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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

Implementation of total health care expenditures (THCE) data collection for the spending targets program pursuant to Health and Safety Code sections 127501 *et seq.* (hereinafter spending targets program).

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 required to adopt emergency regulations to implement THCE data collection for the spending targets program and the initial adoption of these regulations is statutorily deemed to be an emergency for purposes of administrative rulemaking. (Health & Saf. Code, § 127501.2, subd. (a).) This is OHCA's initial adoption of emergency regulations to implement THCE data collection for the spending targets program.

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. (Health & Saf. Code, § 127501.2, subd. (a)(1).)

Health and Safety Code section 127501.10 created the Health Care Affordability Board (Board). Appointed Board members began serving in the Spring of 2023. As required by statute, the Board discussed these proposed emergency regulations at two separate meetings on December 19, 2023 and January 24, 2024. (Health & Saf. Code, § 127501.2, subd. (c).)

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. For purposes of these proposed THCE data collection regulations, OHCA identified relevant stakeholders based on

subject matter expertise and convened a series of technical workgroup meetings to inform regulation development. OHCA held technical workgroup meetings, facilitated by OHCA staff and contracted spending target policy experts, on the following dates:

- June 15, 2023
- July 20, 2023
- August 17, 2023
- August 21, 2023 (Medi-Cal Specific)
- September 18, 2023 (Medi-Cal Specific)
- September 21, 2023
- October 19, 2023
- December 7, 2023

OHCA posted a draft of these regulations on its public website on October 27, 2023, with a 35-day window for comments. Additionally, OHCA held a public workshop (in-person and virtual) during the comment period on November 14, 2023. Approximately four parties made comments at the workshop and the Office received five letters with substantive comments from health care advocates, industry lobby groups, and medical associations. OHCA provided a summary of the public comments regarding the October 2023 draft of these regulations to the Board at its December 19, 2023 meeting. Following thorough consideration of input received from all stakeholders, OHCA made responsive changes to these regulations and provided an update regarding those changes to both the Health Care Advisory Committee and the Board at their respective January 23 and 24, 2024 meetings.

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, and 127501.4.

INFORMATIVE DIGEST

Existing Law

Existing law requires OHCA to adopt and promulgate regulations for the purpose of collecting data and other information from health care entities necessary to carry out the functions of the office. (Health & Saf. Code, §§ 127501, subd. (c)(17) and 127501.4,

subd. (k).) The regulations may include, but are not limited to: "…detailed reporting schedules, technical specifications, and other resources to ensure the submission of accurate data in a standardized format within the specified timeframes." (Health & Saf. Code, § 127501.4, subd. (k).)

OHCA must prepare a report on baseline health care spending (hereinafter baseline report) on or before June 1, 2025. (Health & Saf. Code, § 127501.6, subd. (a).) OHCA's baseline report shall include aggregated data on THCE, per capita THCE, and as appropriate, disaggregated data by specified categories. (Health & Saf. Code § 127501.6, subd. (b)(2)(A).) OHCA's baseline report will be based on existing public and private data sources as well as THCE data for the 2022 and 2023 calendar years. (Health & Saf. Code, § 127501.4, subd. (d)(1).) Payers and fully integrated delivery systems must extract, aggregate, and submit this THCE data to OHCA on or before September 1, 2024. (Health & Saf. Code, § 127501.4, subd. (d)(1).)

Following public release of the baseline report, OHCA shall prepare and publish its first annual report concerning health care spending trends and underlying factors on or before June 1, 2027. (Health & Saf. Code § 127501.6, subd. (b)(1).) OHCA's first annual report will analyze THCE data for the 2024 and 2025 calendar years. (Health & Saf. Code, § 127501.4, subd. (d)(2).) Payers and fully integrated delivery systems must submit THCE data for the first annual report to OHCA "…based on a reporting schedule established by the office." (Health & Saf. Code, § 127501.4, subd. (d)(2).) For subsequent annual reports, payers and fully integrated delivery systems are required to "…submit data for the relevant calendar years according to the reporting schedule established by the office." (Health & Saf. Code, § 127501.4, subd. (d)(2).)

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, 2024, OHCA must adopt these regulations as soon as possible. (Health & Saf. Code, § 127501.4, subd. (d)(1).) Moreover, because this rulemaking initiates OHCA's first data collection from health care entities, OHCA needs maximum lead time to orient submitters to the Office's secure, online data submission portal.

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).)

OHCA previously adopted regulations implementing the cost and market impact reviews (CMIR) program. (Cal. Code Regs., tit. 22, § 97431, effective December 18, 2023, California Regulatory Notice Register 2023, Volume 52-Z, page 1693, December 29, 2023.) The CMIR program analyzes transactions that are likely to significantly impact market competition and then coordinates with other state agencies to address consolidation, as appropriate. (Health & Saf. Code, § 127507.2, subd. (a)(1).) OHCA now pivots to development of the spending targets program, which requires THCE data collection. When fully implemented in 2028, the 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 creates a new article (Article 2), titled “Health Care Spending Targets,” within Chapter 11.5 of Title 22 of the California Code of Regulations (CCR) and contains THCE data collection regulations implementing SB 184.

This proposal will:

- Establish a section defining terms used in the regulations. (Proposed section 97445.)
- Establish subsections specifying who is a required submitter and how voluntary submitters may request to participate. (Proposed section 97449(a) through (c).)
- Establish a subsection outlining how submitters should coordinate data submission with their subcontracted plans and affiliates. (Proposed section 97449(d).)

- Establish subsections outlining deadlines for submitter registration and data file submission. (Proposed section 97449(e) through (h).)
- Establish subsections outlining other requirements related to data file specifications, test files, data acceptance and correction, and variance requests. (Proposed subsections 97449(i) through (l).)

This proposal also incorporates by reference:

- The *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.0)*, dated February 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.

  OHCA included these requirements in the Guide because it will allow submitters to easily view all information in a single user-friendly document. At approximately 52 pages, including over 100 file layouts and field specifications organized in data file-specific tables, publishing the document in the California Code of Regulations would be inordinately complicated and impractical. It would also potentially confuse submitters and result in erroneous data file submissions.

  OHCA's use of the Guide will be familiar to submitters who participate in spending target programs in other states. For example, Oregon uses a Cost Growth Target Data Specification Manual, which is referenced in the state's implementing regulations, to provide instructions on data submission requirements. Submitters that participate in HCAI's Health Care Payments Data (HPD) program will also be familiar with the purpose and structure of the Guide. The HPD program regulations incorporate a data submission guide with a similar format into its data collection regulations by reference. The Specific Purpose and Necessity of each item contained within the Guide is described in the *Total Health Care Expenditures Data Submission Guide (Version 1.0)* section of this Finding of Emergency.

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

- The *Office of Health Care Affordability: Attribution Addendum*, dated February 2024 ("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. OHCA included this list in a separate document incorporated by reference because OHCA anticipates the names on the list will need to be updated periodically as physician organizations reorganize, enter, and exit the health care market. The Specific Purpose and

Necessity of the Attribution Addendum is described in the *OHCA Attribution Addendum* section of this Finding of Emergency.

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

SPECIFIC PURPOSE AND NECESSITY FOR EACH REGULATION

Section 97445. Definitions.

OHCA provides a general section on definitions for consistency and clarity. OHCA references the terms "fully integrated delivery system" in subsection (f), "payer" in subsection (j), and "physician organization" in subsection (l) to their respective statutory definitions for convenience. The standard terms "Department" in subsection (c), "Director" in subsection (e), and "Office" in subsection (i) are consistent with existing HCAI regulatory structure. They are repeated in this Article for convenience of the reader because readers of this Article may not be familiar with other HCAI chapters or articles within Division 7 of Title 22 of the California Code of Regulations.

Subsection (a). Affiliation.

OHCA derives the definition of "affiliation" from the definition used by the Department of Managed Health Care (DMHC) in 28 CCR § 1300.45(c)(1). There are a wide range of affiliations among health care service plans, health insurers, and other payers or fully integrated delivery systems that meet the criteria to qualify as required submitters pursuant to proposed section 97449(a).

The definition is necessary because the submission of data files from affiliated required submitters will require coordination between the entities ("affiliates") to ensure data files are complete and accurately reflect enrollment (*e.g.*, no omitted spending or double-counted spending based on total enrollment). The circumstances of an affiliation may impact how required submitters choose to aggregate and submit total health care expenditures (THCE) data.

Subsection (b). Control.

OHCA derives the definition of "control" from the definition used by the DMHC in 28 CCR § 1300.45(d).

Pursuant to proposed section 97449(d), required submitters are responsible for coordinating data submission among their affiliates. OHCA defines the term affiliate or affiliation by refence to "situations in which an entity controls, is controlled by, or is

under common control with another entity." (*See* proposed section 97445(a).) Therefore, the definition of "control" is necessary so required submitters can determine whether total health care expenditure data submission must be coordinated with other entities.

Although there will be no enforcement related to the baseline report or the 2025 baseline spending target, OHCA's focus on an entity's level of control when defining affiliate is consistent with the statutory enforcement framework in Health and Safety Code section 127502.5(d)(6)(B):

> The director shall consider all of the following to determine the penalty:
>
> …
>
> (B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any **affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.**
>
> … (emphasis added.)

Subsection (d). Directly contracted plan.

The definition of "directly contracted plan" is based on the DMHC's definition of "primary plan" in 28 CCR § 1300.67.2.2(b)(13)(A). OHCA chose the term "directly contracted plan" instead of "primary plan" because the former is more descriptive and avoids confusion with the health care reimbursement term of art "primary payer."

There are myriad contracting arrangements among payers and fully integrated delivery systems that support the delivery of health care services to Californians. These contracts may include delegated arrangements between two payers or fully integrated delivery systems that are both required to submit THCE data to OHCA pursuant to proposed section 97449(a).

