spending using a standardized methodology for OHCA to accurately report on performance of health care entities against the Primary Care Investment Benchmark.

Section 4.9.2, "Primary Care Paid via Non-Claims."

The purpose of this section is to instruct payers how to apportion non-claims payments to primary care and report them in the Primary Care file. Specifically, this section lists each Expanded Non-Claims Payments Framework payment subcategory and provides the methodology endorsed by OHCA's Investment and Payment Workgroup for apportioning these payments to primary care. For example, under category A "Population Health and Practice Infrastructure Payments," spending under some subcategories will be fully allocated to primary care (such as subcategory A2 "Primary care and behavioral health integration"), while other subcategories will only be partially allocated to primary care (such as subcategory A3 "Social care integration").

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[11] *See, e.g.*, 18 Del. Admin. Code § 1322-4.0 (defining "Primary Care Place of Service," "Primary Care Provider," and "Primary care services" for purposes of spending measurement); North Carolina Primary Care Payment Reform Task Force Report to Joint Legislative Oversight Committee on Health and Human Services, dated April 17, 2024 (North Carolina Report) at p. 8, available at: https://webservices.ncleg.gov/ViewDocSiteFile/87160, last accessed January 31, 2025 (outlining North Carolina's three-component approach to defining primary care spending).

[12] *See* Health & Saf. Code, §§ 1367.03(f)(2) and 1367.035 (outlining DMHC's Network Timely Access and Network Adequacy Reporting Requirements); *see also* DMHC PCP and PCP Non-Physician Medical Practitioner Report Form, Primary Care Physician (PCP) Report Tab, Form No. 40-266, available at: https://dmhc.ca.gov/Portals/0/Docs/OPL/PCPandPCPNon-PhysicianMedicalPractitionerReportForm(FormNo_%2040-266).pdf?ver=Veh56WTWkVp8AKrB7Tyq3Q%3D%3D, last accessed January 31, 2025.

Figure 3 is added to illustrate the equation for allocating shared savings and recoupments to primary care, which is relevant to subcategories C3-C6 of the Expanded Non-Claims Payments Framework. The equation is shown to provide conceptual clarity on how to calculate the portion of risk settlement payments allocated to primary care spending.

Figure 4 is added to illustrate the equation for allocating capitation and full risk payments to primary care, which is relevant to subcategories D1, D2, D5, and D6 of the Expanded Non-Claims Payments Framework. The equation is shown to provide conceptual clarity on how to calculate the individual components comprising primary care spend via capitation and full risk payments.

OHCA developed these instructions in consultation with experts on primary care spending measurement, using existing apportionment approaches in Maryland, Delaware, and Rhode Island as a starting point.[13] This section is necessary because submitters must apportion non-claims payments to primary care using a standardized methodology for OHCA to accurately report on performance of health care entities against the Primary Care Investment Benchmark.

Section 5, "File Layouts and Field Specifications."

In each subsection, updates include re-numbering as needed due to additions or deletions, and corresponding text edits as described in Sections 1-4, above.

Sections 5.1 and 5.2

Sections 5.1 and 5.2 are the tables of data elements that must be submitted with each data file's header and trailer records. OHCA amends these tables for consistency with the proposed APM and Primary Care file types identified in Section 3.1 of the Guide Version 2.0. OHCA incorporates the reasons it provides for these new file types in Section 3.1, "Required Files" here.

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[13] *See* Maryland Manual at p. 49, available at: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/documents/2025_MCDB_data_submission_manual.pdf, last accessed February 3, 2025 (apportioning specified non-claims payments categories A and B to primary care); Delaware's Manual at p. 10, available at: https://insurance.delaware.gov/wp-content/uploads/sites/15/2024/03/2025-ASDS-Data-Submission-Manual.pdf, last accessed February 3, 2025 (limiting inclusion of some non-claims payments to primary care); Rhode Island Health Care Cost Growth Target and Primary Care Spend Data Submission Guide (Rhode Island Manual) at pp. 19-20, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-08/RI%20TME%20%26%20PC%20Spend%20Data%20Submission%20Guide_CY22-23%20v.10%208-22-2024.pdf, last accessed February 3, 2025 (limiting inclusion of some non-claims payments to primary care).

Sections 5.3 through 5.7

These are the tables of data elements that must be submitted with the five existing required data files identified in Section 3.1 of the Guide Version 2.0. OHCA updates these tables for consistency with the proposed amendments to existing data submission requirements. OHCA incorporates the reasons it provides for these amendments in Section 3, "File Intake Requirements," and Section 4, "Data Submission Information" here.

