January 29, 2026

Megan Brubaker
Office of Health Care Affordability
Department of Health Care Access and Information
2020 W El Camino Ave., Suite 1200
Sacramento, CA 95833

Subject: **CHA Comments on Draft Version 3.0 of the Total Health Care Expenditures Data Submission Guide**
(Submitted via email to OHCA@HCAI.CA.GOV)

Dear Ms. Brubaker,

California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment on the draft Version 3.0 of the Total Health Care Expenditures (THCE) Data Submission Guide.

Hospitals' concerns include:

- The latest draft fails to account for serious concerns raised about the lack of standardized, auditable, and comparable provider attribution methodology across payers.
- The exclusion of Medi-Cal supplemental payments — a key piece of hospitals' financial pictures — is not fully explained
- The integration of OHCA's definition of behavioral health spending risks undercounting, capturing only a portion of the behavioral health services hospitals provide.

Despite Changes, Proposed Methodology Fails to Resolve Serious Risks

CHA appreciates OHCA's efforts in Version 3.0 of the THCE Data Submission Guide to further formalize provider attribution, including through the updated OHCA Attribution Addendum and revisions to the Attributed Total Medical Expenditure (TME) file requirements. The addition of Taxpayer Identification Numbers (TINs) to the Attribution Addendum will support more precise provider identification, and OHCA's clarification of how the 1,000-member reporting threshold is to be calculated by submitters is similarly helpful. However, improving attribution granularity and transparency does not address long-standing issues regarding the lack of standardized, auditable, and comparable provider attribution methodology across payers.

As CHA detailed in its December 1, 2023, comment letter on the THCE Data Collection draft regulations, accurate attribution of total medical expenditures is absolutely essential to the integrity of the spending target program. Payer discretion in assigning members to providers without methodological standards and validation creates a high risk of misattribution, non-comparable results, and misleading provider-level comparisons. Those concerns are not substantively addressed in Version 3.0 of the guide.

While the guide specifies how expenditures would be allocated across organizations once attribution decisions are made, it still does not establish minimum standards for how members would be attributed to provider organizations in the first place (if attribution is not determined in a different way, such as through capitated, delegated, or accountable care organization arrangements). The guide also does not describe any OHCA-led process for validating the correctness or appropriateness of a payer's submitted description of their payer-developed attribution — currently only described in the 500-character data item (SQS008) — or comparability of payer-developed attribution methods beyond technical data integrity checks.

To address the core concerns and recommendations described in more detail in CHA's December 1, 2023, letter, OHCA must either:

1. Establish a standardized default attribution methodology for payer-developed attribution, or
2. Require more robust methodological disclosure and validation of payer-developed attribution approaches before using provider-level THCE results for public reporting, benchmarking, or policy development

Without standardized, transparent, and validated provider attribution rules, OHCA risks developing provider-level THCE comparisons that reflect payer-specific attribution decisions rather than true differences in provider performance, cost structure, or care delivery. **CHA respectfully requests that OHCA address these unresolved attribution issues before relying on attributed THCE data for provider-level comparisons.**

Proposal Excludes Major Medi-Cal Supplemental Payments Without Explanation

CHA also appreciates OHCA's efforts in Version 3.0 of the THCE Data Submission Guide to bring greater clarity to the treatment of Medi-Cal specific payments through the new OHCA Medi-Cal Payments Addendum. As CHA previously noted in its December 1, 2023, comment letter, supplemental payments represent a substantial portion of total provider payments in Medi-Cal — particularly for hospitals, as supplemental payments to private hospitals regularly constitute more than 30% of total Medi-Cal payments. **CHA welcomes OHCA's decision to specify which Medi-Cal payment types are to be excluded or included from the reporting in the Alternative Payment Model, Primary Care, and Behavioral Health files.**

At the same time, the addendum largely excludes major hospital-specific Medi-Cal payments — including the Hospital Quality Assurance Fee (HQAF) and other supplemental Medi-Cal payments — from reporting in these files for Medi-Cal managed care enrollees. While CHA understands the complexity and challenges associated with accurately estimating these payments at the health plan level, the draft guide and addendum do not provide any explanation or rationale as to why these payments were excluded, nor how their exclusion should be interpreted in the context of public reporting.