The definition of "directly contracted plan" is necessary so required submitters can determine which payer or fully integrated delivery system among the parties in a plan-to-plan contract (defined in proposed section 97445(k)) is responsible for THCE data submission. This definition will promote accurate and complete data submissions and facilitate OHCA's analysis and reporting.

Subsection (g). Health insurer.

The definition of “health insurer” is based on the statutory definition of payer in Health and Safety Code section 127500.2(o)(2), which includes: “[a] health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.” The term “health insurer” is shorthand for this category of payer and OHCA restates the statutory language in the regulation for the convenience of the regulated public. This definition is necessary to distinguish between health insurers, licensed and regulated by the Department of Insurance, to provide health insurance, and health plans, licensed and regulated by the DMHC, to provide health care service plan products.

Subsection (h) Health plan.

The definition of “health plan” is based on the statutory definition of payer in Health and Safety Code section 127500.2(o)(1):

> (o) “Payer” means private and public health care payers, including all of the following:
>
> (1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) …
>
> …

The term “health plan” is shorthand for this category of payer and OHCA restates the statutory language in the regulation for the convenience of the regulated public. The definition is necessary because one of the criteria for qualifying as a required submitter pursuant to proposed section 97449(a) requires payers to calculate the total number of covered lives in the entity’s commercial health plan products in California as of December 31 of each year calendar prior to the THCE data submission year.

The definition clarifies that health plans do not include health care service plans that hold only a restricted or limited license under 28 CCR § 1300.49(a). This clarification is necessary to avoid confusion regarding use of the term “plan” since some physician organizations also operate as restricted health care service plans or limited health care service plans regulated by the DMHC. Entities holding only a restricted or limited license with the DMHC may enter into contractual arrangements with health plans to share financial risk for the provision of health care services but are prohibited from directly marketing or selling health plan products to consumers or group purchasers. (Cal. Code Regs., tit. 28, § 1300.49, subds. (a)(3) and (a)(6).)

Subsection (k). Plan-to-plan contract.

The definition of “plan-to-plan contract” is based on the definition used by the DMHC in 28 CCR § 1300.67.2.2(b)(13). It is common practice in California’s health care delivery system for health plans to delegate certain health plan functions to other health plans through a plan-to-plan contract. Activities delegated may include enrollment (based on product and market segment) and claims processing. Proposed sections 97445(d) and 97445(p), respectively, define directly contracted plan and subcontracted plan by reference plan-to-plan contracting arrangements.

The definition of “plan-to-plan contract” is necessary so that payers and fully integrated delivery systems understand the specific type of contracting arrangement that gives rise to these relationships between contracting entities. This definition will promote accurate and complete data submissions and facilitate OHCA's analysis and reporting.

The definition also clarifies that the term does not include contractual arrangements between a payer or fully integrated delivery system and a physician organization. This clarification is necessary to avoid confusion regarding use of the term “plan” since some physician organizations are restricted health care service plans or limited health care service plans licensed by the DMHC.

Subsection (m). Registered submitter.

Proposed sections 97449(g), 97449(h), 97449(j), and 97449(k) use the term “registered submitter” to refer collectively to required submitters and approved voluntary submitters that have registered in the THCE Data Portal. OHCA defines this term here for brevity and clarity.

Subsection (n). Reporting year.

The definition of “reporting year” is necessary so registered submitters understand the relevant time period for data included in each data file submitted to OHCA. The definition clarifies that a reporting year includes total health care expenditure data based on the service year, as opposed to the date paid or reconciled. For example, reporting year 2023 would include total health care expenditure data with an incurred date, or date of service, in 2023, even if it was paid in 2024. The definition will ensure consistent and accurate data submission to facilitate OHCA’s measurement of year-over-year spending growth.

Subsection (p). Subcontracted Plan.

The definition of “subcontracted plan” is based on the definition used by the DMHC in 28 CCR § 1300.67.2.2(b)(13)(B). The purpose of the definition of “subcontracted plan” is to distinguish between the directly contracted plan and subcontracted plan in a plan-to-plan contract. The definition of “subcontracted plan” is necessary to clarify the entity in a plan-to-plan contract responsible for reporting THCE data to OHCA. This definition will promote accurate data submissions and facilitates OHCA's analysis and reporting.

Subsection (q). System.

Proposed sections 97445(m), 97445(r), 97445(u), 97449(d), 97449(e), 97449(h), and 97449(k) use the term “System.” The Total Health Care Expenditures Data System is the database to which submitters will send their data via the THCE Data Portal (defined in section 97445(r)) in order to facilitate OHCA’s analysis and reporting. OHCA defines this term here so that it does not have to be repeatedly defined or described in regulation.

Subsection (r). THCE Data Portal.

Proposed sections 97449(e), 97449(f), 97449(g), 97449(j), 97449(k), and 97449(l) use the term “Data Portal.” The THCE Data Portal is the secure data submission mechanism by which submitters register, make variance requests, and submit data files to the System. OHCA defines this term here so that it does not have to be repeatedly defined or described in regulation.

Subsection (s). THCE Data Submission Guide.

As described above in the *Informative Digest*, this definition introduces the instructions for reporting data. This definition is necessary because it incorporates by reference OHCA’s *Total Health Care Expenditures Data Submission Guide (Version 1.0)*, dated February 2024 (the “Guide”) and directs the reader where it may be obtained.[1] The Guide is the comprehensive document that instructs payers and fully integrated delivery systems how to extract and aggregate total health care expenditure data for submission to OHCA. The Guide also provides technical specifications, file layouts, reporting schedules, and other instructions to ensure the submission of accurate THCE data in a standardized format.

[1] The Specific Purpose and Necessity of each item contained within the Guide is described in the *Total Health Care Expenditures Data Submission Guide (Version 1.0)* section of this Finding of Emergency.

Subsection (t). OHCA Attribution Addendum.

As described above in the *Informative Digest*, this definition introduces the reference document for reporting attributed total medical expense data. This definition is necessary because it incorporates by reference the *OHCA Attribution Addendum*, dated February 2024 (Attribution Addendum) and directs the reader where it may be obtained.[2] The Attribution Addendum contains a list of physician organizations with unique identifiers that submitters must use when attributing total medical expenses. The Attribution Addendum promotes consistency and standardization in the attributed THCE data submitted to OHCA and facilitates measurement of attributed year-over-year spending growth.

Subsection (u). Voluntary submitter.

The definition of "voluntary submitter" is necessary to distinguish between payers and fully integrated delivery systems that are required submitters, pursuant to proposed section 97449(b), and those entities OHCA has approved to voluntarily submit data pursuant to proposed section 97449(c).

The definition is also necessary to clarify that payers and fully integrated delivery systems otherwise exempt from the requirements in proposed Article 2 may request approval from OHCA to register to submit data voluntarily. Specifically, proposed sections 97449(a)(2) and (a)(3) exempt certain payers and fully integrated delivery systems from Article 2 based on covered lives thresholds. One reason why OHCA utilizes covered lives thresholds is to avoid creating an undue administrative and financial burden for entities that account for a very small proportion of statewide THCE. However, if an exempted entity is capable and willing to meet OHCA's data submission requirements, OHCA encourages voluntary participation.

Section 97449. Total Health Care Expenditures Data Submission.

Subsection (a). Who Must Submit.

Health and Safety Code section 127501.4(d)(1) requires OHCA to establish requirements for payers and fully integrated delivery systems to submit data and other information necessary to measure THCE and per capita THCE for the 2022 and 2023 calendar years. This initial data submission, along with existing state and federal data sources, will form the basis of OHCA's baseline report on health care spending. For ongoing annual reporting, OHCA must also establish data submission requirements for

[2] The Specific Purpose and Necessity of the Attribution Addendum is described in the *OHCA Attribution Addendum* section of this Finding of Emergency.

payers and fully integrated delivery systems for the 2024 and 2025 calendar years and beyond. (Health & Saf. Code, § 127501.4, subd. (d)(2).)

Subsection (a) is necessary because it specifies which payers and fully integrated delivery systems are required to submit THCE data to OHCA. For clarity, OHCA organizes subsections (a)(1) through (a)(3) by commonly understood health care markets – Medi-Cal managed care, Medicare Advantage, and commercial – and describe the criteria that must be satisfied for a payer or fully integrated delivery system operating in each market to qualify as a required submitter. A payer or fully integrated delivery system only needs to meet one of the three criteria to qualify as a required submitter.

The Act does not require OHCA to set minimum enrollment thresholds for payer and fully integrated delivery system submission of THCE data. However, after considering the experiences of other states that have implemented spending target programs, OHCA determined that minimum enrollment thresholds are necessary to: (1) focus OHCA's data collection and analysis resources on entities representing most California health care spending, (2) avoid collecting data from entities too small to contribute to the generation of statistically meaningful results, and (3) balance the administrative cost of data collection, validation, analysis, and reporting with an objective of data completeness.

Subsection (a)(1).

Subsection (a)(1) requires a payer or fully integrated delivery system that is a Medi-Cal managed care plan contracted with the Department of Health Care Services (DHCS) to provide full scope benefits to 40,000 or more Medi-Cal beneficiaries to submit THCE data to OHCA. OHCA has chosen 40,000 as the number of beneficiaries because this amount would encompass approximately 23 Medi-Cal managed care payers and fully integrated delivery systems and would exclude certain specialty Medi-Cal managed care plans with very low enrollment (*e.g.*, On Lok PACE, Positive Healthcare).[3] It would capture approximately 99.6% of the Medi-Cal managed care market in California.[4] Therefore, OHCA determined 40,000 is the most appropriate threshold.

[3] Wilson, Katherine. 2022 Edition – California Health Insurers, Enrollment (October 27, 2022), California Health Care Foundation (CHCF), available at https://www.chcf.org/publication/2022-edition-california-health-insurers-enrollment/#related-links-and-downloads, last accessed December 22, 2023.CHCF's analysis makes use of data from DMHC and California Department of Insurance (CDI) databases.

