

Office of Health Care Affordability
Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

April 29, 2026



Agenda

1. Updates
2. Annual Submitter Registration
3. New Behavioral Health File
4. Submitter Round Table
5. Next Steps

Updates

OHCA Updates

The Office of Administrative Law approved updates to the THCE data submission regulations and incorporated documents on April 20, 2026.

Incorporated Document	Contents
Data Submission Guide (Version 3.0)	Requirements for submitter registration and data submission
OHCA Attribution Addendum, dated April 2026	Physician organizations for use in the Attributed TME file
OHCA Behavioral Health Addendum, dated April 2026	Code sets used to identify payments to report in the Behavioral Health file
OHCA Medi-Cal Payments Addendum, dated April 2026	Instructions for inclusion or exclusion of Medi-Cal payment types in all files
OHCA Primary Care Addendum, dated April 2026	Code sets used to identify the portion of payments to include in the Primary Care file

OHCA Updates

- Proposed data submission enforcement regulations were published on the HCAI website on April 17, 2026, and discussed at the Health Care Affordability Board meeting on April 22, 2026.
- Regulations include an extension request process, carve-outs for newer files, and administrative penalty amounts.
- **Comments due to OHCA@HCAI.ca.gov by May 11, 2026.**
- Draft documents available for review at: <https://hcai.ca.gov/about/laws-regulations/>

Onpoint Updates

Onpoint Health Data sent three communications to existing data portal users earlier this month:

1. Onpoint's Claims Data Manager (CDM) renamed Data Harbor.
2. Multi-Factor Authentication (MFA) is now required to access Data Harbor. Users may choose to receive an authentication code by email, text message, or voice call.
3. Existing submitters must re-submit their public PGP key to Onpoint by June 1.

Contact ohca-support@onpointhealthdata.org with any questions.

Annual Submitter Registration

Annual Submitter Registration

- Registration will open on May 1, 2026 in Onpoint's Data Harbor.
- Previously registered contacts and workgroup attendees will receive an email with a link to the registration form.
- Only **one** registration form is needed from each licensed entity. A single form may contain multiple points of contact for the submitter.
- Registration forms must be submitted by **May 29, 2026**.

Annual Submitter Registration

Information required to complete registration form:

- Parent Company name, Submitter/Legal Entity name, California license issuer and license number.
- Market Categories for which the submitter will report data and member count as of December 31, 2025. The market categories selected at registration **must** match the contents of the data submission later this year.
- Business, regulatory, and technical points of contact for the submitter. Additional contacts may be provided in the Comments, if necessary.

New Behavioral Health File

Behavioral Health Spending Measurement

1. Schedule

- Payers will submit aggregate behavioral health spending data beginning in September 2026, covering the years 2024-2025.
- OHCA will release the first report on behavioral health spending, using this data, in the summer of 2027.

2. What Will Be Submitted

- Claims and non-claims payments for behavioral health care (as defined by OHCA).
 - Aggregated by performance year and market category.
 - Using the Expanded Non-Claims Payments Framework categories and subcategories for analysis and reporting.
- Detailed methodology is provided in DSG 3.0.

Measuring Behavioral Health Spending

Numerator

$$\begin{array}{|c|} \hline \text{Claims-based payments} \\ \hline \text{for behavioral health} \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Non-claims-based} \\ \hline \text{payments for behavioral} \\ \hline \text{health} \\ \hline \end{array} = \begin{array}{|c|} \hline \text{Total behavioral} \\ \hline \text{health spending} \\ \hline \end{array}$$