OHCA also makes changes to data elements in Sections 5.3-5.7 that are not addressed elsewhere in this document. Specifically, OHCA adds data fields for "Submission Year" in each subsection. The purpose of these data fields is to identify the submission year applicable to each data file. These additional data fields are necessary because each THCE data submission cycle includes two years of spending data, with one of the years reflecting updated data (*e.g.*, the 2024 data submission included calendar year 2022 and 2023 data, and the 2025 data submission will include calendar year 2023 and 2024 data). Accordingly, beginning with the September 2025 data submission, submitters will be providing OHCA with updated spending data for a calendar year previously submitted. To ensure accurate reporting, OHCA needs to know whether a data file reflects spending submitted for the first time, or if it reflects updated spending (*e.g.*, whether calendar year 2023 spending data was submitted to OHCA in 2024 or 2025).

In Section 5.3 OHCA adds a data field for "Member Responsibility (Claims)" (SWT013) and adds the parenthetical "(Capitation)" to the existing data field "Member Responsibility" (SWT015) in order to collect member responsibility amounts split by claims and capitation payments in the Statewide TME file. OHCA makes corresponding revisions to Sections 5.4 and 5.5 to collect member responsibility amounts split by claims and capitation payments in the Attributed TME and Regional TME files. These updates were suggested by a stakeholder during the September 2024 data submission and are necessary because member responsibility amounts are reflected differently in claims allowed amounts (*i.e.*, member responsibility is generally included in the allowed amount) versus capitation payment amounts (*i.e.*, member responsibility is not included in the capitation paid amount). The amendments to these data fields improve the overall accuracy of the data received by OHCA and provide information needed to contextualize reporting of member responsibility data.

In Section 5.4, OHCA also adds language specific to the data field for "Age Band (in Years)" instructing submitters to use a new Age Band '9' in scenarios where a submitter does not have access to the member's age. OHCA adds this instruction based on questions received during the September 2024 data submission about what to do in this very rare circumstance. Because OHCA needs additional insight into unknown member age to contextualize reporting, OHCA also adds a question in the Submission Questionnaire File asking submitters to briefly describe why they do not have access to a member's age.

Finally in Section 5.5, the Service Planning Area is deleted under "Region" for reasons explained below in the discussion of Appendix C, Regions. In Section 5.7, OHCA strikes the data field named "Valid Values" because it is no longer applicable or necessary following the initial September 2024 data submission and because this information is already captured in the Header Record of each file in Field ID HD008.

Sections 5.8 through 5.9

These are the tables of data elements that must be submitted with the proposed APM and Primary Care file types identified in Section 3.1 of the Guide Version 2.0. OHCA incorporates the necessity statements for each required data file type from Section 3.1, "Required Files" here.

Appendix A, "Claims Service Category to Bill Code Mapping"

OHCA adds the parenthetical "(HCPCS codes V2020-2799)" in reference to optical services in this appendix for clarity. OHCA proposes this change in response to submitter feedback received during the September 2024 data submission. Specifically, a submitter requested additional specificity to ensure claims for optical services are accurately categorized. This change is necessary to promote data standardization across submitters and to enable apples-to-apples data comparisons. OHCA selected this code set in consultation with experts on health care claims coding.

Appendix B, "Expanded Non-Claims Payments Framework"

OHCA strikes and replaces the existing Appendix B in the Guide with an expanded, updated iteration of the appendix with instructive non-claims payment subcategories. OHCA amends the title of the appendix to "Appendix B: Expanded Non-Claims Payments Framework" to reflect these changes.

The updated Appendix B provides guidance to submitters on mapping payment types to non-claims payment categories for purposes of reporting total medical expenses in the Statewide TME and Attributed TME file types. It also provides guidance to submitters on mapping APM payment arrangements to non-claims payment subcategories in the APM file and primary care non-claims payments to payment subcategories in the Primary Care file. For submitters familiar with the Health Care Payment Learning and Action Network (HCP-LAN)'s Alternative Payment Models (APM) Framework, payment types are also mapped to the corresponding HCP-LAN APM Framework category.[14] The HCP-LAN APM Framework provided a basis for the development of OHCA's Expanded Non-Claims Payments Framework and informed the descriptions of the categories and subcategories included in Appendix B. OHCA updated Appendix B in collaboration with HCAI's HPD program and contracted experts to ensure consistency across HCAI's data collection programs.

[14] *See* HCP-LAN APM Framework website, available at: https://hcp-lan.org/apm-framework/, last accessed February 3, 2025.

