OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

January 21, 2026

HCAI

Department of Health Care Access and Information

Agenda

1. OHCA Updates
2. Frequently Asked Questions
3. Submitter Round Table
4. Next Steps

OHCA Updates

OHCA Public Reporting

- OHCA will publish two reports using the calendar year 2023-2024 data collected in 2025:
  - Interim Report on Health Care Spending showing TME and THCE growth will be published in June 2026
  - Health System Performance Baseline Report with Alternative Payment Model and Primary Care data in Q3 2026

Data Submission Regulations

- Draft updates to THCE data collection regulations and data submission guide were published on the HCAI website on January 5, 2026
- Proposed updates will be discussed at the Health Care Affordability Board meeting on January 28, 2026
- **Comments due to OHCA (**OHCA@HCAI.ca.gov**) by January 30, 2026**
- Draft documents available for review at: https://hcai.ca.gov/about/laws-regulations/

Proposed DSG Changes for 2026

- Medi-Cal Managed Care data will be required in all files
- For Commercial and Medicare Advantage plans, copies of filed Medical Loss Ratio (MLR) reports must be emailed to OHCA with data submission, unless exempted
- Separate reporting of self-insured member months and spending in Statewide TME file only
- Added cross-file data quality checks as an appendix for reference

Proposed DSG Changes for 2026

- Update to Appendix B: Payment Arrangements and Classifications
  - Retitled and includes fee-for-service only claims subcategory (X9)
- Update to Appendix C: Condition and Procedure Types
  - Clarification that example codes should be used in Submitter Questionnaire File field SQS024
- Addition of addenda to DSG
  - Primary Care Code Set appendix replaced by Primary Care Addendum
  - Behavioral Health Addendum contains behavioral health code set
  - Medi-Cal Payments Addendum highlights inclusions and exclusions of total medical expense for PRC, APM, and BHV files

Updates to the APM File for 2026

- Reorganizing allocation methodology into steps
- Inclusion of process map for allocating member-level expenses
- Clarifications on member months – include all months of coverage for members assigned to a payment subcategory, including when there is no utilization and/or $0 claims and non-claims expenditures

Updates to the PRC File for 2026

- Primary Care Addendum
  - Additional primary care provider taxonomies (e.g., Physician Assistant, General)
  - Additional primary care services (e.g., New CPT codes from the 2026 Medicare Physician Fee Schedule)
- Confirmation that claims spending is determined at the claim line level
- Clarification on allocation for Practice Transformation (payment subcategory A4) and EHR/HIT Infrastructure (payment subcategory A5) limits
- Clarification that to allocate capitation payments to primary care within the same payment subcategory (e.g., Professional Capitation) a unique ratio must be developed for each contracted capitation payment
- Clarification on member months in the primary care file – only reported for months of coverage during which a payment was made on behalf of a member in the corresponding payment subcategory. Member months can be duplicative across payment subcategories.

Updates to the PRC File for 2026 – Medi-Cal Only

- Update on identification of physician, nurse practitioner, and physician assistant primary care providers using 274 file submitted to DHCS for Annual Network Certification in January following the reporting year
- Additional guidance on inclusion of claims for the Vaccines for Children Program

New Behavioral Health (BHV) File for 2026

Data collection includes:

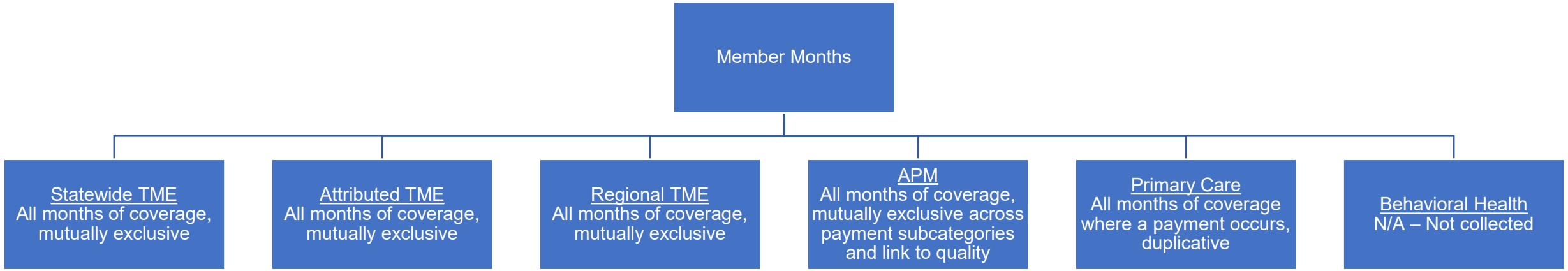
- Medical claims with a primary behavioral health diagnosis
- Medical claims for behavioral health screening and assessment services without a primary behavioral health diagnosis
- Medi-Cal medical claims without a primary behavioral health diagnosis for members under 21
- Pharmacy claims for behavioral health treatments
- Primary care and behavioral health integration payments and behavioral health capitation payments
- Allocation methodologies for other non-claims payment subcategories