[4] *Id.*

This threshold is necessary to ensure that OHCA receives the most comprehensive and complete THCE data possible without placing an undue administrative and financial burden on the state's smallest Medi-Cal payers. In establishing this threshold of 40,000 beneficiaries, OHCA considered higher and lower minimum enrollment thresholds, and consulted health care experts regarding the impacts of alternative thresholds on the overall completeness of THCE data.

This subsection also provides the number of Medi-Cal beneficiaries must be calculated as of December 31 of each calendar year prior to the submission year. This date was selected to align with the HPD program's plan size threshold requirements, which also require calculation of enrollment as of December 31. (*See* Cal. Code Regs., tit. 22, § 97310.) For example, to determine whether it is a required submitter for the annual data submission due in 2025, a potential required submitter would calculate its enrollment based on its total enrolled Medi-Cal beneficiaries as of December 31, 2024. This provision is necessary because total enrollment fluctuates month-to-month, and a potential required submitter needs a date certain to determine whether it meets the minimum enrollment threshold. By requiring calculation once a year at the end of the year, but mandating data submission for the entire calendar year if the threshold is met, OHCA will be able to obtain consistent and comparable data from required submitters.

This subsection further provides it is not effective until the first annual data file submission year, which requires submitter registration by May 31, 2025, and data submission by September 1, 2025, pursuant to proposed sections 97449(e)(2) and (h)(2). The purpose of this provision is to delay implementation of THCE data submission for Medi-Cal managed care plans by one year. This provision is necessary because OHCA needs additional time to determine whether it can obtain comprehensive THCE data for the Medi-Cal managed care market segment from existing state and federal data sources. This is 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).) Although not effective immediately, this subsection is necessary in this proposed emergency regulation so that potential required submitters can begin to prepare for data collection.

Subsection (a)(2).

Subsection (a)(2) requires a payer or fully integrated delivery system that enrolls or insures 40,000 or more covered lives in Medicare Advantage products to submit THCE data to OHCA. A covered life is an individual enrolled in or covered by a health plan or health insurer. "Covered lives" is a term of art well understood in the health care industry. OHCA has chosen 40,000 as the number of covered lives because this amount would encompass approximately 12 Medicare Advantage payers and fully integrated delivery systems and capture approximately 97.9% of the Medicare

Advantage market in California.[5] Therefore, OHCA determined 40,000 is the most appropriate threshold.

This threshold is necessary to ensure OHCA receives the most comprehensive and complete THCE data possible without placing an undue administrative and financial burden on entities operating Medicare Advantage plans with very low enrollment. In establishing this threshold of 40,000 covered lives, OHCA considered higher and lower minimum enrollment thresholds, and consulted health care experts regarding the impacts of alternative thresholds on the overall completeness of THCE data.

This subsection also provides the number of covered lives in Medicare Advantage products must be calculated by adding together all the covered lives in the entity's Medicare Advantage products in California as of December 31 of each calendar year prior to the submission year. OHCA selected this date to align with the HPD program's plan size threshold requirements, which also require calculation of enrollment as of December 31. (*See* Cal. Code Regs., tit. 22, § 97310.) The 40,000 covered lives threshold is based on the total number of covered lives across all the entity's Medicare Advantage products. This provision is necessary for the same reasons cited in reference to proposed section 97449(a)(1), *supra*.

Subsection (a)(3).

Subsection (a)(3) requires a payer or fully integrated delivery system that enrolls or insures 40,000 or more covered lives in commercial products to submit THCE data to OHCA. OHCA has chosen 40,000 as the number of covered lives because this amount would encompass approximately 14 commercial payers and fully integrated delivery systems and capture approximately 99.9% of the commercial market in California.[6] Therefore, OHCA determined 40,000 is the most appropriate threshold.

This threshold is necessary to ensure OHCA receives the most comprehensive and complete THCE data possible without requiring submission from entities that are too small to contribute to the generation of statistically meaningful results. In establishing this threshold of 40,000 covered lives, OHCA considered higher and lower minimum enrollment thresholds, and consulted health care experts regarding the impacts of alternative thresholds on the overall completeness of THCE data.

This subsection provides the number of covered lives in commercial products must be calculated by adding together all the covered lives in the entity's commercial health insurance products and commercial health plan products in California as of December 31 of each calendar year prior to the submission year. OHCA selected this date to align

[5] *Id.*
[6] *Id.*

with the HPD program's plan size threshold requirements, which also require calculation of enrollment as of December 31. (*See* Cal. Code Regs., tit. 22, § 97310.) The 40,000 covered lives threshold is based on the total number of covered lives across all the entity's commercial health insurance (defined in proposed section 97445(g)) and commercial health plan (defined in proposed section 97445(h)) products. This provision is necessary for the same reasons cited in reference to proposed section 97449(a)(1), *supra*.

This subsection further clarifies that "commercial" refers to products that are not Medi-Cal or Medicare Advantage products to avoid confusion regarding Medicare Advantage products that may be marketed directly to consumers.

Subsection (b). Market Category Data Submission.

Subsection (b) requires payers or fully integrated delivery systems that meet any of the criteria in subsection (a)(1) through (a)(3) to submit data for all required market categories as outlined in the Guide, to the extent consistent with federal law.

The purpose of this requirement is to obtain a comprehensive submission of THCE data from entities that meet OHCA's covered lives threshold in some market categories, but not others. One of the primary reasons OHCA identifies required submitters using a covered lives threshold is to ensure data submission from entities representing the largest share of health care spending in California. As required submitters, these larger entities will be required to develop infrastructure to extract, aggregate, and submit data to OHCA. The requirement that these entities submit comprehensive data is necessary to achieve OHCA's objective of data completeness when measuring and publicly reporting THCE.

Subsection (b) also provides payers or fully integrated delivery systems that meet any of the subsection (a)(1) through (a)(3) criteria will be collectively referred to as "required submitters" in subsequent proposed regulations. OHCA uses a collective term for brevity and to distinguish between required submitters and voluntary submitters that OHCA has approved to voluntarily submit data pursuant to proposed section 97449(c). OHCA incorporates the Guide in proposed section 97445(s), and cross-references that section here for convenience of the reader.

Subsection (c). Voluntary Data Submission.

Subsection (c) establishes a process for payers and fully integrated delivery systems otherwise exempt from the requirements of Article 2 to request approval from OHCA to voluntarily submit THCE data. This subsection provides how to request approval, what

information must be provided to OHCA, and explains OHCA will notify requestors if they are approved to register to submit data.

This voluntary data submission process is necessary to give notice to potential voluntary submitters that entities capable and willing to meet OHCA's data submission requirements are encouraged to participate. The voluntary participation process supports OHCA's objective of data completeness when measuring and publicly reporting THCE.

The requirement that potential voluntary submitters request approval to participate in writing is necessary so that OHCA can appropriately track and evaluate requests. For convenience, subsection (c) allows an authorized agent of a potential voluntary submitter to make a request in the event that an eligible entity contracts with a third-party to submit THCE data on its behalf.

Subsection (c) requires each written request to provide: (1) the potential voluntary submitter's contact information, (2) the number of covered lives enrolled or insured, and (3) the types of coverage offered. The requestor's contact information is necessary so that OHCA can communicate with the requestor to process the request and for notification of approval or disapproval. The number of covered lives and types of coverage offered are necessary for OHCA to determine whether the usefulness of the requestor's voluntary data submission supports any additional administrative costs for data collection, validation, analysis, and reporting borne by the Office.

Subsection (d). Coordination of Data Submission.

It is common practice in California's health care delivery system for health plans to delegate certain health plan functions to other health plans through a plan-to-plan contract. Activities delegated may include enrollment (based on product and market segment) and claims processing. Subsection (d) instructs required submitters how to coordinate THCE data submission in scenarios where two required submitters are parties to a plan-to-plan contract, and/or one or more required submitters are affiliated with each other. The purpose of this subsection is to provide clarity to required submitters regarding who is responsible for effectuating data submission in these complex contracting arrangements.

Subsection (d)(1) provides the directly contracted plan in a plan-to-plan contract (i.e., the payer or fully integrated delivery system directly contracted with a group purchaser, individual subscriber, or a public agency to arrange for the provision of health care services to members) is responsible for reporting data for its members. For example, in Los Angeles County, a Medi-Cal beneficiary enrolled in L.A. Care Health Plan may choose to receive services from one of L.A. Care's subcontracted "Plan Partners" such

as Anthem Blue Cross.[7] In this example, L.A. Care Health Plan, as the directly contracted plan, would be responsible for obtaining any necessary data from Anthem Blue Cross and submitting the data to OHCA.

This subsection is necessary because any confusion regarding the entity responsible for data submission increases the likelihood that incomplete, erroneous, or duplicate data may be submitted to OHCA. OHCA makes the directly contracted plan responsible for data submission for its members because the directly contracted plan, as opposed to its various subcontracted delegates, is in the best position to perform any de-duplication of data and confirm that the total health care expenditure data submitted to OHCA is accurate and complete.

Subsection (d)(2) provides affiliated required submitters are responsible for coordinating data submission among their affiliates. The purpose of this subsection is to clarify that in scenarios where required submitters are affiliated with each other, the required submitters, as opposed to OHCA, are responsible for coordinating their data submission(s) and confirming that complete data for all affiliated required submitters is transmitted to OHCA. This subsection is necessary because required submitters are in the best position to understand their various management, contracting, and ownership structures, and how those structures impact the extraction and aggregation of THCE data.

Subsection (e). Registration Deadline.

Subsection (e)(1) requires required submitters and approved voluntary submitters to register in the Data Portal by April 30, 2024 to submit data through the System for the 2022 and 2023 reporting years. This subsection uses the phrase “initial data file submission” to refer to the statutory requirement in Health and Safety code section 127501.4(d)(1) that THCE data for the 2022 and 2023 calendar years be submitted on or before September 1, 2024.