Considering the importance of Medi-Cal supplemental payments to hospital financing, **CHA requests that OHCA clearly articulate the rationale for inclusions and exclusions in the Medi-Cal Payments Addendum and explain how they align with public reporting, particularly for behavioral health.** Absent such clarification, the analytical results may misrepresent Medi-Cal hospital spending and could be misinterpreted in future public THCE reports.

Methodology Would Capture Only A Fraction of Behavioral Health Spending

OHCA has taken an important step toward consistently measuring behavioral health spending across payers in the draft guide by operationalizing its definition of behavioral health spending and requiring payers to apply OHCA's behavioral health code sets and classification rules when submitting data. However, CHA remains concerned that the definition continues to materially undercount clinically meaningful behavioral health spending by largely limiting inclusion to claims with a primary behavioral health diagnosis, plus a narrow set of screening and assessment CPT codes when behavioral health is not the primary diagnosis, in addition to behavioral health pharmacy claims. As CHA previously noted in its September 3, 2025, comment letter on OHCA's proposed behavioral health spending definition and measurement methodology, **this approach would exclude a wide range of behavioral health services that are routinely delivered secondary to an individual's physical health condition — but are nonetheless essential to high-quality, patient-centered care.** Members of OHCA's Affordability Advisory Committee have similarly emphasized that substantial behavioral health care occurs in visits where behavioral health is not coded as the primary diagnosis. One committee member shared the example of well-child visits, in which pediatricians routinely evaluate and manage conditions like ADHD. Under OHCA's current methodology, these clinically significant behavioral health interventions would not be counted, understating the true level of behavioral health spending.

Hospitals, as well as their outpatient clinics and emergency departments, also deliver concurrent medical care and behavioral health treatment every day to patients with primary diagnoses related to physical health conditions (e.g., heart failure, pregnancy or postpartum care, and infections related to substance use). In these encounters, patients frequently receive clinically meaningful behavioral health interventions such as substance use disorder counseling, medication-assisted treatment initiation, counseling sessions, and detox services, even though a behavioral health diagnosis may not appear as the primary diagnosis on the claim. Under OHCA's current methodology, much of this spending would not be counted as behavioral health spending on THCE reports unless it is limited to screening or assessment.

As CHA previously emphasized, this creates a risk that OHCA's measurement of behavioral health spending will be systematically understated and that investments in integrated hospital-based behavioral health services will be undercounted. During both the November 2025 OHCA board meeting and December 2025 OHCA Investment and Payment Workgroup meeting, OHCA committed to further studying this issue by conducting Health Care Payment Database analyses to identify spending associated with secondary diagnoses, and to evaluate whether additional behavioral health billing codes should be incorporated into the definition. **CHA thanks OHCA for its commitment to further studying this issue.**

Considering OHCA's decision to embed this behavioral health definition into the THCE Data Submission Guide, **CHA respectfully urges OHCA to follow through on that commitment by analyzing the prevalence of additional behavioral health-related CPT and HCPCS codes on claims with secondary behavioral health diagnoses and assessing the feasibility of expanding the code set beyond screening and assessment.** Counting additional behavioral health claim line items is unlikely to be significantly more burdensome than the current approach and would vastly improve the accuracy and credibility of behavioral health spending measurement.

Absent such refinement, the integration of OHCA's behavioral health definition into THCE reporting risks operationalizing what is likely a significant undercount in OHCA's measurement of behavioral health spending and could distort future behavioral health investment benchmarks, public reporting, and policy conclusions.

CHA appreciates the opportunity to comment on the proposed THCE Data Submission Guide Version 3.0 and looks forward to continued engagement with OHCA to address the issues outlined above. CHA remains committed to working collaboratively toward our shared goals of promoting affordability, access, quality, and equity in California's health care system.