Frequently Asked Questions

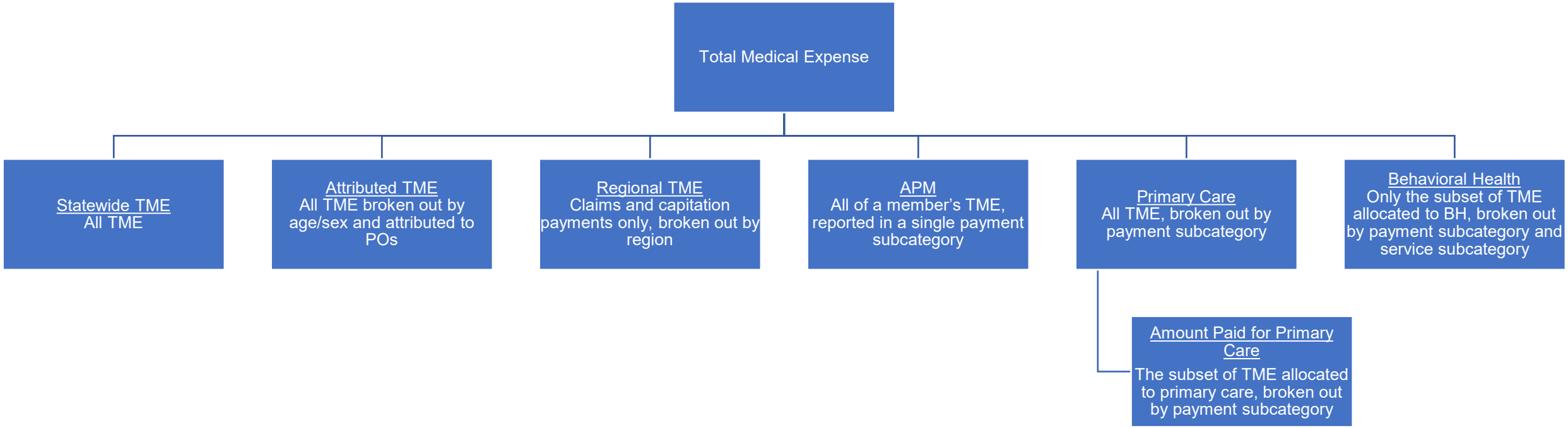
Inclusion and Exclusion Reminders

- Include payments for Durable Medical Equipment
  - When paid via claims – Claims: Other
  - When paid via non-claims – Other Non-Claims Payments
- Exclude the following:
  - Specific set of lines of business
  - Reinsurance recoveries or premiums
  - CMS reconciliation payments, *e.g.*, Medicare sweep or Part D
  - Premiums
  - ACA risk transfer payments
  - PBM administrative fees
  - Internal plan expenses

Member Months Across the OHCA Files



Total Medical Expense Across the OHCA Files



Note: In 2026, Medi-Cal Managed Care Plan TME in the APM, PRC, and BHV files will differ from TME reported in the SWT, ATT, and RET files according to the instructions in the OHCA Medi-Cal Payments Addendum.

Differences in TME, APM, and PRC Files

Payment and Member Month Attribution Example

E.g., member covered for 12 months, $2,400 total professional capitation payments ($200 for 12 months), and $300 total in FFS claims payments (over 3 separate months)

	Statewide, Attributed, and Regional TME Files	APM File Total Amount Allowed	PRC File Total Amount Allowed
Member Spend $2,700 total	$2,400 reported in Capitation and Full Risk Payments	$2,700 reported in D2, Professional Capitation	$2,400 reported in D2, Professional Capitation
	$300 reported by service category in Claims fields		$300 reported in X9, FFS Claims
Member Months 12 covered months	12 member months	12 reported in D2, Professional Capitation	12 reported in D2, Professional Capitation
			3 reported in X9, FFS Claims

APM File

- Categorizes all payments for a member (claims and non-claims) and all months of coverage into ONE payment subcategory
- Payments and member months included in a payment subcategory linked to quality (or not) cannot be in another payment subcategory linked to quality (or not)
- When all months of coverage and all payments (total medical expense) for members are included in one payment subcategory (whether linked to quality or not) the total medical expenses per member, per month are similar* across payment subcategories

*OHCA expects minimal variation.

PRC File

- 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
- Member months for Performance payments (payment category B) should be based on the period for which the performance was assessed, not just the date of service (e.g., 12 months if an annual assessment instead of 1 month where a screening was conducted)
- Allocation of Condition-related, episode-based and total cost of care shared savings payments (payment subcategories C3-C6) to primary care are limited based on the shared savings and recoupments allocation equation provided in the DSG
- If Procedure-related, episode-based shared savings payments (payment subcategories C1 and C2) are reported in the PRC file, Submitter Questionnaire File field SQS024 must be completed

PRC File

- Categorizing capitation payments
  - Capitation payments for primary care services ONLY can be reported as Primary Care Capitation (payment subcategory D1)
  - 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)
- 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
  - 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

Submitter Resources

- OHCA teams are available for technical assistance meetings
- Send questions to OHCA@HCAI.ca.gov
- Validation document in Onpoint CDM Portal
- Data Submitter Workgroup Materials: https://hcai.ca.gov/affordability/ohca/slow-spending-growth/thce-data-submitter-workgroup/

Submitter Round Table

Next Steps

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- Comments on proposed updates to data collection regulations and DSG are due to OHCA by January 30, 2026
- Next workgroup meeting – March 2026
- Send questions to OHCA@HCAI.ca.gov