OHCA disaggregates THCE and primary care data by non-claims payment categories and subcategories to enable more granular data analysis of year-over-year spending growth within each category. The updated Appendix B is necessary so submitters can correctly categorize expenses by mapping non-claims payment categories to specified payment types. It is also needed for submitters to attribute members in payment arrangements to payment subcategories to measure progress towards the APM Adoption Goals.

Appendix C, "Regions"

Presently, Appendix C maps California counties to the 19 Covered California rating regions, except for Los Angeles County (rating regions 15 and 16), which is further divided into the 8 Service Planning Areas (SPAs) specified by the Los Angeles County Department of Public Health.[15] OHCA initially determined the use of SPAs was necessary for meaningful regional data analysis due to the relatively large size of Los Angeles County's population compared to other regions. However, based on OHCA's experience with the September 2024 data submission, the higher level of data granularity for Los Angeles County created unnecessary complications for submitters as they prepared the Regional TME file.

Accordingly, OHCA plans to utilize HPD program data for more detailed geographic analyses within Los Angeles County and amends Appendix C to replace the existing SPAs with Covered California rating regions (RR) 15 and 16. Consistent with this proposed change, OHCA strikes all references to SPAs and five-digit Los Angeles County zip codes from Appendix C. OHCA adds rows for RR15, "Los Angeles (East)" and RR16, "Los Angeles (West)," along with the first three digits of the zip codes in each respective RR. OHCA also makes a non-substantive change to correct a typographical error in "San Bernardino" in the "County Name" column.

Appendix D, "Condition and Procedure Types"

Appendix D provides guidance to data submitters regarding how to categorize procedure and condition-specific episode-based payment arrangements. Specifically, submitters will use these categories to identify types of episode-based payment arrangements when completing Field ID SQS024, "Procedure and Condition-Specific Episode-based Payment Arrangements," in the Submission Questionnaire File.

This appendix lists four specific procedure types (cardiovascular, gastrointestinal, orthopedic, and transplant) and a catch-all procedure type (other procedures) with examples commonly associated with each procedure type (*e.g.*, colonoscopy as an example of a gastrointestinal procedure). The Description and Examples of Procedures columns are necessary to ensure submitters accurately categorize procedure-related,

[15] *See* County of Los Angeles Public Health: Service Planning Areas, available at: http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm, last accessed January 22, 2025.

episode-based payment arrangements in the Submission Questionnaire File. Similarly, this appendix lists four specific condition types (chronic/outpatient-based, acute/hospitalization-based, oncology, and pregnancy) and a catch-all condition type (other conditions) with examples commonly associated with each condition type where necessary (*e.g.*, colorectal cancer as an example of an oncology condition type). The Description and Examples of Conditions columns are necessary to ensure submitters accurately categorize condition-related, episode-based payment arrangements in the Submission Questionnaire File.

Appendix D is necessary for submitters to share information on Expanded Non-Claims Payments Framework subcategories C1-C4, which are included as part of OHCA's APM Adoption Goals. The data reported using Appendix D supports OHCA's work to promote the shift from payments based on fee-for-service to alternative payment models. (*See* Health & Saf. Code, § 127504, subd. (a).).

Appendix E, "Primary Care Code Sets"

As explained in Section 4.9.1, "Primary Care Paid via Claims," there are three components that must be present on a claim for it to count towards primary care spending: (1) a primary care provider, (2) a primary care place of service, and (3) a primary care service. Appendix E lists the codes submitters will use to identify each of these three components on a claim.

Primary Care Providers Taxonomy List

Submitters will identify primary care providers using specified Health Care Provider Taxonomy codes maintained by the National Uniform Claim Committee (NUCC).[16] OHCA selected the listed codes in consultation with experts and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed by the primary care provider taxonomy code sets used in Colorado and North Carolina.[17] The NUCC Name is also provided for convenience of the submitter in ensuring the correct taxonomy code is used.

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[16] *See* National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy website, available at: https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40, last accessed February 3, 2025.

[17] *See* Primary Care Spending and Alternative Payment Use in Colorado 2020-2022 (Colorado Report) at pp. 24-26, available at: https://civhc.org/wp-content/uploads/2024/03/CIVHC-Report-of-Primary-Care-Spending-January-2024-corrected-prospective-payment-graphs-01232024.pdf, last accessed February 3, 2025 (listing Colorado's specified primary care provider taxonomy codes); North Carolina Report at pp. 24-25, available at: https://webservices.ncleg.gov/ViewDocSiteFile/87160, last accessed February 3, 2025 (listing North Carolina's specified primary care provider taxonomy codes).