Sincerely,

Victoria Valencia
Vice President, Data Analytics

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Kim Johnson
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan

OHCA Draft Revised THCE Regulations – CAHP Comments (*dated 01/30/26*)			
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4	§ 97449 (k)(3)	Remediation	We request the Office extend the period for file remediation to ten (10) business days from five (5) as proposed, and the enumerated turnaround time for payer submitters to remedy files should be specific to requirements as explained in writing in the Data Submission Guide or Addenda, not, for example, for requested changes pertaining to non-written regulation or guidance from the Office. In example, changes to the file formats or instructions communicated via email, verbally or through PowerPoint to payers after the finalization of the Data Submission Guide should not be subject to a strictly enumerated deadline for remediation, given that payers were not put on formal notice of such requirements. With regard to the general timeframe for turning around remediated files, five business days is insufficient time to make major changes to a file.

OHCA Draft Revised THCE Data Submission Guide 3.0 – CAHP Comments (*dated 01/30/26*)			
Page	**Section**	**Topic**	**Comment or Recommended Edit**
N/A	General Comment	Implementation Timeline	**DSG Release** • The timeframe given for implementing significant levels of change is not adequate given that the final DSG is not published until late Q1, with a submission deadline of September 1. During these few months, all the design, development, and testing have to occur. Generally, this level of change would take about a year. • Mid-year clarifications to the DSG requirements create additional complexity. • In addition to the normal development cycle, the need to make changes to file production requires additional funding and escalation of issue resolution. **We recommend OHCA:** • **Draft and publish DSG on an earlier timeline (ideally by the end of Q4) to allow more time to implement changes.** • **Where possible, avoid mid-year changes or corrections to the DSG to reduce burden.**
N/A	General Comment	Impact of Changes	**Payer Size** • Implementing changes is more challenging for larger payers with multiple lines of business operating under different licenses.

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			• For example, with the additional of Medi-Cal Managed Care reporting and the BH file, payers will need to submit 24 files for each month and as payers have to submit two years of data. This is a total of 48 files each year. **Proposed Changes for 2026** • Major updates to the logic and variations among markets makes it difficult to create a more automated, sustainable solution and forecast needed resources. • Adding a new file (e.g., Behavioral Health) requires development and testing within a few months for each of our three registered entities. Payers also pull data from multiple sources given our size, creating additional complexity. o For Medi-Cal, payers are adding 5 new file formats and having to develop the logic within three months. • Updating and adding new code lists requires significant testing. **Feedback Process** • Proposals presented at Data Submitter Workgroup meetings sometimes lack detail or context (e.g., anticipated changes to self-insured reporting), while other discussion items do not (e.g., behavioral health measurement and specifications).

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			We recommend OHCA: • **Work with payers throughout the year to determine the costs and benefits of any proposed changes, considering factors such as value of the proposed change to data accuracy compared to the costs of implementation among different types of plans.** • **Enhance Data Submitter Workgroup meetings as a forum to vet all data submission proposals, providing detail and context around recommendations.** • **In defining data submission completeness considerations for enforcement, provide flexibility regarding the completion of cross-file validation with payers, given the complexity of adding new files, logic and codes. (See additional notes on cross-file validation below.)**
N/A	General Comment	Cross-File Validation	**Submission Status** • Although there is automated validation as files are sent, the cross-file validation is not part of this automated process. As such, it is not clear whether a file has passed or not. • Confirming validation procedures and when a file is considered submitted will affect enforcement.

