



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

Total Health Care Expenditures (THCE) Data Submitter Workgroup

June 17, 2026



Agenda

1. Data Submission Reminders
2. Best Practices for APM, PRC, and BHV files
3. Technical Assistance Meetings
4. Next Steps

Data Submission Reminders

Data Submission Reminders

- Earlier this month, all registered submitters received an email confirming their Submitter Codes and SFTP account information (if applicable).
- Onpoint Data Harbor will open for submissions by July 1, 2026.
- All files must be submitted by September 1, 2026.

Data Submission Reminders

- Recommend testing PGP encryption early to avoid obstacles that could delay file submission.
- When submitting test files, populate 'T' in the Test File Flag (HD006) in each file's header record.
- If transferring data via SFTP, transfer files to your SFTP account's "TEST" directory.

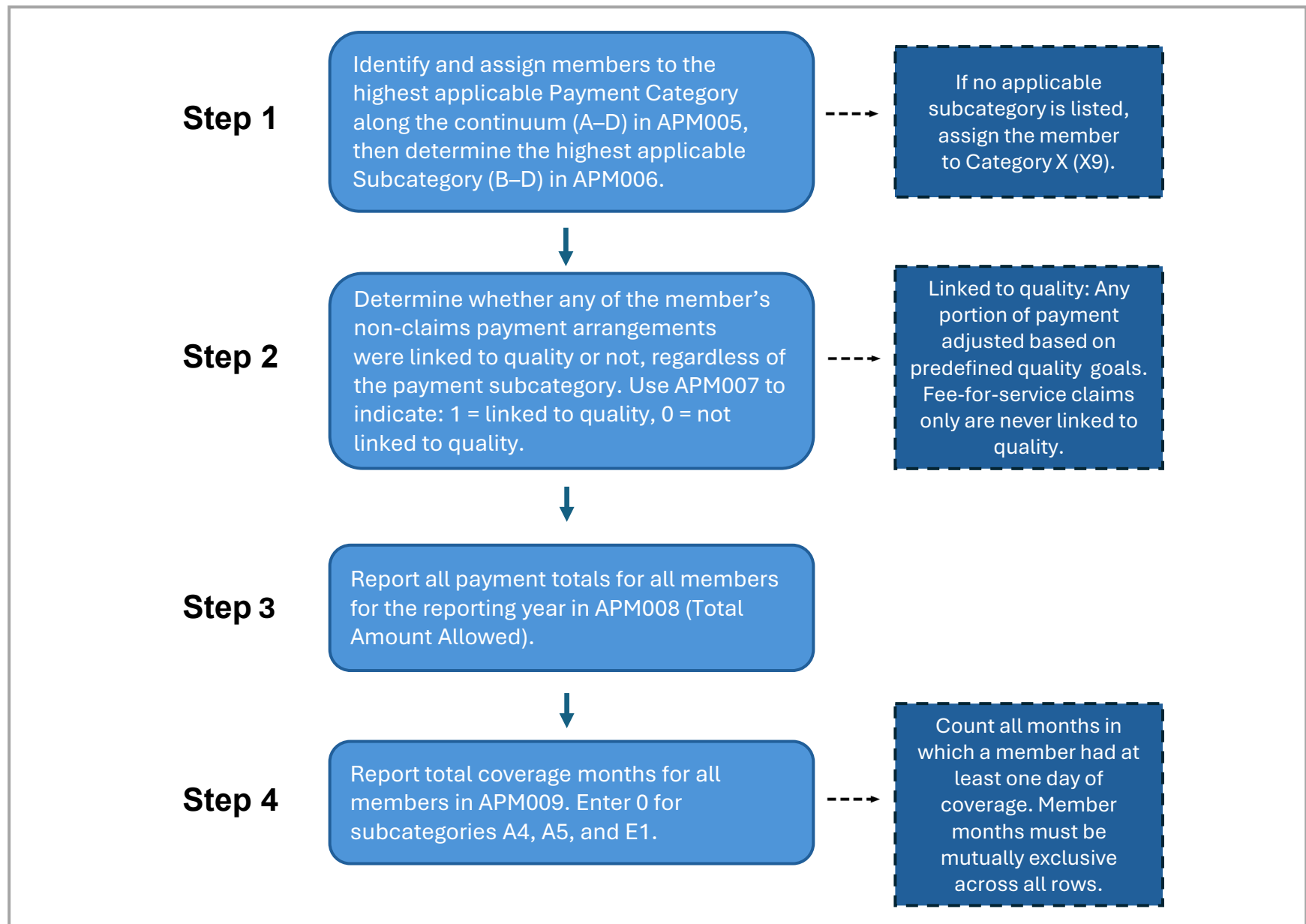
Data Submission Reminders

- Review documentation for automated, real-time data validations on the Documentation page in Data Harbor.
- Review Appendix E of Data Submission Guide v3.0 for cross-file validations that occur after all files are submitted.
- Use Data Harbor to track file submission progress, review validation errors, and submit variance requests (if needed).
- Contact ohca-support@onpointhealthdata.org for technical assistance with file submission.

Best Practices for APM, PRC and BHV files

APM File

A member's total medical expense is considered linked to quality if **any** payment made on their behalf would be adjusted based on specific predefined goals for quality, regardless of the payment subcategory in which it is reported. The link to quality is based on **eligibility** for an incentive payment, not if an actual payment was made. Payment examples include **eligibility for any incentives**, such as the Align. Measure. Perform. (AMP) program.