x 100% =

Behavioral health spending as a % of total medical expense

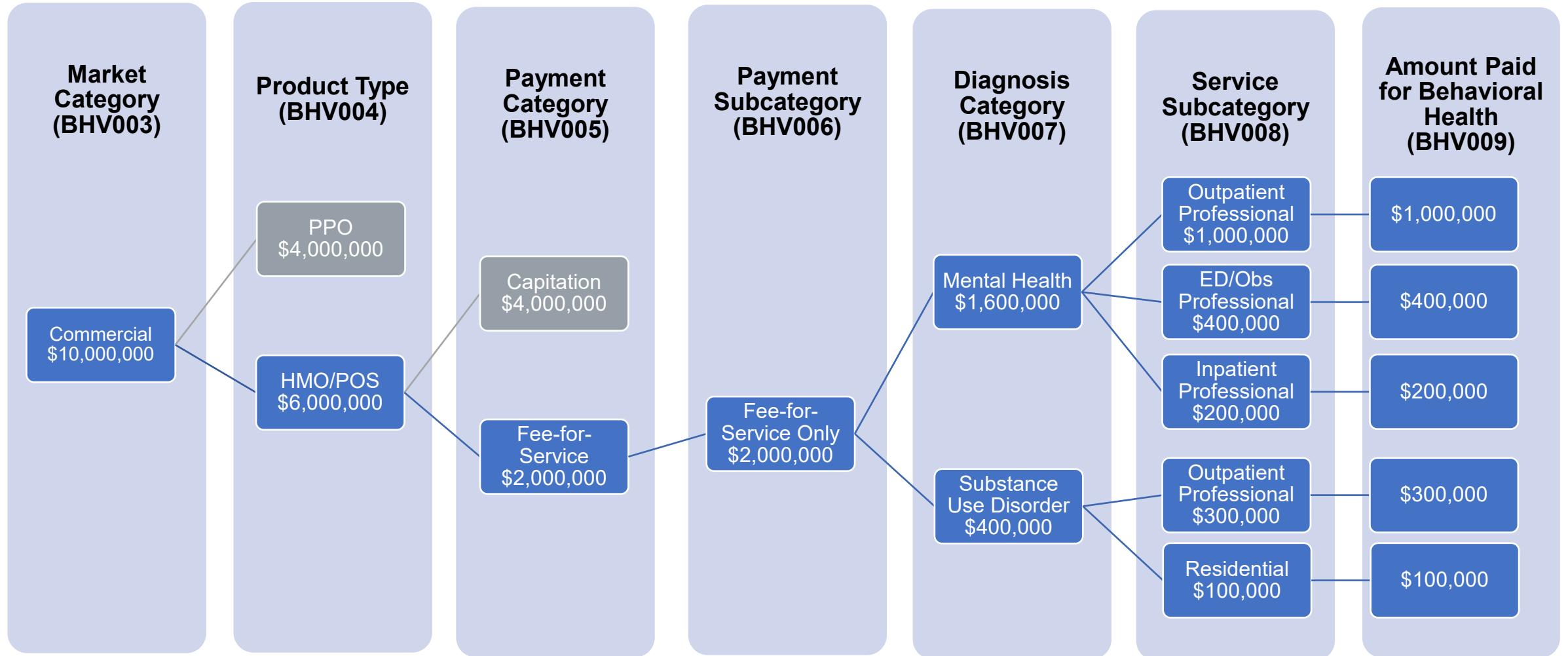
$$\begin{array}{|c|} \hline \text{Total claims-based} \\ \hline \text{payments} \\ \hline \end{array} + \begin{array}{|c|} \hline \text{Total non-claims-based} \\ \hline \text{payments} \\ \hline \end{array} = \begin{array}{|c|} \hline \text{Total medical} \\ \hline \text{expense} \\ \hline \end{array}$$

Denominator

Note: The numerator will include pharmacy spend for behavioral health medications and patient out-of-pocket responsibility for behavioral health services obtained through the plan i.e., services for which a claim or encounter was generated. The denominator will include all pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

Behavioral Health File Layout

Behavioral Health File



Note: All market categories are required to submit the Behavioral Health File (BHV).

Behavioral Health File Layout

Col. #	Field ID	Field Name	Type	Max	Description
1	BHV001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	BHV002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	BHV003	Market Category	Integer	1	<p>Use this field to report the market category code. Refer to Market Categories for more information. Valid values include:</p> <ul style="list-style-type: none"> • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care • 4 = Medicare Advantage • 5 = Dual Eligibles (Medi-Cal Expenses Only) • 6 = Dual Eligibles (Medicare Expenses Only) • 7 = Dual Eligibles (Medi-Cal and Medicare Expenses) <p>Note: The Market Category(ies) selected at registration must match the contents of the data submission.</p>
4	BHV004	Product Type	Integer	1	<p>Use this field to designate the product type. Refer to Market Categories for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include:</p> <ul style="list-style-type: none"> • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other <p>For other Market Categories, valid value includes:</p> <ul style="list-style-type: none"> • 0 = Not applicable