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			Response Timelines • Cross-file validation is currently dependent upon OnPoint to run their internal process and send back a response to the payer, even if all the files are submitted by Sept 1. Feedback response times range from days to weeks. **Data Quality Expectations** • Current reporting year's outline of data quality checks for this year was unclear and does not really layout procedures in detail. **We recommend OHCA:** • **Clarify file validation and review status in automated and manual messages post-submission, and move cross-file validation into the automated response process.** • **Ensure any enforcement and submission timelines and procedures align.** • **Take manual review processes and timelines into account in setting enforcement standards.** • **Create a data quality document that outlines all the automated and cross-file validation rules and explains items in detail with examples of how each validation will occur.**
11	Section 3.1	Medical Loss Ratio	We oppose additional reporting requirements for payers to submit their Medical Loss Ratio reports, except for those who

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			"timely submit a copy of form CMS-10418 to the DMHC pursuant to 28 CCR 1300.67.003." In prior submission cycles, the Office has accessed these publicly available files directly from CCIIO, DMHC, and DHCS. Without further information as to issues the Office has encountered accessing such files, we oppose additional data submission burdens for payers that add administrative resourcing requirements. We also question the exemption for the timely submissions to DMHC and why such MLR reports are exempted, but not those to CCIIO and DHCS. Additionally, payers have noted that their Medicare MLR Report is submitted in December and therefore will not be available by the OHCA submission deadline of September 1. At that time, they will have neither the Medicare MLR report nor proof of exemption via submission to DMHC. We recommend that OHCA address the differing reporting timelines between Commercial and Medicare lines of business and clarify how and when submitters are expected to provide Medicare MLR Reports.
12	Section 3.1	Cross-File Data Quality Checks – "After a complete set of files has been submitted and passed automated validations, OHCA will perform a series of manual cross-file data checks and will notify submitters of any findings."	We request the Office include language about how long the maximum time will be before the payer receives notification of the data checks. Payers would like to understand and account in their planning for the Office's required turnaround times to produce the results of such checks, given that payers may potentially be subject to enforcement proceedings for untimely or incomplete data submissions, and the Office has not specified that any delay resulting from the Office's actions will not be considered in determining non-compliance.

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15	Section 4, Generally	Urgent Care Spending	As shared previously, payers recommend the Office include spending associated with urgent care POS in its primary care spending calculation. Such spending was originally included in the data the Office used to set the primary care investment benchmarks currently in place. For that reason, and the reason that many members access primary care services in urgent care settings, we strongly recommend the Office include such spending.
17	Section 4.3.3	Special Rules for Medicare Advantage Data	We recommend that OHCA provide examples of what OHCA considers to be "optional supplemental benefits" on p. 17 to avoid disparate interpretations by health plans.
18	Section 4.4	Self-Insured	We recommend the Office separate self-insured spending data completely from commercial plan spending (e.g., fully-insured DMHC-licensed and CDI-registered products) given that health plans are not financially at-risk for these products, and that their benefits and coverage requirements often vary widely from the aforementioned state-regulated products. Grouping self-insured products with fully-insured ones will not offer helpful insights into spending trends in these two distinct markets.
26	Fig. 1, Behavioral Health Capitation (Category D4)	Behavioral Health Capitation	Payers express strong opposition to the requirement to categorize as D4/ value-based care membership spending that spending associated with members who only have behavioral health capitation that has links to quality and no linkage to other Alternative Payment Models. The behavioral health capitation model does not have a provider who acts as the "quarterback" for the member's spend, and the behavioral health capitation payment itself is such a small component of a member's overall

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			health care cost. The Office's methodology requires payers to assign a member's entire spend profile to the behavioral health capitation payment subcategory, and that seems like a misrepresentation, and possible inflation, of overall provider payment transformation.
27	Section 4.8	Payments on behalf of a member are considered "linked to quality" if any non-claims payments made on their behalf to any provider are adjusted based on specific predefined goals for quality.	We recommend OHCA clarify whether in the scenario where a provider didn't meet the criteria and therefore there was no payout, Quality Indicator is automatically No (as there was nothing to adjust for quality goals). We recommend that OHCA reconcile the following two statements: • p. 27: "Payments on behalf of a member are considered 'linked to quality' if any non-claims payments made on their behalf to any provider are adjusted based on specific predefined goals for quality," and; • p. 26 "A payment subcategory is applicable to a member if the member was covered by any contracted payment arrangement meeting the subcategory's description during the reporting year, even if the member had no utilization and/or $0 claims and non-claims expenditures." One implies member is counted even with no payment, but the other uses "payment" to determine link to quality. Please clarify whether member covered under zero-pay arrangement is counted only to determine payment sub-category, but not counted for link to quality.