APM File Payment Assignment Example

Member's Payment Subcategories	Amount
Pay-for-Performance (B2) linked to quality	\$500
Primary Care Capitation (D1) not linked to quality	\$1,200
Fee-for-service claim (X9)	\$4,300
Member's Total Medical Expense	\$6,000

In this example, the plan made three different types of payments on behalf of the member during the reporting year.

Payment Subcategory	Linked to Quality?	Total Amount Allowed	Member Months	Per Member, Per Month
D1	Yes	\$6,000	12	\$500

In the APM File, all of the member's expense should be reported in the Primary Care Capitation payment subcategory and linked to quality.

APM File Payment Assignment Example

Payment Subcategory	Linked to Quality?	Total Amount Allowed	Member Months	Calculated Per Member, Per Month
D1	Yes	\$60,000	120	\$500
D1	No	\$12,400	240	\$517
D2	Yes	\$31,500	500	\$520
D2	No	\$5,800,000	12,000	\$493

In the APM File, unless there is significant variation in the care for all members in that Payment Subcategory, whether linked to quality or not, PMPM spend should be relatively similar since all of the members in the arrangement's total medical expense and months of coverage are assigned to the payment subcategory-link to quality combination. OHCA does not expect PMPMs in different Payment Subcategories or in the same Payment Subcategory when linked to quality or not to vary significantly.

Primary Care (PRC) File

- The submitter must report any claims incurred on behalf of members in the primary care file, even if the majority of spend is capitated or non-claims
- Member months in the primary care file are not mutually exclusive across payment subcategories
 - Report months of coverage during which a payment in the corresponding payment subcategory was made on behalf of a member
 - Months where a member was covered, but no payment was made shall not be reported
- Member months for payments (*e.g.*, performance payments, shared savings payments, etc.) should be based on the period for which the payment was made, not just the date of service (*e.g.*, 12 months for an annual assessment instead of 1 month where a screening was conducted, or 3 months for a quarterly payment)

Behavioral Health (BHV) File

- Submitters must complete the primary care file prior to the behavioral health file to ensure that any Payment Subcategory payments allocated to primary care are NOT also allocated to behavioral health (e.g., Pay for Performance Payments – Payment Subcategory B2)
- 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.
- Capitation payments for behavioral health services ONLY shall be reported as Behavioral Health Capitation (Payment Subcategory D4)
- 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)

Behavioral Health (BHV) File

- 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 behavioral health 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

SQS File Episode-Based Shared Savings Arrangement Reporting

- Episode-based shared savings arrangements (Payment Subcategories C1-C4) must be reported in the Primary Care File and the Submitter Questionnaire File (SQS)
 - Behavioral Health Condition-related, Episode-Based Shared Savings arrangements should be reported in the BHV file
- These arrangements must also be reported in the field SQS024 – Procedure and Condition-Specific Episode-based Payment Arrangements based on the **type of episode-based arrangement**
- Appendix D identifies the types of episode-based arrangements
 - Condition examples include cardiovascular, gastrointestinal, orthopedic, etc.
 - Procedure examples include chronic/outpatient-based, acute/hospitalization-based, oncology, etc.
- Please use the types in Appendix D, not program names in SQS024

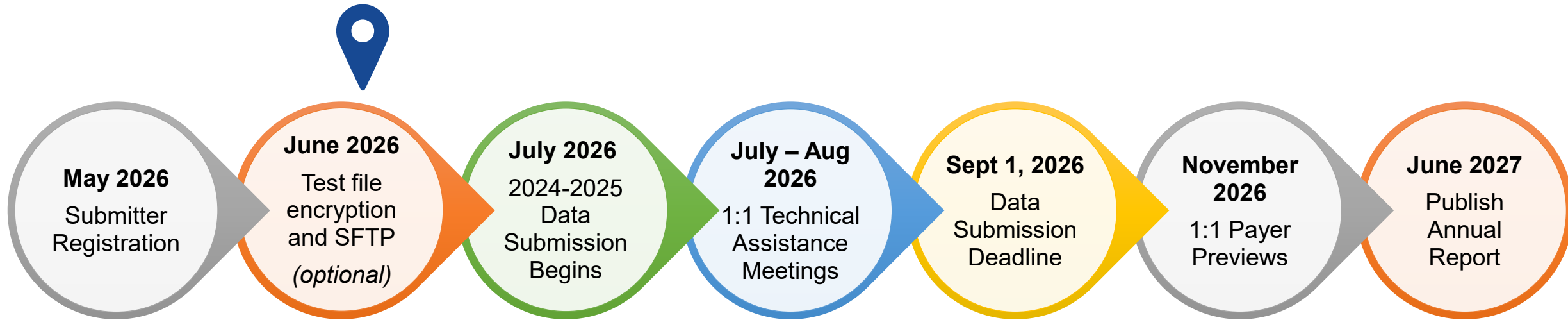
1:1 Technical Assistance Meetings

- In lieu of July and August workgroup meetings, OHCA will offer 30 minute 1:1 sessions with each submitter
- OHCA will contact the individuals identified during registration to schedule the sessions
- Submit questions in advance to facilitate a productive discussion
- Submitters are strongly encouraged to take advantage of this opportunity as they prepare data files for submission

Submitter Round Table

Next Steps

2026 Data Collection Timeline



Next Steps

- OHCA will reach out to schedule 1:1 Technical Assistance meetings
- Reminder: THCE Data Portal (Onpoint Data Harbor) will open for submissions by July 1, 2026.
- Data submissions are due by September 1, 2026.
- Send questions or requests for future workgroup topics to OHCA@HCAI.ca.gov