Behavioral Health File Layout

Col. #	Field ID	Field Name	Type	Max	Description
5	BHV005	Payment Category	Text	1	<p>Use this field to report the payment category. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include:</p> <ul style="list-style-type: none"> • A = Population health and practice infrastructure payments • B = Performance payments • C = Shared savings payments and recoupments • D = Capitation and full risk payments • E = Other non-claims payments • X = Fee-for-service
6	BHV006	Payment Subcategory	Text	2	<p>Use this field to report the payment subcategory based on the initial character in the Payment Category (BHV005). Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include:</p> <ul style="list-style-type: none"> • A1 = Care management/care coordination/population health/medication reconciliation • A2 = Primary care and behavioral health integration • A3 = Social care integration • A4 = Practice transformation payments • A5 = EHR/HIT infrastructure payments • B1 = Retrospective/prospective incentive payments: pay-for-reporting • B2 = Retrospective/prospective incentive payments: pay-for-performance • C1 = Procedure-related, episode-based payments with shared savings • C2 = Procedure-related, episode-based payments with risk of recoupments • C3 = Condition-related, episode-based payments with shared savings • C4 = Condition-related, episode-based payments with risk of recoupments • C5 = Risk for total cost of care (e.g., ACO) with shared savings • C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments • D1 = Primary care capitation • D2 = Professional capitation • D3 = Facility capitation • D4 = Behavioral health capitation • D5 = Global capitation • D6 = Payment to integrated, comprehensive payment and delivery systems • E1 = Other non-claims payments • X9 = Claims: Total

Behavioral Health File Layout

Col. #	Field ID	Field Name	Type	Max	Description
7	BHV007	Diagnosis Category	Text	1	<p>Use this field to report the diagnosis category- mental health or substance use disorder. Refer to the OHCA Behavioral Health Code Set for guidance. When Payment Subcategory (BHV006) is 'X9', valid values include:</p> <ul style="list-style-type: none"> • M = Mental Health • S = Substance Use Disorder <p>When Payment Subcategory (BHV006) is not 'X9', valid value includes:</p> <ul style="list-style-type: none"> • N = Not Designated
8	BHV008	Service Subcategory	Text	1	<p>Use this field to report the service subcategory. Refer to Appendix X: Behavioral Health Service Subcategories. When Payment Subcategory (BHV006) is 'X9', valid values include:</p> <ul style="list-style-type: none"> • A = Inpatient; Facility • B = Emergency Department/Observation; Facility • C = Outpatient Facility • D = Residential Care • E = Inpatient; Professional • F = Emergency Department/Observation; Professional • G = Outpatient Professional Primary Care • H = Outpatient Professional Non-Primary Care • I = Other Services • J = MH Pharmacy • K = SUD Pharmacy <p>When Payment Subcategory (BHV006) is not 'X9', valid value includes:</p> <ul style="list-style-type: none"> • N = Not Categorized
9	BHV009	Amount Paid for Behavioral Health	Integer	12	<p>Report the total of all payments made across providers for behavioral health during the reporting year. For fee-for-service payments follow the instructions in Behavioral Health Paid via Claims to determine the portion allocated to behavioral health. For non-claims payments follow the instructions specific to each payment subcategory outlined in Behavioral Health Paid via Non-Claims.</p> <p>Note: This is a money field reported in whole dollars. This field may contain a negative value. When Payment Subcategory (BHV006) is 'C1', 'C2', 'C5', 'C6', 'D1', or 'D3', Amount Paid for Behavioral Health shall be 0.</p>
10	BHV898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format.
11	BHV899	Record Type	Text	3	Use this field to report the value of 'BHV' to indicate behavioral health reporting at the submitter level.

Behavioral Health Claims Definitions and Processes

Behavioral Health Spending Definition and DSG 3.0 Page Numbers

Claims

- Medical claims with a primary behavioral health diagnosis (p. 33-36)
- Medical claims for behavioral health screening and assessment services without a primary behavioral health diagnosis (p. 36-38)
- Medi-Cal medical claims for specific behavioral health services without a primary behavioral health diagnosis for members under 21 (p. 38-41)
- Pharmacy claims for behavioral health treatments (p. 41-42)