Subsection (e)(1) is necessary to instruct required submitters and approved voluntary submitters when they must complete the registration process described in proposed section 97449(f) for purposes of the initial data file submission. Based on HCAI’s experience with the HPD program, which also requires specified payers to register in a Data Portal and submit claims payment data, it is necessary to require registration for the initial data submission approximately two months prior to the anticipated submission of data files. OHCA anticipates submitters will have access to and will initiate submission of THCE data for both the 2022 and 2023 reporting years by July 1, 2024.

[7] *See* “L.A. Care Health Plan: Plan Partners,” https://www.lacare.org/health-plans/medi-cal/plan-partners, last accessed December 20, 2023.

This date accounts for the minimum 180-day claims run-out period needed to reconcile calendar year 2023 claims adjudicated between January 1, 2024 and June 30, 2024.

Registration for the initial data file submission will be OHCA's first opportunity to establish a list of submitters and assign unique submitter codes for data tracking. It will also be OHCA's first opportunity to engage in targeted submitter outreach and education. Allowing for two months between registration and the initial data file submission is necessary to give OHCA sufficient lead time to ensure submitters have the capability to submit all required data files in a secure manner.

Following the initial data file submission deadline of September 1, 2024, subsection (e)(2) requires required submitters and approved voluntary submitters to register in the Data Portal annually by May 31 of every year. This subsection is necessary to instruct required submitters and approved voluntary submitters when they must complete registration after the initial data file submission deadline and on an ongoing basis. Because most submitters will already be familiar with the THCE data submission process by its second year, OHCA anticipates it will only need one month lead time between registration and annual data file submission in 2025 and beyond.

Subsection (f). Registration Process.

Subsection (f) requires entities that qualify as required submitters and all approved voluntary submitters to register in the Data Portal. This requirement is necessary because electronic registration is the most secure, efficient, and convenient method for OHCA to receive registration information and for plans and submitters to provide this information. All submitter interactions with OHCA outlined in the regulations and incorporated Guide will occur via the Data Portal. Centralized electronic registration will enable OHCA to keep a record of submitters, track data submissions, and identify who is transmitting data files to the system.

This subsection is necessary to clarify only required submitters and approved voluntary submitters must register in the Data Portal, and entities exempt from the requirements of proposed Article 2 are not obligated to register with OHCA. Required submitters must affirmatively register with OHCA instead of OHCA contacting required submitters. For initiation of THCE data collection, payers and fully integrated delivery systems are in the best position to initially determine whether they are subject to proposed Article 2.

Subsection (f) also requires entities registering in the Data Portal to provide all required registration information specified in the Guide. This requirement is necessary so OHCA can obtain a standard set of identifying information, contact information, and licensing information from each registered submitter to inform accurate measurement and public reporting of submitted data. As explained elsewhere in this Finding of Emergency, the Guide is the comprehensive document that provides technical specifications, file

layouts, reporting schedules, and other instructions to ensure the submission of accurate THCE data in a standardized format. OHCA included these requirements in the Guide because it will allow submitters to easily view all information in a single, user friendly document.

Subsection (g). Registration Information Update.

Subsection (g) requires registered submitters to update registration information in the THCE Data Portal within 15 calendar days of any changes to their registration information. The purpose of this subsection is to ensure OHCA has up-to-date contact information for registered submitters to facilitate timely communication. This subsection is necessary because OHCA anticipates that registered submitters will undergo regular staffing changes in the normal course of business. OHCA chose 15 calendar days because it is the same registration information update timeframe used by the HPD program. (Cal. Code Regs., tit. 22, § 97334.) This timeframe will be familiar to many submitters who also participate in the HPD program. Additionally, based on HCAI's experience with the HPD program, 15 calendar days is a sufficient amount of time to update information and is not overly burdensome for registered entities.

Subsection (h). Data File Submission Deadline.

Health and Safety Code section 127501.4(d)(1) requires payers and fully integrated delivery systems to submit THCE data for the 2022 and 2023 calendar years on or before September 1, 2024. Subsection (h)(1) restates this statutory deadline for both convenience and emphasis and clarifies data files must be submitted as specified in the Guide. This subsection is necessary to make clear to registered submitters when the initial data file submission is due to OHCA and how data files should be submitted.

Health and Safety Code section 127501.4(d)(2) requires payers and fully integrated delivery systems to submit data "for the 2024 and 2025 calendar years based on a reporting schedule established by the office." Likewise, "[f]or subsequent annual reports, payers and fully integrated delivery systems shall submit data for the relevant calendar years according to the reporting schedule established by the office." (Health & Saf. Code, § 127501.4, subd. (d)(2).) Consistent with this legislative mandate, subsection (h)(2) establishes an annual September 1 data submission deadline beginning with reporting year 2024. This provision clarifies data files must be submitted as specified in the incorporated Guide. This subsection is necessary so registered submitters understand when annual data file submissions are due to OHCA and how data files must be submitted.

Subsection (i). Data File Technical Requirements.

Health and Safety Code section 127501.4(k) requires OHCA to adopt regulations "to collect data and other information it determines necessary from health care entities, except exempted providers, to carry out the functions of the office." More specifically, "…[t]he regulations may include, but are not limited, detailed reporting schedules, technical specifications, and other resources to ensure the submission of accurate data in a standardized format within the specified timeframes." For the same reasons stated in the *General Policy Statement*, *supra*, OHCA utilizes the Guide to provide the file format, technical specifications, and other data submission standards necessary to effectuate this legislative directive.

Subsection (i) requires data files submitted to OHCA to comply with the specifications in the Guide. This subsection is necessary so submitters understand where to locate data file technical requirements.

Subsection (j). Test File Submission.

The THCE Data Portal includes functionality that allows registered submitters to "submit" test files to confirm their ability to create and send data files according to system requirements. Subsection (j) informs registered submitters of the available test file process, and states test files submitted through the portal must be identified as test files based on specifications in the Guide. This subsection also clarifies for registered submitters that test files will not be considered submitted to OHCA for reporting purposes. Although the test file process is optional, this subsection is necessary to clarify for registered submitters they must meet certain requirements if they choose to submit test files.

Subsection (k). Data Acceptance and Correction.

Subsection (k)(1) provides that data files submitted to the system that do not meet the file intake specifications detailed in the Guide will be rejected. The subsection also states that registered submitters will be notified within five business days of submission whether a data file has been accepted or rejected, listing three reasons for rejection.

This subsection is necessary so registered submitters are aware that OHCA will perform an initial validation of the data fields within each submitted data file at the time of submission. If OHCA cannot validate a data field, it will notify a registered submitter promptly to facilitate remediation and resubmission. Likewise, if a data file does not contain any initially identified reasons for rejection, OHCA will notify a registered submitter promptly the file is accepted and that no further action is required. This data acceptance process is necessary to set expectations for submitters around data

accuracy and completeness. It is also necessary to establish reasonable timeframes for the data acceptance process so that registered submitters have more certainty regarding the length of the process.

The three reasons for rejection listed in subsection (k)(1) are: “[i]nvalid file format, file layout, or data types,” “[i]ncomplete or illogical data,” and “[o]ther technical deficiencies related to file submission, storage, or processing.”

Rejection due to “[i]nvalid file format, file layout, or data types” captures scenarios where data files cannot be validated due to the submitter’s failure to comply with the standardized formatting, layout, or data type requirements specified in the Guide. Failure to comply with these requirements would necessitate rejection because data standardization is necessary to aggregate and analyze THCE data across submissions.

Rejection due to “[i]ncomplete or illogical data” captures scenarios where data files are missing required information or contain data that does not make sense. A rejection on this basis would be necessary to give the submitter an opportunity to remediate an omission or explain a seemingly illogical entry to OHCA. Complete and logical data is necessary to accomplish OHCA’s objective of data completeness and to ensure that any apparent data inconsistencies can be put into context in public reporting.

Rejection due to “[o]ther technical deficiencies related to file submission, storage, or processing” captures scenarios where a technical deficiency in a file prevents successful file submission by the submitter, or storage or processing by OHCA. A rejection on this basis would be necessary because the data file would not be usable by OHCA. Understanding the reasons for rejection will allow submitters to correct any errors and submit useable data to OHCA going forward.

Subsection (k)(2) provides if a previously accepted data file contains initially unidentified errors, OHCA will notify the submitter through the Data Portal. The submitter is required to respond to the notification within three business days. This subsection is necessary to inform submitters OHCA will engage in continued validation of data files following initial data submission. Continued validation is necessary because incomplete or erroneous data impedes OHCA’s ability to aggregate and analyze THCE data. The purpose of the requirement that submitters respond to a notification from OHCA within three business days is to ensure data issues are resolved in a timely fashion. OHCA considered shorter and longer response times but chose three business days because it will allow OHCA to identify an error, send a notification, receive a submitter response, and triage a resolution based on the response within approximately one week. This is necessary so communications regarding data issues occur promptly and are resolved effectively without impacting OHCA’s ability to comply with public reporting deadlines.

Subsection (k)(2) also provides OHCA may make multiple requests for corrections or resubmissions of data. This subsection acknowledges the data acceptance and correction process requires an ongoing dialogue between OHCA and submitters. Incomplete or erroneous data may be identified in different stages of OHCA's aggregation and analysis. Addressing errors as they are identified promotes efficiency and ensures both submitters and OHCA have as much time as possible to resolve any issues. This provision is necessary so OHCA can monitor data quality for the duration of data analysis to ensure accurate and complete public reporting.

Subsection (*l*). Requesting a Variance.

Subsection (*l*) explains a submitter unable to submit data files meeting the Guide's file intake specifications may request and obtain a "temporary variance to those requirements." OHCA's temporary variance process is based on the process utilized by the HPD program and should be familiar to many submitters.

OHCA recognizes in some circumstances a submitter may not reasonably be able to meet the Guide's file intake requirements. The purpose of this subsection is to allow for reasonable modification of the Guide's requirements on a case-by-case basis to give submitters time to adjust or correct issues. Because standardized, consistent data is necessary for later analysis, this provision only allows temporary variances. OHCA expects all submitters will eventually meet the Guide's file intake specifications.