This section of Appendix E is necessary to ensure submitters use a consistent and standardized method to identify claims-based primary care spending that counts towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Primary Care CMS Places of Service

Submitters will identify primary care places of service using specified Place of Service codes for Professional Claims maintained by the Centers for Medicare and Medicaid Services (CMS).[18] OHCA selected the listed codes in consultation with experts and after extensive stakeholder engagement. The CMS primary care Place of Service codes selected by OHCA were also informed by the code set utilized in North Carolina.[19] The Place of Service name is also provided for convenience of the submitter in ensuring the correct Place of Service code is used.

This section of Appendix E is necessary to ensure submitters use a consistent and standardized method to identify claims-based primary care spending that counts towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

HCPCS/CPT Primary Care Services

Submitters will identify primary care services using specified Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes maintained by CMS and the American Medical Association (AMA).[20] OHCA selected the listed codes in consultation with experts, the DHCS, and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed by the primary care service code set used in Colorado and the primary care service code set included in the New England States' All-Payer Report on Primary Care Payments.[21] The Description is also provided for convenience of the submitter in ensuring the correct HCPCS and CPT codes are used.

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[18] *See* Centers for Medicare and Medicaid Services (CMS) Place of Service Code Set, available at: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets, last accessed February 4, 2025.
[19] *See* North Carolina Report at p. 25, available at: https://webservices.ncleg.gov/ViewDocSiteFile/87160, last accessed February 4, 2025.
[20] *See* CMS HCPCS Main Page, available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system, last accessed February 4, 2025.
[21] *See* Colorado Report at pp. 28-42, available at: https://civhc.org/wp-content/uploads/2024/03/CIVHC-Report-of-Primary-Care-Spending-January-2024-corrected-prospective-payment-graphs-01232024.pdf, last accessed February 4, 2025; The New England States' All-Payer Report on Primary Care Payments at p. 60, available at: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf, last accessed February 20, 2025.

This section of Appendix E is necessary to ensure submitters use a consistent and standardized method to identify primary care claims that count towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

OHCA Attribution Addendum

Amended section 97445(t) incorporates by reference the *Office of Health Care Affordability: Attribution Addendum*, dated April 2025 (Attribution Addendum) because it is necessary to provide submitters with an up-to-date, standardized list of physician organizations for purposes of attributing total medical expenses in the Attributed TME file. The proposed version of the Attribution Addendum is the document's third iteration and reflects OHCA's continued efforts to refine its attribution approach for total medical expenses. The proposed version of the Attribution Addendum reflects updated physician organization names and identifying information, which OHCA will continue to update through the regulatory process as listed entities reorganize, enter, and exit the health care market. The proposed version of the Attribution Addendum also adds a column for "National Provider Identifier (if available)" as an additional data element to assist submitters in accurately identifying physician organizations. OHCA incorporates the reasons it provided in reference to the proposed addition of a data field for NPI to the Attributed TME file, discussed in Section 4.5, "Member Attribution" here.

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. Seeking to initially focus on larger entities, OHCA identified physician organizations with greater than 5,000 attributed members across the commercial and Medicare Advantage market categories for reporting year 2023. OHCA found the identified organizations captured approximately 13.7 million members and 69 percent of all covered lives across the relevant market categories. Indeed, 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. Accordingly, 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.

OHCA considered lower thresholds with an ultimate objective of data completeness, but found lower thresholds did not capture physician organizations with a number of attributed members significant enough to justify their continued inclusion on the Attribution Addendum. Instead, as specified in Section 4.5 of the Guide Version 2.0, OHCA will continue to collect data for physician organizations with at least 1,000 attributed members using Organization Code '7777' and the Organization Name field (ATT004).

The final version of the Attribution Addendum will be available on, and may be downloaded from, the HCAI website, located at: https://hcai.ca.gov/.

ANTICIPATED BENEFITS OF THE PROPOSAL

These proposed emergency regulations effectuate the Legislature's intent to have a comprehensive view of health care spending, cost trends, and variation that will inform actions to reduce the overall rate of growth in health care costs. (*See* Health & Saf. Code, § 127500.5, subd. (b).) By measuring progress towards reducing the rate of growth in per capita total health care spending, OHCA intends to lower consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care. (*See* Health & Saf. Code, § 127500.5, subd. (o)(1).) These clarifying amendments will ensure OHCA receives complete and accurate total health care expenditure data in a standardized format.