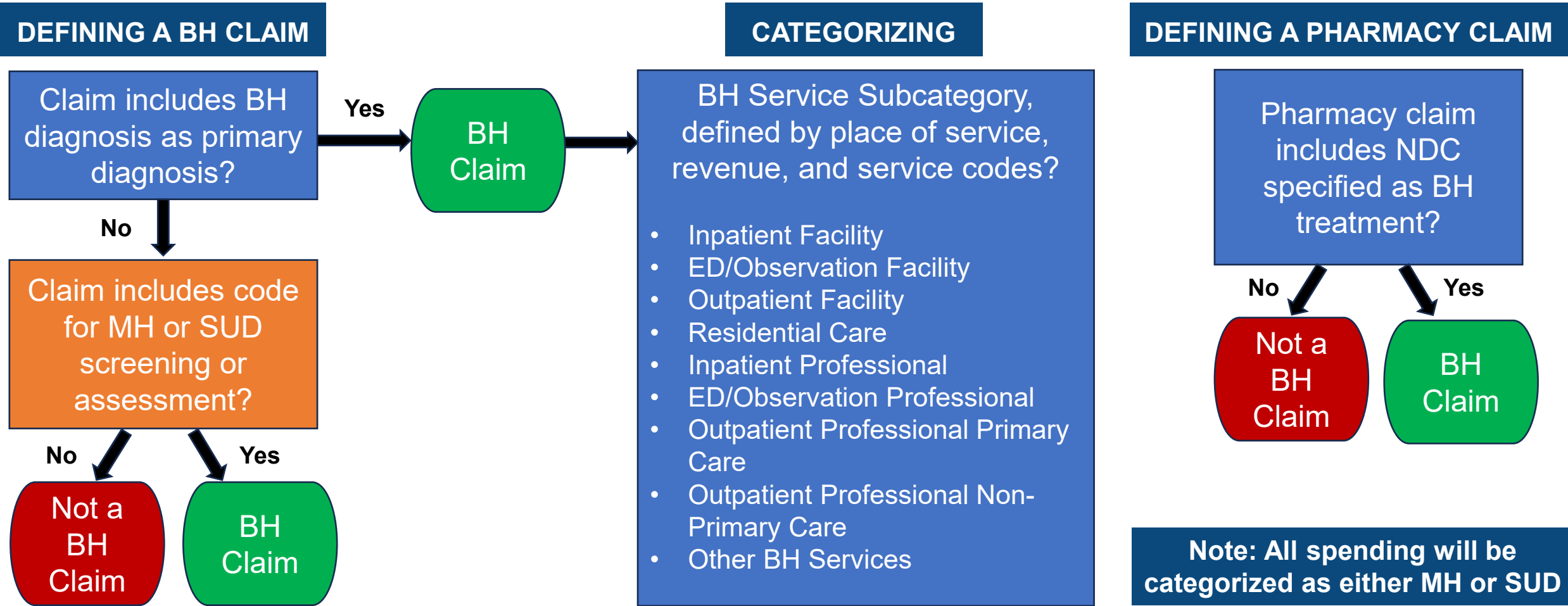
Non-Claims

- Primary care and behavioral health integration payments and behavioral health capitation payments (p. 42-43)
- Allocation methodologies for other non-claims payment subcategories (p.42-46)

Behavioral Health Claims Measurement Definition Principles

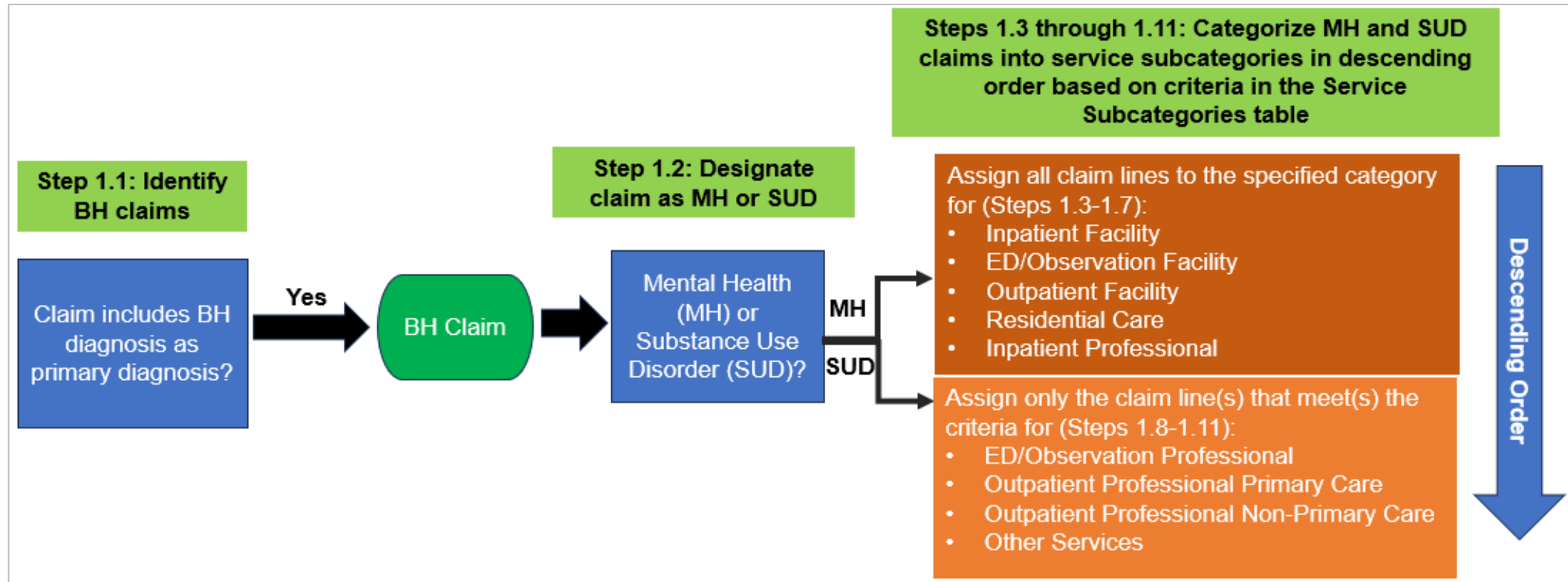
- 1. Include all claims with a primary behavioral health diagnosis** in measurement.
 - Claims with service codes for mental health or substance use disorder screening or assessment also included, regardless of primary diagnosis code.
- 2. Categorize claims** using place of service, revenue, and service codes.
 - “Other Services” category captures claims with a primary behavioral health diagnosis code that do not have a place of service, revenue, or service code associated with another subcategory.
- 3. Include pharmacy claims** with a National Drug Code (NDC) specified by OHCA as a behavioral health treatment.
 - Measured separately, so can be included or excluded for analysis.
 - Categorized as mental health or substance use disorder claims based on NDC.
 - Behavioral health diagnosis not required.