Subsection (*l*)(1) outlines how submitters may request temporary variances. This subsection requires submitters to "clearly identify the issue, the plan for correction, and the anticipated date of correction." The purpose of this requirement is to establish a convenient process for temporary variance requests to be submitted through the Data Portal. The information requested is general because the circumstances necessitating a variance may be varied and specific to the submitter. The information requested is necessary so OHCA can assess the situation and determine whether it should grant a temporary variance.

Subsection (*l*)(2) requires OHCA to respond to variance requests within five business days of the date the request was submitted. OHCA will review each variance request on a case-by-case basis based on the specific circumstances of the request. The purpose of this requirement is to ensure there is a reasonable amount of time for OHCA to review the request and ask the submitter any clarifying questions. This requirement is necessary so submitters have certainty regarding when OHCA will respond through the Data Portal.

Total Health Care Expenditures Data Submission Guide (Version 1.0)

Proposed section 97445(s) incorporates by reference the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.0)*, dated February 2024 (the "Guide") because it is necessary to provide submitters with detailed technical specifications for the extraction, aggregation, and submission of THCE data in a standardized format.

OHCA developed the Guide after extensive consultation with experts familiar with California's health care delivery system and THCE data collection programs implemented by other states. The Guide will be available to payers and fully integrated delivery systems, other interested stakeholders, and the general public on HCAI's website, located at: https://hcai.ca.gov/.

OHCA includes the technical specifications for THCE data submission in the Guide because publication in the California Code of Regulations would be inordinately complicated and impractical. The Guide is over 50 pages long and includes over 100 file layouts and field specifications organized in data file-specific tables. OHCA anticipates the Guide's primary users will be the data analysts and information technology specialists charged with preparing and submitting the required data as opposed to compliance professionals or legal staff. A user-friendly guide format is the most appropriate, least confusing means to communicate necessary information to these individuals in one convenient and comprehensive document.

Additionally, the purpose and structure of the Guide will be familiar for submitters that participate in the HPD program. The HPD program incorporates a data submission guide with a similar format into its data collection regulations by reference. OHCA's use of the Guide will also be familiar to submitters who participate in spending target programs in other states. For example, Connecticut, Oregon, and Washington utilize technical specification manuals to provide instructions on data submission requirements.

The following descriptions provide the specific purpose and necessity of each section of the Guide, incorporated by reference in these proposed regulations.

Section 1 of the Guide, "Introduction."

The purpose of this section is to provide an overview of what the Guide is. It is a guide to assist submitters in the extraction, aggregation, and submission of THCE data in a standardized format. This section also contains background information on OHCA, citations to the Act, and a link to OHCA's website for additional resources

contextualizing the data collection. This section is necessary to introduce the data collection to submitters and provide context for submitters on how to use the Guide.

Section 1.1 of the Guide, “Contact Information.”

The purpose of this section is to provide Guide users with contact information for OHCA program management and vendor staff available to answer general questions regarding the data submission process. This section is necessary to ensure users direct questions to the correct inboxes and/or telephone numbers to facilitate quick resolution of any technical issues.

Section 1.2 of the Guide, “Data Submission Deadlines.”

Health and Safety Code section 127501.4(d)(1) sets a September 1, 2024, statutory deadline for the first THCE data submission. For subsequent years, Health and Safety Code section 127501.4(d)(2) requires OHCA to establish a reporting schedule identifying the “relevant calendar years” for each annual data submission. Section 1.2 of the Guide fulfills this legislative requirement.

Specifically, Section 1.2 of the Guide informs submitters the first data submission, which will be used for OHCA’s baseline report, is due by September 1, 2024. Section 1.2 of the Guide also provides an overview of the reporting schedule for subsequent annual data submissions, commencing with the data submission due by September 1, 2025. Finally, Section 1.2 of the Guide instructs submitters what to do when data submission deadlines fall on a weekend or state holiday and specifies each annual data submission will include data for the previous two calendar years. Section 1.2 of the Guide is necessary to make clear when to submit THCE data to OHCA and which calendar years to include.

Section 1.3 of the Guide, “Changes to this Guide.”

The purpose of this section is to reinforce and restate Health and Safety Code section 127501.4(k), which requires OHCA to engage with relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received when promulgating data collection regulations. Section 1.3 of the Guide is necessary to address stakeholder feedback expressed during the comment period for these proposed regulations that requested language emphasizing OHCA’s commitment to a robust stakeholder engagement process when drafting future versions of the Guide.

In furtherance of transparency, OHCA also provides the subscription page URL for notices of public meetings and regulatory actions. Any interested party may freely sign up at https://hcai.ca.gov/mailing-list/.

Section 2 of the Guide, "Submitter Registration."

Proposed section 97449(e) mandates required submitters and approved voluntary submitters register in the THCE Data Portal (defined in proposed section 97445(r)) and "provide all required registration information as specified in the Guide." Section 2 of the Guide is necessary to inform payers and fully integrated delivery systems of the method for establishing an account to register and log in to the Data Portal. All submitter interactions described in the Guide will occur via the secure Data Portal. OHCA will make the Data Portal available online via https://hcai.ca.gov/login/.

Section 2 of the Guide provides the following required registration information submitters will input during the registration process. To identify the registering entity and to facilitate communication between OHCA and appropriate submitter contacts, the Guide requires:

- Legal entity name and address
- A regulatory contact (first and last name, phone, email, and mailing address)
- A business contact for submission issues (first and last name, phone, email, and mailing address)
- A technical contact for each data file type (first and last name, phone, email, and mailing address)

This section requires a legal entity name and address, as opposed to a "doing business as" name or trade name, because the various trade names anticipated submitters utilize in the California health care market can be a source of confusion. This section requires regulatory, business, and technical contacts, so OHCA and/or its data management vendor can direct communications to the correct contact based on topic. For example, communications regarding the registration process would be directed to a regulatory contact and communications regarding a data element validation issue would be directed to the technical contact for the relevant file type. This section requires first and last name, phone, email, and mailing addresses for each contact to facilitate follow-up communication from OHCA if a communication sent through the Data Portal is unopened.

For purposes of data validation, the Guide requires information on submitter market category or categories, discussed in Section 4.4 of the Guide, *supra*:

- Commercial (Full Benefits)
- Commercial (Partial Benefits)

- Medi-Cal Managed Care
- Medicare Advantage
- Medi-Cal Expenses for Dual Eligibles
- Medicare Expenses for Dual Eligibles
- Dual Eligible Special Needs Plans (D-SNPs)

Some submitters may operate in the commercial, Medi-Cal Managed Care, and Medicare Advantage health care markets and have THCE data that falls into all seven market categories. Others may operate in only the Medicare Advantage market and have THCE data that falls into one or two market categories. The number of market categories applicable to a submitter's data dictates the number of rows that will be in each of the five required file types comprising a complete data submission. More applicable market categories mean more rows in each required file. OHCA will use the information on applicable market categories obtained during registration to help confirm that the files in a submitter's data submission are complete.

The Guide also requires additional information, including:

- License Type(s) and License Number(s) for all licensed health plans for which the submitter will be reporting THCE data
- National Association of Insurance Commissioners (NAIC) Code(s), if applicable, for any health insurers for which the submitter will be reporting THCE data

OHCA asks for this information to facilitate accurate identification of registering entities. This information also helps OHCA merge data submissions with existing state and federal data sources, including data sources maintained by state and federal licensing agencies and trade associations. Submitters who are required to file with the Department of Insurance pursuant to 10 CCR 2308.1 will have an NAIC code. Finally, OHCA needs this information to validate a registering entity's final data submission contains data for all health plans and health insurers identified during the registration process.

- A list identifying the organizations on the OHCA Attribution Addendum and any other organizations for which the submitter can attribute total medical expenses for California members according to the Member Attribution instructions outlined in Section 4.5 of this Guide. The list shall also identify the Taxpayer Identification Numbers (TIN) that the submitter associates with each organization for payment purposes. The list shall include all organizations contracted for at least 1,000 member lives during the applicable reporting years (*e.g.*, 2022 and 2023 for the 2024 submission). Newly identified organizations will be added to future iterations of the OHCA Attribution Addendum.

The organization list shall be submitted as a pipe ("|") delimited text file (.txt) with one row per record in the following format…

OHCA asks for this organization list during submitter registration to facilitate any necessary updates to the OHCA Attribution Addendum (Attribution Addendum). The Attribution Addendum, incorporated by reference pursuant to proposed section 97449(t), contains a list of physician organizations with unique identifiers that submitters must use when attributing total medical expenses.

OHCA set a threshold of at least 1,000 member lives during the applicable reporting year after consultation with experts on the relevant capitated, delegated, and Accountable Care Organization (ACO) arrangements in California. The 1,000 member lives threshold is intended to serve as a starting point for development of the Attribution Addendum. OHCA considered a lower member lives threshold but determined that 1,000 member lives strikes an appropriate balance between the level of insight into attributed spending needed by OHCA for initiation of the spending targets program and the administrative costs for data collection, validation, and analysis borne by the Office. As discussed in more detail in the statement of necessity for Section 4.5 of the Guide, "Member Attribution," OHCA intends to use the baseline data collection to further develop the attribution approach that will be used in later years. OHCA incorporates the statement of necessity it provides for Section 4.5. of the Guide here.

OHCA requires submitters to include each organization's federal tax ID number to facilitate identification when there are multiple similar names among listed organizations.

OHCA requires submitters to provide the organization list in a pipe delimited text file because a standardized, structured data file reduces manual processing and human error. Using a text file approach, rather than a specific software product output, lessens the burden on submitters from purchasing new software. Whichever standard business software used by the submitter will be able to save in "text file" format. Pipe delimiting fields is a standard data approach, familiar to the industry.