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27	Section 4.8	Use the Quality Indicator field (APM007) to indicate whether payments on behalf of a member were linked to quality. Fee-for-service only claims are never considered "linked to quality." Data for payments linked to quality and those that are not linked to quality are reported discretely.	We recommend that OHCA clarify whether the statement on p. 27 that Fee-for-service only claims are never considered "linked to quality" means that arrangements that pay quality-related rewards in the form of increased fee schedule (claims) will not be counted as APM for OHCA.
31	Section 4.9	Vaccines – "For the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories only: If the HCPCS/CPT code on the claim is included in the Medi-Cal Only Vaccines for Children (VFC) Program Services table in the OHCA Primary Care Addendum, only the claim lines with a modifier of SL shall be included in Amount Paid for Primary Care (PRC008)."	We support the inclusion of such spending for Medi-Cal Managed Care, but also strongly recommend these service codes be included for all lines of business. Governor Newsom and the state Legislature have signaled strong support for maintaining access to childhood immunizations, and payers in California have supported maintaining coverage in light of federal developments. Leaving out associated spending with the administration of these immunizations will not help to incentivize the provision of such services, nor offer the Office spending data insights into these critical services.
65	Section 5.6, Col. #6	Pharmacy Rebate File – ""For the Commercial (Partial Benefits) market category, create a reasonable estimate of pharmacy rebates…."	We recommend removing this additional requirement. Not all payers will be able to report these data, as rebates are carved out by each customer, and not all customers will share these data with payers. Additionally, rebate spending data include proprietary information like contract rates etc., so we request the Office provide legal rationale if the expectation is that payers will be required to share such data.
69	Section 5.7	Attestation – "By typing your name in this field, you certify under penalty of perjury under the laws of the State of California that	We strongly recommend the Office remove the language "under penalty of perjury under the laws of the State of California." We find this language to be inappropriate for such a data submission

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		the information provided in your organization's file submission is true and correct to the best of your knowledge."	and question the Office's authority to require attestation of data accuracy under penalty of perjury, given that this submission is not connected to a formal legal proceeding under the Penal Code. Even if so, this requirement creates legal liability for payers and their employees. Under California law, a conviction of perjury can lead to up to four years in prison. We question the need for this language, and would point out that other state regulators such as DMHC only require regulated entities to "certify" or "affirm" the accuracy of their data. We would welcome further direct discussion with the Office on this matter to discuss the need for this requirement and to reach a comprise that works for both the Office and regulated entities.
68(SQS024), 74(PRC006), and 78(BHV006)	Section 5.7, 5.9, and 5.10	5.7 Submission Questionnaire File; 5.9 Primary Care File; and 5.10 Behavioral Health File	In the Data Layout at SQS024, we recommend that OHCA clarify that this field is required when amounts are reported for Payment Subcategory C1, C2, C3, or C4 in either the Primary Care File or the Behavioral Health File. It currently only speaks to Primary Care.

From:	Katie-Elyse Turner
To:	[redacted]; HCAI OHCA
Cc:	Finance_RADL; Govregaffairs
Subject:	Re: THCE Data Submitter Workgroup #nonsec#
Date:	Friday, January 30, 2026 1:28:53 PM
Attachments:	[redacted]

Good afternoon Jacob,

Writing to deliver Health Plan of San Mateo's comments, recommendations and questions in response to the draft Total Health Care Expenditures (THCE) Data Submission Guide 3.0.

We look forward to working with OHCA on this year's submissions. In the meantime, please let us know if we can provide clarification or additional information on our comments.