Process Map for Identifying Behavioral Health (BH) Claims



Medical Claims with a Primary Behavioral Health Diagnosis

Medical claims with a primary behavioral health diagnosis are identified, designated, and categorized based on the process below.



Example Medical Claim with a Primary Behavioral Health Diagnosis

Facility claims are identified as behavioral health and designated as mental health vs. substance use disorder using the primary diagnosis field. They are categorized based on the revenue code.

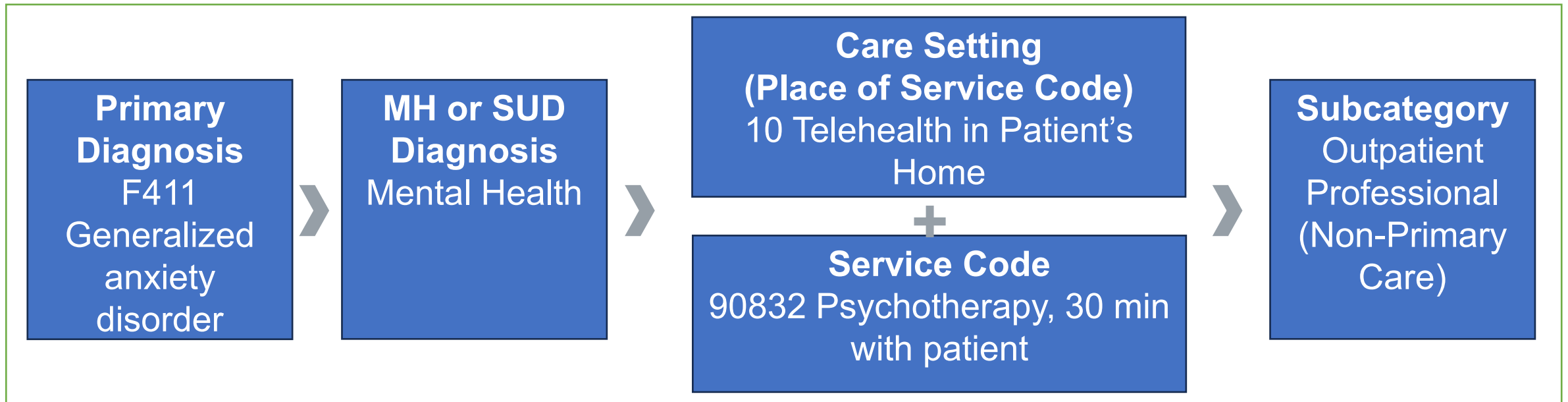
Facility Claim Example