TECHNICAL, THEORETICAL, AND/OR EMPIRICAL STUDY, REPORTS, OR DOCUMENT(S) RELIED UPON:

Other State Laws, Regulations, and Guidance:

- Colorado law
  - Primary Care Spending and Alternative Payment Model Use in Colorado, 2020-2022 at pp. 24-44, available at: https://civhc.org/wp-content/uploads/2024/03/CIVHC-Report-of-Primary-Care-Spending-January-2024-corrected-prospective-payment-graphs-01232024.pdf, last accessed February 20, 2025.
- Delaware law
  - Delaware Insurance Commissioner Affordability Standards Data Submission Manual at pp. 9-23
  - 18 Del. Admin. Code § 1322-4.0
- Maryland law
  - Maryland Health Care Commission 2025 Medical Care Data Base Data Submission Manual at Appendix H
- North Carolina law
  - North Carolina Primary Care Payment Reform Task Force Report to Joint Legislative Oversight Committee on Health and Human Services, dated April 17, 2024 at pp. 8-9 and 24-25
- Oregon law (Oregon Health Authority, Sustainable Health Care Cost Growth Target Program):
  - Oregon's Health Care Cost Growth Target Program: Data Specification Manual (CGT-2) at pp. 17-18
- Rhode Island law
  - Rhode Island Health Care Cost Growth Target and Primary Care Spend Data Submission Guide, dated August 22, 2024 at pp. 19-20

Reports / Articles:

- Wilson, Katherine. 2025 Edition – California Health Insurers, Enrollment (February 25, 2025), California Health Care Foundation, available at: https://www.chcf.org/publication/california-health-insurers-enrollment-almanac/#related-links-and-downloads, last accessed March 3, 2025.
- Cohen DJ, Totten AM, Philips RL Jr., Jabbarpour Y, Jetty A, DeVoe J, Pappas M, Byers J, Hart E. Measuring Primary Healthcare Spending. Technical Brief No. 44. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 75Q80120D00006.) AHRQ Publication No. 24-EHC013. Rockville, MD: Agency for Healthcare Research and Quality; May 2024. DOI: https://doi.org/10.23970/AHRQEPCTB44.
- The New England States' All-Payer Report on Primary Care Payments, available at: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf, last accessed February 20, 2025.

Public Meetings:

- September 20, 2023 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- October 18, 2023 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- November 15, 2023 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- December 20, 2023 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- January 17, 2024 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- February 21, 2024 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- February 28, 2024 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- March 19, 2024 Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- March 20, 2024 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- April 17, 2024 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- May 14, 2024 Health Care Affordability Advisory Committee Meeting - Relevant Presentation Slides, Minutes.
- May 15, 2024 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- May 22, 2024 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.

- June 20, 2024 Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- June 26, 2024 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- October 9, 2024 Total Health Care Expenditures Data Submitter Workgroup – Relevant Presentation Slides.
- October 14, 2024 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- October 30, 2024 Health Care Affordability Advisory Committee Meeting - Relevant Presentation Slides, Minutes.
- January 15, 2025 Total Health Care Expenditures Data Submitter Workgroup – Relevant Presentation Slides.
- January 21, 2025 Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- January 22, 2025 Total Health Care Expenditures Data Submitter Workgroup – Relevant Presentation Slides.
- January 28, 2025 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- February 25, 2025 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- February 26, 2025 Total Health Care Expenditures Data Submitter Workgroup – Relevant Presentation Slides.
- March 25, 2025 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- March 26, 2025 Total Health Care Expenditures Data Submitter Workgroup – Relevant Presentation Slides.

Written comments received and considered concerning January 2025 draft proposal:

- January 30, 2025 email from Molina Healthcare of California
- January 31, 2025 letter from the California Association of Health Plans

CONSISTENCY AND COMPATIBILITY WITH EXISTING STATE REGULATIONS

During the process of developing this regulation, HCAI conducted a search of any similar regulations on this topic and concluded that these regulations are neither inconsistent nor incompatible with existing state regulations.

LOCAL MANDATE

No local mandate is imposed on a local agency or school district that requires reimbursement pursuant to Government Code section 17500 *et seq*.

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DISCLOSURES REGARDING THE PROPOSED ACTION:

FISCAL IMPACT ESTIMATES

Cost or savings to any local agency or school district requiring reimbursement pursuant to Government Code section 17500 et seq.: None.

Cost or savings to any state agency:

OHCA does not anticipate any additional cost or savings from this proposal beyond those it initially reported.

Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None.

Other nondiscretionary cost or savings imposed on local agencies: None.

Cost or savings in federal funding to the state: None.