Finally, Section 2 of the Guide explains that upon approval of a registration, each registering entity will receive a unique Submitter Code. The Submitter Code is a data element in all seven of the required files comprising a complete data submission. OHCA will use the Submitter Code to link submitted files to each registered entity.

Section 2.1 of the Guide, "Test File Submission."

Proposed section 97449(j) explains registered submitters may use the THCE Data Portal to submit test files "identified as specified in the Guide." The purpose of Section

2.1 of the Guide is to specify a test file should be identified in the file header record using the "Test File Flag" described in the Section 5.1, "Header Record" table. Section 2.1 of the Guide is necessary so OHCA can distinguish a test file submission, which is not submitted for reporting purposes, from a real (production) file submission.

Section 3 of the Guide, "General File Specifications."

Proposed section 97449(i) provides data files submitted to OHCA must comply with the file format, field specifications, and other standards in the Guide. The purpose of Section 3 of the Guide is to identify the five files that comprise a complete data submission and to instruct submitters how to format text entered into each data field across all five files. For example, in every file, data must be submitted as a text file that is pipe ("|") delimited with one row per record and no empty rows.

Required File Types

OHCA lists the following five file types in Section 3 of the Guide:

1. Statewide Total Medical Expenses (TME) – total medical expenses for covered health benefits during the reporting period broken out by market category.
2. Attributed TME – total medical expenses for covered health benefits during the reporting period attributed to organizations and broken out by market category, age, and sex.
3. Regional TME – total medical expenses for covered health benefits during the reporting period broken out by geographic region and market category.
4. Pharmacy Rebates – statewide medical and retail pharmacy rebate data broken out by market category.
5. Submission Questionnaire – attestations and confirmation that instructions in the Guide were followed when preparing data for submission.

The Statewide TME file, Attributed TME file, Regional TME file, and Pharmacy Rebates files are necessary for OHCA to collect THCE data at a level of granularity appropriate for OHCA's baseline and initial annual reports. (Health & Saf. Code § 127501.6, subd. (b)(2)(A) [stating that the baseline report shall include aggregated data on THCE, per capita THCE, and as appropriate, disaggregated data by specified categories].) OHCA's collection of specified disaggregated or "broken out" data within each file is based on extensive consultation with experts on spending target programs in other states and takes the data magnitude of each required file into consideration. Higher data magnitude means more granularity and potentially provides greater insight into spending. However, it increases the overall administrative burden for submitters and the data processing and analysis burden for OHCA. For example, disaggregation by member age and sex is necessary for OHCA to perform demographic risk adjustment when measuring year-over-year spending growth at the payer and provider entity levels.

A demographic risk adjustment (or health status adjustment) is a process whereby data is modified using a risk score based on demographic information. Because collecting demographic information potentially increases the total number of rows within each file by thousands, data broken out by age and sex is only requested in one file type.

The Submission Questionnaire file is necessary for submitters to perform an initial validation check on their data submissions. OHCA has studied the experience of other states with spending target programs and understands that data validation is time-intensive, particularly in the first year of THCE data collection. The Submission Questionnaire file should reduce the overall number of back-and-forth communications between submitters and OHCA during the data validation process.

The Submission Questionnaire file is also where OHCA requests a brief narrative description of each submitter's member-level attribution and estimation methodologies and aggregate information on fees earned from self-insured accounts. The specific purpose and necessity of these questions is explained in Sections 4.5 of the Guide through 4.7 of the Guide, *supra*.

Required File Formats

The general file specifications in Section 3 of the Guide are necessary so submitters can develop and write the software code utilized to extract and aggregate data from their internal systems into a pipe delimited text file, as discussed above. Standardized, structured pipe delimited text files (when compared to spreadsheets with keyed data) reduce manual data processing and human error. The file specifications listed in Section 3 will ensure that data submitted to OHCA is standardized for THCE Data Portal intake. This facilitates timely data acceptance and allows OHCA to perform apples-to-apples data analysis across files from multiple submitters.

Section 4 of the Guide, "General Information."

Whereas Section 3 of the Guide provides general specifications for how data submissions should be formatted, the purpose of Section 4 of the Guide is to provide instructions for how THCE data should be extracted and aggregated. The specific purpose and necessity of each requirement in Section 4 of the Guide is discussed in more detail below.

Section 4.1 of the Guide, "Data Completeness."

This section provides each data submission (i) shall include data for the previous two calendar years, (ii) shall not apply a "paid through date" or otherwise limit claims run-

out, and (iii) shall report the allowed amount for covered benefits. This section further instructs submitters what data to include in the "allowed amount."

The purpose of specifications (i) and (ii) is to mitigate data completeness issues in scenarios where claims run-out exceeds the minimum 180-day claims run-out period described in Section 4.1.1 of the Guide (*i.e.*, scenarios where claims are not finalized by the time data is extracted and therefore not reported to OHCA). Together, these requirements ensure all calendar year data beginning with calendar year 2023 will be submitted to OHCA twice, and when extracted and reported to OHCA for the second time, will reflect a claims run-out period of at least 540 days.

Regarding specification (iii), OHCA requires submitters to report allowed amounts for covered benefits that include both the amount paid by the submitter to the provider and the member's financial responsibility so reported amounts reflect what is commonly known as the negotiated or contracted rate, regardless of whether the member actually made a payment. This requirement ensures reported amounts do not undercount member responsibility by excluding unpaid amounts and/or medical debt.

This section is necessary to ensure THCE data submitted to OHCA is as complete as possible at the time of extraction. Because the requirements in Section 4.1 are also necessary for submitters to develop and write the software code utilized to extract and aggregate data from their internal systems, OHCA incorporates the reasons it provides for data standardization in Section 3 of the Guide here.

Section 4.1.1 of the Guide, "Claims Payments."

The purpose of this section is to provide submitters with instructions for how to identify the universe of claims that should be reported for a given calendar year. Specifically, this section instructs submitters how to calculate the minimum 180-day claims run-out period that must be used when extracting data. This section also instructs submitters claims should be included in a calendar year based on the incurred date or date of service, not the date paid or reconciled. This section further instructs submitters incurred but not reported (IBNR) or incurred but not paid (IBNP) factors should not be applied. IBNR and IBNP factors are terms of art in the insurance industry, and in the context of heath care claims, generally refer to scenarios where a service has been performed, but no claim is on file.

This section is necessary because OHCA is required to include data for claims-based payments for covered benefits in its calculation of THCE. (Health & Saf. Code, § 127500.2, subd. (s)(1).) Because the requirements in Section 4.1.1 are also necessary for submitters to develop and write the software code utilized to extract and aggregate data from their internal systems, OHCA incorporates the reasons it provides for data standardization in Section 3 of the Guide here.

Section 4.1.2 of the Guide, “Non-Claims Payments.”

The purpose of this section is to provide submitters with instructions for how to identify the universe of non-claims payments that should be reported for a given calendar year.[8] Specifically, this section instructs submitters how to calculate the minimum 180-day non-claims reconciliation period that must be used when extracting data. This section also authorizes submitters to apply reasonable and appropriate estimations of non-claims liability for providers that are expected to be reconciled after the 180-day reconciliation period. As with claims-based payments, this section instructs submitters to report non-claims based on the date incurred or date of service, not the date paid or reconciled.

This section is necessary because OHCA is required to include all non-claims based payments for covered benefits in its calculation of THCE. (Health & Saf. Code, § 127500.2, subd. (s)(2).) Because the requirements in Section 4.1.2 are also necessary for submitters to develop and write the software code utilized to extract and aggregate data from their internal systems, OHCA incorporates the reasons it provides for data standardization in Section 3 of the Guide here.

Section 4.1.3 of the Guide, “Pharmacy Rebates.”

The purpose of this section is to provide submitters with instructions for how to identify the pharmacy rebate data collected in the Pharmacy Rebates file, located in Section 5.6 of the Guide.

During the comment period for these proposed regulations, OHCA considered comments from stakeholders expressing concern the pharmacy rebate data described by OHCA was overly broad. Based on these comments, OHCA made clarifying changes to the pharmacy rebates description. OHCA is statutorily required to collect data on all health care spending in the state, including any “[p]harmacy rebates and any inpatient or outpatient prescription drug costs” not otherwise reported by a payer or fully integrated delivery system as a claims-based payment, non-claims based payment, consumer cost-sharing amount, or component of administrative costs and profits. (*See* Health & Saf. Code § 127500.2, subd. (s)(5).) Accordingly, the pharmacy rebates description in Section 4.1.3 is intentionally inclusive to meet OHCA’s overall objective of data completeness. The pharmacy rebates description was developed in collaboration with HCAI’s Health Care Payments Data (HPD) program and contracted experts to ensure consistency across HCAI’s data collection programs.

[8] Non-claims payments are payments made to providers for something other than a fee-for-service claim. OHCA provides guidance to submitters on how to map payment types to non-claims payment categories in "Appendix B: Non-Claims Payment Framework” of the Guide.

This section is necessary because OHCA is required to include pharmacy rebate data in its calculation of THCE. (Health & Saf. Code, § 127500.2, subd. (s)(5).) Because the requirements in this section are also necessary for submitters to develop and write the software code utilized to extract and aggregate data from their internal systems, OHCA incorporates the reasons it provides for data standardization in Section 3 of the Guide here.

Section 4.2 of the Guide, "Data Variance Requests."

The purpose of this section is to inform submitters that OHCA's Data Variance Request process is available in scenarios where a submitter is unable to submit a data file meeting the file intake specifications in the Guide. This section provides OHCA will respond to requests within five business days and requests will be reviewed on a case-by-case basis. This section further provides data variance requests granted by OHCA will be limited in duration (temporary) and will not carry over to future data submission years. OHCA incorporates the statement of necessity it provides for proposed section 97449(l) here. While the requirements for the variance request are listed in proposed section 97449(l), the concept of a variance is described here for convenience of the reader.