Example Medical Claim with a Primary Behavioral Health Diagnosis

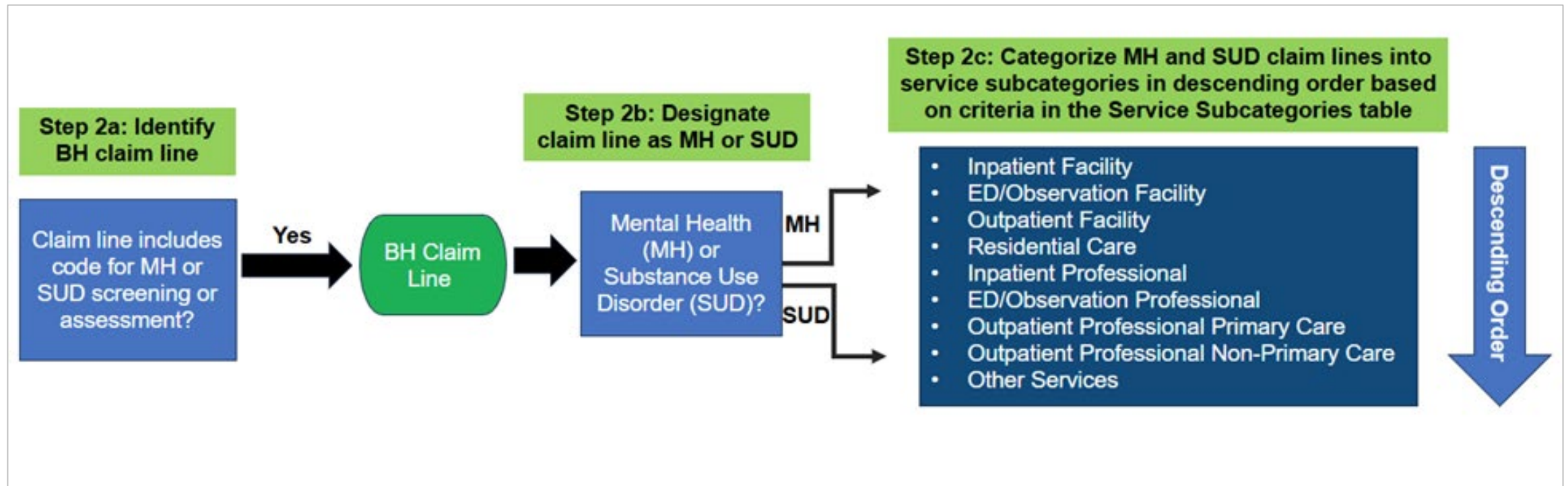
Professional claim lines are identified as behavioral health and designated as mental health or substance use disorder using the primary diagnosis field. They are categorized based on the care setting and service code.

Professional Claim Example



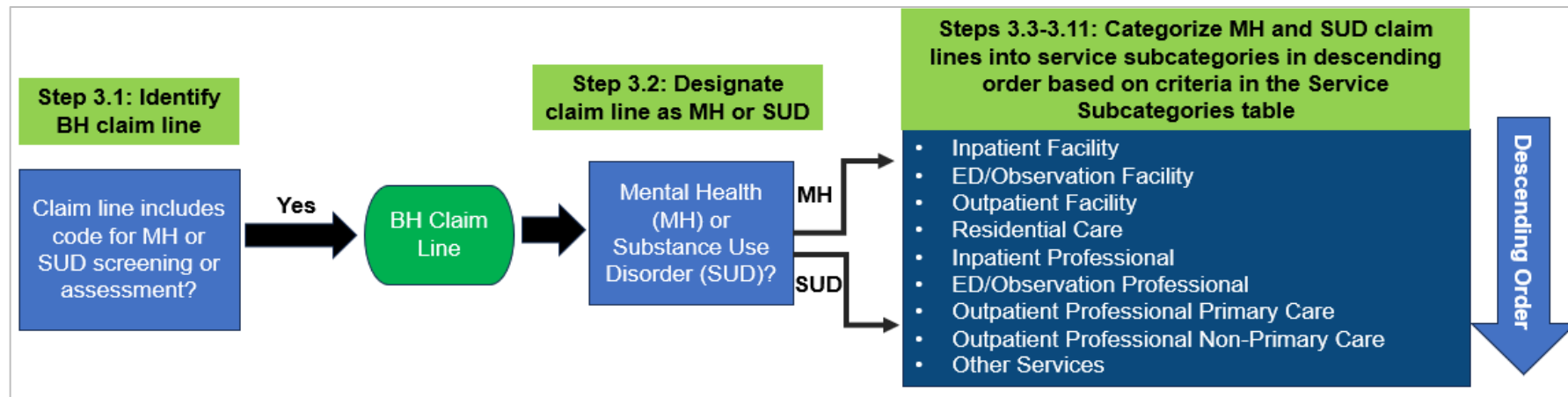
Medical Claims for BH Screening and Assessment Services

Medical claim lines for behavioral health screening and assessment services are identified, designated, and categorized based on the process below. They do not require a BH diagnosis.