1. **Primary Care File - Disallowing use of NPI to identify primary care providers: Page 30 of the Draft DSG prohibits the use of NPIs to identify Primary Care Providers (PCPs). Historically, many health plans did not require taxonomy codes for claim adjudication or payment. Relying solely on claim-level taxonomy will lead to a significant understatement of primary care spending, undermining the accuracy of the Primary Care Investment Benchmark.**
    a. **Recommendation: permit use of the primary taxonomy code associated with a provider's NPI in the NPPES when claim-level data is missing**
    b. **Rationale: the primary taxonomy of a NPI serves as a reliable proxy.**
    c. **Safeguards: Existing logic in Steps 2 through 4 of the methodology already mitigates misclassification risks.**

2. **Primary Care File - Identifying Primary Care paid via claims – Step 2 – Mapping providers to DHCS and DMHC submissions: Step 2 of the primary care identification methodology requires identifying primary care providers based on their presence on the DHCS 274 and DMHC Annual Network Review filings. Because these filings are point-in-time snapshots of the *current* active and contracted provider network, they exclude any providers who were terminated before the snapshot date, even if those providers rendered significant primary care services during the reporting year. Relying on these snapshots leads to a significant understatement of primary care spending, as it ignores expenditures for terminated and non-contracted providers who were active during the measurement period.**
    a. **Recommendation: remove Step 2 from the primary care identification logic**
    b. **Rationale & Safeguards: The existing criteria in Step 1 (Taxonomy) and Steps 3 and 4 (Location codes and Procedures) provide a more accurate and comprehensive methodology for capturing all relevant primary care spending without the limitations of point-in-time network snapshots.**

3. **OHCA Medi-Cal Payments Addendum: The Health Plan supports the exclusion of Directed Payments and Pass-through payments from THCE reporting, as these revenue and expense items are processed by MCPs at DHCS's direction and are separate from Medi-Cal benefits. However, the exclusion of specific Medi-Cal benefits such as Nonemergency Medical Transportation (NEMT), non-medical transportation (NMT), Community Supports (CS), and Enhanced Care Management (ECM)**

creates an incomplete picture of Medi-Cal health care expenses and complicates comparisons across market segments. In addition, the inclusion of Long-Term Care (which is a high-cost category of service) and incontinence supplies, both of which are generally excluded from commercial and MA expenses, in Medi-Cal expenses exacerbates the reporting imbalance.

   a. **Recommendation: include all Medi-Cal benefits in THCE reporting to completely reflect the total health care expenses of Medi-Cal Managed Care Plans and support more accurate comparisons across market segments.**

4. **APM – Attributing members to payment subcategories B1 & B2: Page 26 of the Draft DSG states:** *"A payment subcategory is applicable to a member if the member was covered by any contracted payment arrangement meeting the subcategory's description during the reporting year, even if the member had no utilization and/or $0 claims and non-claim expenditures."* **A literal interpretation of this text would report a beneficiary enrolled in a quality-linked pay-for-performance (P4P) arrangement under Payment Category B2 and Quality Indicator 1, regardless of whether the provider met performance targets or earned an incentive payment. This differs from verbal directives provided during the 2025 Submitter Workgroup meetings, where submitters were instructed to report members in Category B1 or B2 only if a non-claim incentive payment was earned and paid.**

   a. **Request: Please clarify explicitly in the Final DSG whether attribution is triggered by the contractual status of the member (enrollment) or the financial outcome of the arrangement (payment).**

5. **OHCA Behavioral Health Addendum April 2026: The following codes are billable for behavioral health treatment (BHT) but are not included in the "Medi-Cal Only Services Under 21". Note that the bolded codes (99366, 99368, S5110, and S5111) can be billed for non-BHT services.**

PROC	Description
0362T	Dangerous behavior identification/supporting assessment related to ABA Therapy
0373T	Exposure behavior treatment
99366	Medical team conference (face-to-face)
99368	Medical team conference (not face-to-face)
H0046	Mental health service, nos
S5108	Supervision related to ABA Therapy
S5110	Home care training, family; per 15 min session
S5111	Home care training, family; per session

Regards,
Katie-Elyse

Katie-Elyse Turner
[redacted]

Katie-Elyse Turner | Director of Financial Planning and Analysis

Health Plan of San Mateo
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