Section 4.3 of the Guide, "Included Population."

The purpose of this section is to provide submitters with instructions for how to identify the included member population for purposes of extracting and aggregating THCE data. These included population specifications are necessary because data submissions must be consistent and comparable across calendar years for OHCA to accurately measure spending growth on a year-over-year basis. Because the specifications in Section 4.3 are also necessary for submitters to develop and write the software code utilized to extract and aggregate data from their internal systems, OHCA incorporates the reasons it provides for data standardization in Section 3 of the Guide here.

Specifically, this section requires submitters to report all health care spending for covered benefits on behalf of or by California residents, irrespective of whether the care is received inside or outside of California. This instruction is necessary because there are many scenarios where California residents receive covered health care services out-of-state. For example, emergency services received on a vacation or prior-authorized non-emergency services from an out-of-state specialist provider.

This section also excludes health care spending for non-residents of California. This instruction is necessary because legislative intent makes measurement of per capita health care spending on behalf of or by California residents paramount – it is "in the

public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal." (Health & Saf. Code, § 127500.5, subd. (a)(1).)

This section also clarifies that when submitters report spending by region, members shall be assigned to a region based on the member's residence address, as opposed to a work or primary care physician address. This clarification is necessary so all submitters use the same rules for assigning members to a region.

This section further clarifies that in scenarios where a claim is the financial responsibility of more than one payer or fully integrated delivery system, spending data for the claim shall only be reported by the primary payer under coordination of benefits rules. The coordination of benefits process as well as the terms "primary payer" and "secondary payer" are well-known terms of art in the health insurance industry and help payers and fully integrated delivery systems determine their relative payment responsibilities when an individual has multiple forms of health care coverage. This clarification is necessary because if a secondary payer reports coverage expenses, the reported expenses would generally double count a portion of the allowed amount paid by the primary payer.

Finally, this section provides submitters should only include spending data for members for whom the submitter is the directly contracted plan. OHCA incorporates the statement of necessity it provides for proposed section 97449(d) here.

Section 4.4 of the Guide, "Market Categories."

Proposed section 97449(b) provides a required submitter shall submit data for all required market categories as outlined in the Guide, to the extent consistent with federal law. The purpose of Section 4.4 of the Guide is to provide these seven required market categories, which OHCA selected after extensive consultation with experts familiar with California's health care delivery system and the THCE data collection programs implemented by other states.

Section 4.4 also includes an explanation of how to determine whether commercial spending should be categorized in the "Commercial (Full Benefits)" or "Commercial (Partial Benefits)" market categories. OHCA added this explanation based on feedback received through the public workshop for this proposed regulation. Specifically, the "Commercial (Full Benefits)" market category is used when a submitter is able to report information on all claims and/or capitation paid on behalf of a member. The "Commercial (Partial Benefits)" market category is used when a submitter does not have all of the information on claims and/or capitation paid on behalf of a member. In this scenario, the submitter must create an estimate of expenses on a per member, per month basis. The purpose of this section is to instruct submitters how to estimate spending data in scenarios where certain covered health care services are "carved-out" (an industry term of art referring to special types of services, e.g. behavioral health

benefits and pharmacy benefits) and claims or encounter data are not available to the submitter. OHCA allows submitters to use their own methodology to estimate expenses in the "Commercial (Partial Benefits)" market category, provided that the methodology is based on the submitter's "Commercial (Full Benefits)" population. Submitters must briefly describe their methodology to OHCA in field SQS019 of the Submission Questionnaire File so OHCA is able to assess the overall comparability of the data received from submitters. These commercial market categories allow OHCA additional insight into how much of a submitter's reported commercial spending is based on actual versus estimated expenses.

Section 4.4 is necessary because OHCA must collect data disaggregated by market category to inform more granular data analysis comparing year-over-year growth in THCE across categories. (Health & Saf. Code, §§ 127501.6, subd. (a) and 127501.6, subd. (2)(A) [collectively stating that the baseline report shall include reporting on "[t]otal health care expenditures, per capita total health care expenditures, and, as appropriate, disaggregated data by categories…"].) For example, OHCA anticipates annual growth in THCE for the Medi-Cal Managed Care market category versus the Commercial market category will differ based on reporting done by other spending target states. OHCA needs disaggregated data by market category to better understand these differences. Because the specifications in Section 4.4 are also necessary for submitters to develop and write the software code utilized to extract and aggregate data from their internal systems, OHCA incorporates the reasons it provided for data standardization in Section 3 of the Guide here.

Additionally, Section 4.4 explains how to report claims for dual eligibles (an industry term of art for members who are enrolled in both Medicare and Medi-Cal) when claims cannot be easily categorized as either Medicare or Medi-Cal expenses. This instruction is necessary to ensure submitters are using the same rule for categorizing expenses in these scenarios to promote consistency and standardization in submitted data.

Section 4.4 also explains how the Statewide TME File will further disaggregate commercial spending within each market category by product type and payment arrangement. The product types include: (1) products commonly referred to as HMO or point of service (POS) products, which require a primary care provider to manage a member's care; (2) products commonly referred to as preferred provider organization (PPO) or exclusive provider organization (EPO) products, which allow members to schedule visits without a referral; and (3) any other product types. Most submitter product types will fall into categories one or two, but OHCA included a third category to capture product types that do not fall into either category one or two. Based on feedback received during the comment period for the proposed regulation, OHCA added a field in the Statewide TME File for commercial product type. Categorizing commercial spending by product type and payment arrangement is necessary for OHCA to assess the potential impacts of payment arrangement and product type on annual spending growth.

Finally, Section 4.4 informs submitters that data for the "Medi-Cal Managed Care" and "Medi-Cal Expenses for Dual Eligibles" market categories will not be collected through these proposed regulations until September 1, 2025. OHCA will collect data for these market categories directly from the DHCS and Centers for Medicare & Medicaid Services for the baseline data collection due September 1, 2024. This one-year delay will allow OHCA to determine whether it can obtain comprehensive THCE data for these market categories from existing state and federal data sources. It is 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).)

Section 4.5 of the Guide, "Member Attribution."

The purpose of this section is to provide 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 proposed section 97445(t). For organizations that are not assigned an organization code by OHCA because they are not listed in the Attribution Addendum, this section explains how to use generic organization codes '7777,' '8888,' and '9999.' These generic codes are necessary so OHCA can identify provider organizations that may need to be added to future versions of the Attribution Addendum depending on the number of attributed members (codes '7777' and '8888'), and to identify member spending that cannot be attributed to any organization using any of the methods described by OHCA (code '9999').

Member-level attribution enables measurement of total medical expenses at the physician organization level. In these initial proposed data collection regulations, member-level attribution is necessary so OHCA can test and refine an attribution approach using real data. OHCA requires submitters to attribute total medical expenses in a specified order and to report which attribution method was used because this information will allow OHCA to contextualize attributed spending for purposes of internal analysis and future public reporting.

This section is the result of engagement with payer and fully integrated delivery system stakeholders in OHCA's payer technical workgroup and extensive consultation with experts on the unique complexities of California's health care delivery system. During the comment period for these proposed regulations, many commenters expressed concern the attribution approach described in this section would not accurately attribute total medical expenses for members in non-health maintenance organization (HMO) products. Commenters also expressed concern OHCA's attribution approach does not include an opportunity for provider review of the attribution performed by payers and fully integrated delivery systems. Finally, commenters noted OHCA's attribution approach would only result in attribution of member-level expenditures for a small portion of Californians.

OHCA acknowledges these stakeholder concerns and understands the attribution approach in this section of the Guide will not attribute all total medical expenses to physician organizations. OHCA also understands there may be variation across payers and fully integrated delivery systems in the methods used to attribute some portion of total medical expenses to physician organizations. The attribution approach described in this section is intended to serve as a starting point that will enable OHCA to evaluate the data collected to continue to refine attribution methodologies and inform future data collection and reporting. This is necessary to allow OHCA to further develop, through stakeholder feedback, the attribution approach that will be used in later years.

Section 4.6 of the Guide, "Self-Insured Plans."

The purpose of this section is to request submitters with self-insured lines of business report aggregate information on the fees earned from their self-insured accounts in the Self-Insured Business Field (SQS021) of the Section 5.7, "Submission Questionnaire File" table. This additional information from submitters with self-insured lines of business is necessary to calculate the administrative costs and profit portion of THCE. (Health & Saf. Code, § 127500.2, subd. (s)(4).) OHCA's approach to collecting this information is consistent with other states.[9]

Sections 4.7 through 4.7.2 of the Guide, "Standard Deviation."

The purpose of these sections is to instruct submitters how to calculate and report standard deviation as a per member, per month (PMPM) value in the "Statewide TME File" and "Attributed TME File." OHCA's unit of analysis for calculating standard deviation is member months to ensure the weight of monthly spending for each member is accurately reflected in the average. These sections are necessary so OHCA can calculate confidence intervals using standard deviation values. Confidence intervals allow OHCA to assess variability in THCE. While validation examples are shown using a Microsoft Excel command function, OHCA is not prescriptively requiring submitters to use Excel. Any statistical software program may be used; the Excel example will be useful to many readers and may also assist in finding similar commands in other programs.

[9] *See, e.g.*, *Oregon's Health Care Cost Growth Target Program Data Specification Manual (CGT-2)*, at pp. 11, 21, and 38, https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/CGT-2-Data-Specification-Manual.pdf, last accessed December 19, 2023; *Washington's Health Care Cost Growth Benchmark Program Technical Manual*, at pp. 10, 13, and A-4, https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf, last accessed December 19, 2023.

Section 5 of the Guide, “File Layouts and Field Specifications.”

Column Headers

Each table in sections 5.1 through 5.7 includes the following column headers: Column Number, Field ID, Field Name, Type, Max, and Description. The column headers are necessary to specify the information that must be provided for each data element listed in the table. This ensures the proper values are inputted for each data element.