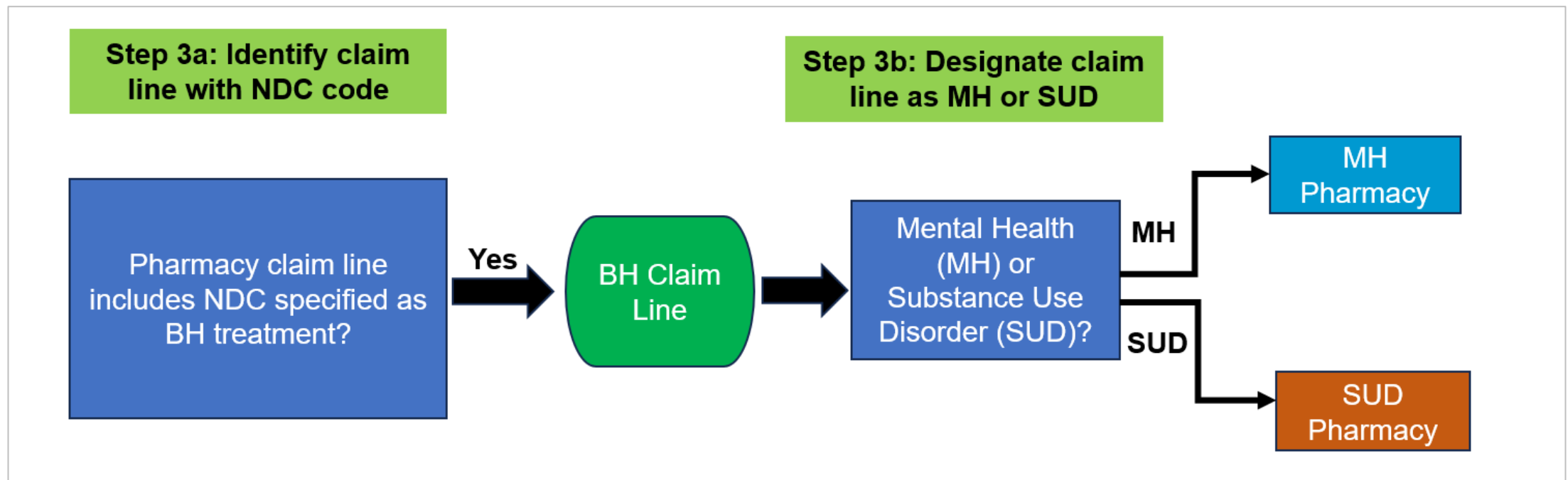
Medi-Cal Medical Claims for Behavioral Health Services for Members < 21 Years

- Some Medi-Cal medical claims for behavioral health services provided to members under 21 years of age do not require a behavioral health diagnosis for billing.
 - Examples of services: Developmental test administration, Psychotherapy, and Depression Screenings
- To identify these claims, use the services included in tab *D. Medi-Cal Only Services <21* and then use the revenue code or place of service code to categorize the claim.



Pharmacy Claims for Behavioral Health Treatment

Pharmacy claims for behavioral health treatment are identified using the National Drug Code (NDC) on the claim and then designated as MH or SUD based on how the NDC is assigned in the code set. Pharmacy is its own subcategory, so these claims do not need to be further categorized.



Behavioral Health Non-Claims Allocation

Behavioral Health Non-Claims Measurement Definition Principles

- Data collection via Expanded Non-Claims Payments Framework.
- Include all behavioral health non-claims subcategories.
- Allocate payments to behavioral health by various methods:
 - **Population health, behavioral health integration, and care management payments** only when paid to behavioral health providers.
 - **Practice transformation, IT infrastructure, and other analytics payments** not to exceed a set upper limit.
 - **Behavioral health capitation payments** included in full.
 - **Professional and global capitation payments** and **payments to integrated, comprehensive payment and delivery systems** allocated to behavioral health using a method similar to that for primary care.

Overview of Recommended Non-Claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	Population Health and Practice Infrastructure Payments	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	Performance Payments	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-Claims Behavioral Health Care Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	Payments with Shared Savings and Recoupments	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Recommended Non-Claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	Capitation and Full Risk Payments	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not Applicable

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Equation for Allocating Practice Transformation (A4), EHR/HIT (A5), and Other Non-Claims (E) Payments to Behavioral Health

$$\boxed{\Sigma \text{ Subcategory A4 or A5 payments}} \times \frac{\boxed{\begin{array}{l} \Sigma (\text{Claims: Total Amount Paid for Behavioral Health}) + \\ (\text{Subcategory D2, D4-D6 Capitation Payments Amount Paid for Behavioral Health}) \end{array}}}{\boxed{\begin{array}{l} \Sigma (\text{Claims: Total}) + \\ (\text{Subcategory D1-D6 Capitation Payments}) \end{array}}} = \boxed{\begin{array}{l} \text{Subcategory A4 or A5 Behavioral Health Spend} \end{array}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

Apportioning Professional and Global Capitation to Behavioral Health

$$\begin{array}{l} \text{Subcategories} \\ \text{D2, D5, D6} \end{array} \left[\begin{array}{l} \text{All payments for Subcategory D4 (Behavioral Health Capitation)} \\ + \\ \frac{\sum (\# \text{ of BH Encounters} \times \text{FFS-equivalent Fee})_{\text{segment}^*}}{\sum (\# \text{ of All Encounters} \times \text{FFS-equivalent Fee})_{\text{segment}}} \times \text{Capitation} \end{array} \right] = \text{Behavioral Health spend paid via capitation}$$

“Segment” means the combination of year, market category, and geographic region for the service.

Note: Methodology aligns with OHCA primary care approach.

Lessons Learned from 2025 Primary Care Data Submissions

Primary Care Lessons Learned	Behavioral Health Implications
<p>Primary Care and Behavioral Health Integration payments (payment subcategory A2) and Primary Care Capitation payments (payment subcategory D1) must be 100% allocated to primary care in the Amount Paid for Primary Care field</p>	<p>Submitters must allocate 100% of A2 Primary Care and Behavioral Health Integration and D4 Behavioral Health Capitation in the Amount Paid for Behavioral Health field. Note: Integration payments are included in both Primary Care and Behavioral Health spend.</p>
<p>Capitation payments for primary care services ONLY shall be reported as Primary Care Capitation (payment subcategory D1)</p>	<p>Capitation payments for behavioral health services ONLY shall be reported as Behavioral Health Capitation (payment subcategory D4)</p>
<p>Capitation payments including any specialty/facility services AND primary care services must be categorized as Professional Capitation (payment subcategory D2) or Global Capitation (payment subcategory D5)</p>	<p>Capitation payments including behavioral health AND any other specialty/facility services must be categorized as Professional Capitation (payment subcategory D2) or Global Capitation (payment subcategory D5)</p>

Lessons Learned from 2025 Primary Care Data Submissions

Primary Care Lessons Learned	Behavioral Health Implications
<p>Professional Capitation (payment subcategory D2), Global Capitation (payment subcategory D5) and Payments to Integrated, Comprehensive Payment and Delivery Systems (payment subcategory D6) must be allocated to primary care using the capitation allocation equation provided in the DSG</p> <ul style="list-style-type: none"> • FFS equivalents must be used to determine the allocation • When FFS equivalents are not available, the Medicare Physician Fee Schedule must be used • When the Medicare Physician Fee Schedule is not available, the Medi-Cal fee schedule must be used 	<p>Submitters should follow the same guidance to allocate Professional Capitation, Global Capitation, and Payments to Integrated, Comprehensive Payment and Delivery Systems to behavioral health care using the allocation equation provided in DSG 3.0</p>

Behavioral Health Data Validation

Cross-file Validations from DSG 3.0

Appendix E

- The same combinations of Market Category and Product Type must be present in the APM, Primary Care, and Behavioral Health files: (APM003 and APM004) = (PRC003 and PRC004) = (BHV003 and BHV004)
- Within each market category and reporting year, the sum of Total Amount Allowed (APM008) in the APM file shall equal the sum of Total Amount Allowed (PRC007) in the Primary Care file and equal the sum of (SWT012) and (SWT014) through (SWT019) in the Statewide TME file
- The sum of Total Amount Allowed (PRC007) where Payment Category (PRC005) = D in the Primary Care file shall equal the sum of Capitation and Full Risk Payments (SWT014) and Member Responsibility (Capitation) (SWT015) in the Statewide TME file

These validations do not apply to data in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories.

Examples of BH Reasonableness Checks

OHCA also performs manual reasonableness checks on the data to identify data points that do not align with our expectations based on industry norms for contracting or spending.

Value	Example Reasonableness Check	Example Suspect Finding, May Trigger Information Request
Amount Paid for Behavioral Health as a Percent of Total Amount Allowed by Subcategory	Evaluate portion of payment subcategory being allocated to behavioral health for reasonableness given non-claims formulas	80% of total amount allowed for professional capitation (PRC007) is allocated to behavioral health (BHV009)
Per Member Per Month Behavioral Health Spend by Subcategory	Evaluate amount paid for behavioral health on a PMPM basis for reasonableness	\$1000 per member per month is attributed to behavioral health capitation (using member months from PRC009)

Submitter Round Table

Next Steps

2026 Data Collection Timeline



Next Steps

- Next workgroup meeting – May 20, 2026
- Technical Assistance (TA) meetings will be offered this summer
- Send questions or requests for future workgroup topics to OHCA@HCAI.ca.gov