The “Column Number” and “Field ID” columns ensure the data elements are in the correct order and also act as identifiers to facilitate communication between the submitter and OHCA about each table. The “Field Name” column identifies the data element. The “Type” column is used for data validation and indicates the type of value that should be inputted into the field (*e.g.*, no alpha characters/text should be entered in an integer field). The “Max” column is also used for data validation and indicates the maximum number of characters that can be entered into the field (*e.g.*, the “File Type” entered cannot be more than three characters, which corresponds to the three-letter codes for each file type).

The “Description” column contains descriptions and notes that are applicable to each data element. For ease of use, OHCA restates the technical specifications detailed elsewhere in the Guide within the “Description” column. This allows submitters to readily access relevant technical specifications as they proceed through the tables for each file type.

Sections 5.1 and 5.2 of the Guide

These are the tables of data elements that must be submitted with each data file’s header and trailer records. Header and trailer records are standard sets of data fields for all file types and are used to collect information necessary to identify the file. These tables are necessary so submitters can develop and write the software code utilized to extract and aggregate data from their internal systems into a pipe delimited text file. OHCA incorporates the reasons it provides for data standardization in Section 3 of the Guide here.

Sections 5.3 through 5.7 of the Guide

These are the tables of data elements that must be submitted with each required data file identified in Section 3 of the Guide. OHCA incorporates the necessity statements for each required data file type from Section 3 of the Guide here.

Appendix A of the Guide, "Claims Service Category to Bill Code Mapping"

Appendix A provides guidance to submitters on mapping claims service categories to bill codes for purposes of reporting total medical expenses in the Statewide TME, Attributed TME, and Regional TME file types. OHCA disaggregates THCE data by service category to enable more granular data analysis of year-over-year spending growth by service category. OHCA selected the service categories in consultation with experts on California's health care delivery system and spending target programs implemented in other states. The codes listed are provided as examples but not meant to be an exhaustive list. Appendix A is necessary so submitters can correctly categorize expenses by mapping claims service categories to specified billing code sets. This ensures data is standardized and consistent across data submissions to enable apples-to-apples data comparisons.

During the comment period for these proposed regulations, one stakeholder expressed concern the service categories OHCA selected will not provide sufficient insight into primary care and behavioral health spending. OHCA acknowledges the service categories in Appendix A do not currently include service categories specific to primary care and behavioral health. OHCA is engaged in ongoing work with stakeholders and subject matter experts in its Investment and Payment Workgroup and Primary Care subgroup to determine the categories of health care professionals who should be considered primary care and behavioral health providers, determine specific procedure codes that should be mapped to primary care and behavioral health care, and instruct submitters on how to calculate non-claims based payments for primary care and behavioral health care. (*See generally*, Health & Saf. Code, § 127501.4, subd. (h)(1).) This ongoing work will be the subject of future rulemaking, including further disaggregation of the claims service categories listed in Appendix A.

Appendix B of the Guide, "Non-Claims Payment Framework"

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. 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.[10] OHCA disaggregates THCE data by non-claims payment categories to enable more granular data analysis of year-over-year spending growth within each category.

[10] *See* HCP-LAN APM Framework website, https://hcp-lan.org/apm-framework/, last accessed December 21, 2023.

OHCA developed Appendix B in collaboration with HCAI's HPD program and contracted experts to ensure consistency across HCAI's data collection programs. Appendix B is necessary so submitters can correctly categorize expenses by mapping non-claims payment categories to specified payment types. This ensures data is standardized and consistent across data submissions to enable apples-to-apples data comparisons.

Appendix C of the Guide, "Regions"

The purpose of Appendix C is to instruct submitters how to determine which value to enter in the Region field on the Regional TME file. OHCA disaggregates THCE using the Regional TME file to enable analysis of year-over-year spending growth by region. The data collected through the Regional TME file is necessary to measure regional spending trends and support OHCA's future work on health care cost targets by sector, including by geographic regions, as appropriate. (Health & Saf. Code, § 127501, subd. (c)(3).)

Appendix C maps California counties to the 19 Covered California rating regions, except for Los Angeles County (rating regions 15 and 16). Los Angeles County is further divided into the 8 Service Planning Areas (SPAs) specified by the Los Angeles County Department of Public Health.[11] OHCA's use of SPAs in Los Angeles County is necessary for meaningful regional data analysis. The population covered by the two Los Angeles County Covered California rating regions represents an area with approximately 10 million people. In contrast, rating region 13, which includes Imperial, Inyo, and Mono counties has a population of approximately 212,000 people. OHCA selected the Covered California rating regions because they are very familiar to submitters and most rating regions (except the two Los Angeles County rating regions) are sized to provide a statistically meaningful sample. OHCA also considered other regional parameters, including zip codes and census tracts, but determined rating regions strike the appropriate balance between necessary data granularity for initiation of the spending targets program and the administrative costs for data collection, validation, analysis, and reporting borne by the Office.

OHCA Attribution Addendum

Proposed section 97445(t) incorporates by reference the *Office of Health Care Affordability: Attribution Addendum*, dated February 2024 (Attribution Addendum) because it is necessary to provide submitters with a standardized list of physician organizations for purposes of attributing total medical expenses in the Attributed TME

[11] *See* County of Los Angeles Public Health: Service Planning Areas, http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm, last accessed December 21, 2023.

file. As with the Guide, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

OHCA acknowledges the Attribution Addendum is not a comprehensive list of all physician organizations operating in California. OHCA included this list in a separate document incorporated by reference because OHCA anticipates it will need to update the list periodically as physician organizations reorganize, enter, and exit the health care market. OHCA will also periodically revise (via regulation) the Attribution Addendum based on information received from submitters, including during the submitter registration process, with an ultimate objective of data completeness. The Attribution Addendum will be readily available to payers and fully integrated delivery systems, other interested stakeholders, and the general public on HCAI's website, located at: https://hcai.ca.gov/.

OHCA developed the Attribution Addendum after consultation with experts familiar with California's health care delivery system and THCE data collection programs implemented by other states. OHCA also solicited stakeholder feedback on the contents of the Attribution Addendum during the comment period for this proposed regulation and added additional organizations to the list based on the feedback received.

The Attribution Addendum contains an "Organization Code" column that lists the unique codes which submitters must use in field ATT003 on the Attributed TME file, as described in Section 5 of the Guide. The "Organization Name" column lists generally used names based on stakeholder input and information received through the submitter registration process described in Section 2 of the Guide. The "DMHC #" column lists the Risk Bearing Organization (RBO) number assigned to some organizations by the DMHC pursuant to Health and Safety Code section 1375.4(b)(6). DMHC #s are cross-referenced to assist in identification since many organizations have similar names. The "Known Subsidiaries" and "Taxpayer Identification Number(s)" columns are also cross-referenced because OHCA anticipates some submitters may use these identifiers to validate attribution when organizations have similar names. Finally, the '7777,' '8888,' and '9999' organization codes are listed for scenarios where data for members is not attributed to organizations listed on the Attribution Addendum, as described in steps 3, 4, and 5 of the Member Attribution methodology described in Section 4.5 of the Guide.

ANTICIPATED BENEFITS OF THE PROPOSAL

These proposed emergency regulations initiate the total health care expenditures (THCE) data collection that will serve as the foundation for OHCA's spending targets program. When fully implemented in 2028, the 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).) The spending targets program's work will 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).)

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

Other State Laws and Regulations:

- Connecticut law (Office of Health Strategy)
  - CT ST § 19a-754h
  - Connecticut Healthcare Benchmark Initiative: Implementation Manual
- Massachusetts (Center for Health Information and Analysis):
  - Mass Gen Laws c. 12C, § 10
  - 957 CMR 2.00
- Oregon law (Oregon Health Authority, Sustainable Health Care Cost Growth Target Program):
  - Oregon Revised Statute 442.386 et seq.
  - Oregon Administrative Rules 409-065-0000 through -0030
  - Oregon's Health Care Cost Growth Target Program: Data Specification Manual (CGT-2)
- Washington law (Washington State Health Care Authority)
  - RCWA 70.390.050
  - Washington's Health Care Cost Growth Benchmark Program: Technical Manual

Reports / Articles:

- Wilson, Katherine. 2022 Edition – California Health Insurers, Enrollment (October 27, 2022), California Health Care Foundation, available at https://www.chcf.org/publication/2022-edition-california-health-insurers-enrollment/#related-links-and-downloads, last accessed December 22, 2023.

Public Meetings:

- August 22, 2023 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.

- September 18, 2023 Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- September 19, 2023 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- November 14, 2023 Proposed THCE Data Collection Regulations Workshop – Presentation Slides, Transcript on Draft Proposed Regulatory Text.
- November 30, 2023 Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- December 19, 2023 Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- January 23, 2024 Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Draft Minutes
- January 24, 2024 Health Care Affordability Board Meeting – Relevant Presentation Slides, Draft Minutes.

General written comments received and considered:

- December 13, 2023 letter from California Hospital Association, Re: CHA Comments on the October 24, 2023 Health Care Affordability Board Meeting and November 30, 2023 Health Care Advisory Committee Meeting
- January 22, 2024 letter from California Association of Health Plans, Re: Total Health Care Expenditures Rulemaking

Written comments received and considered concerning October 2023 draft proposal:

- December 1, 2023 letter from the California Medical Association
- December 1, 2023 letter from California Association of Health Plans
- December 1, 2023 letter from California Hospital Association
- December 1, 2023 letter from Health Access California
- December 1, 2023 letter from America's Physician Groups (considered *as amended* December 7, 2023 to correct typographical error)

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*.

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:

The authorizing legislation contained an appropriation for OHCA's spending targets program, including staffing, contracting resource allocation for IT software, services and infrastructure, and consulting contracts for expert services needed to support OHCA's collection, measurement, and reporting of THCE data. Therefore, although there will be program staff performing data analysis and an electronic data portal for data submission, which are intended to support the work described in regulation, the costs are attributable directly to the legislation.

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.