



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

# Total Health Care Expenditures (THCE) Data Submitter Workgroup

May 20, 2026



# Agenda

1. Data Submission Process
2. OHCA Files Overview
3. Submitter Round Table
4. Next Steps

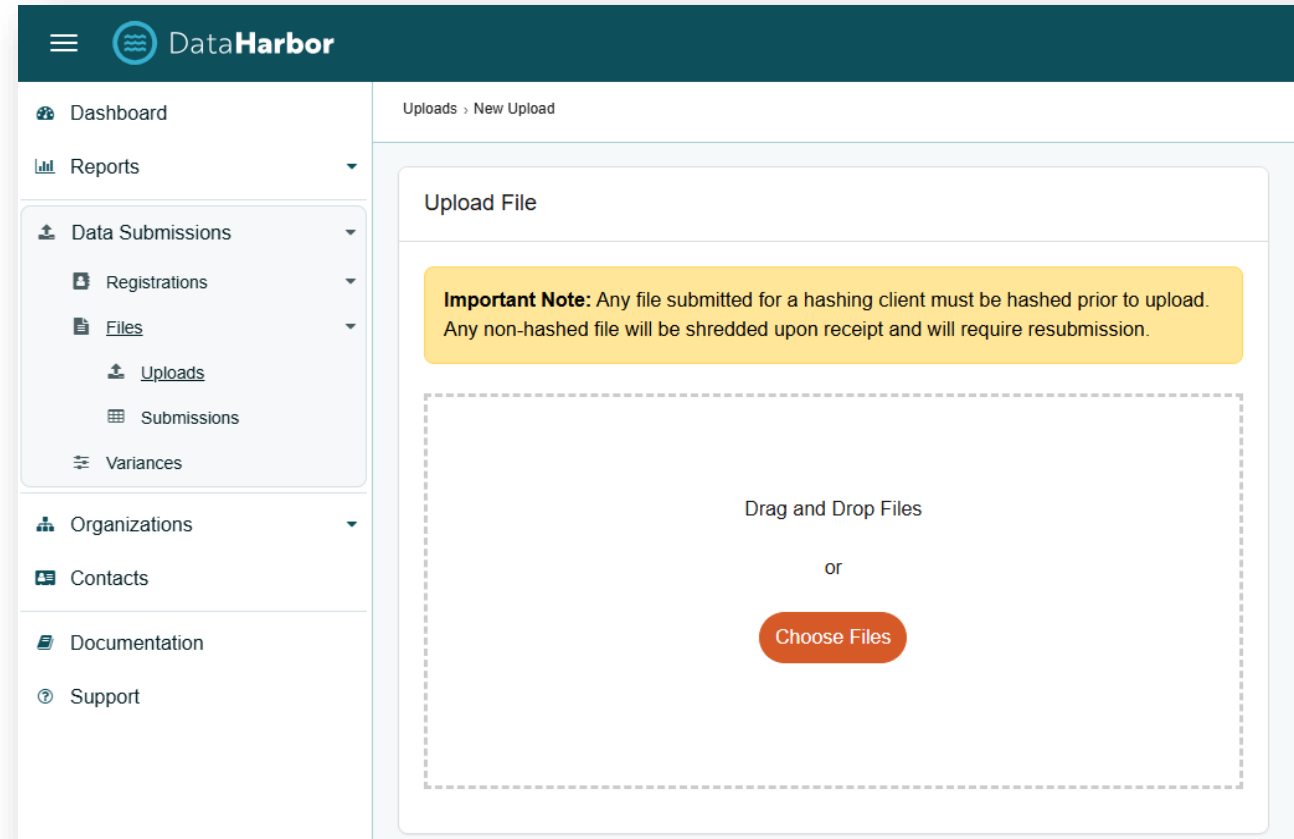
# Data Submission Process

# Data Submission Process

- Data must be submitted in encrypted, pipe-delimited text files according to the instructions in the Data Submission Guide (DSG).
- Each file must include header and trailer rows and may contain two years of data.
- A complete submission includes 8 separate files:
  - Statewide Total Medical Expense (TME)
  - Attributed TME
  - Regional TME
  - Pharmacy Rebates
  - Submission Questionnaire
  - Alternative Payment Model
  - Primary Care
  - Behavioral Health

# Data Submission Process

- Encrypted data files may be submitted using Secure File Transfer Protocol (SFTP) or manually uploaded in the THCE Data Portal.
- Individual files may be uploaded as they are ready.



# Data Submission Process

- Automated validations occur in real-time after submission and results display in the portal.
- Files that do not pass must be re-submitted or have an approved variance request.

Production/Test	Received Date	Stage	Status
● PRODUCTION	1/29/23 9:40pm	Formatting	● FAIL
● PRODUCTION	1/26/23 6:19pm	Formatting	● FAIL
● PRODUCTION	1/26/23 5:58pm	Completeness	● REVIEW
● PRODUCTION	1/26/23 5:50pm	Validation	● PASS

Element Description		Status			
Code	Name	Position	Error Description	Count	First Row Number
APM008	Total Amount Allowed	8	Data Type Mismatch	21	1

# Data Submission Process

- After all 8 files have been submitted and accepted, OHCA and Onpoint teams perform the manual cross-file data quality checks outlined in Appendix E of the DSG.
- In most cases, total dollar amounts should align across all files.
- OHCA may send submitters requests for additional information regarding data inconsistencies or requests for re-submission to correct any errors.

## Appendix E: Cross-File Data Quality Checks

Once all required files have been received from a submitter, OHCA performs the following cross-file data quality checks to confirm data accuracy across all files. Comparisons of dollar figures may have no more than a one percent difference to account for rounding to the nearest whole dollar.

Unless otherwise noted below, all cross-file data quality checks are performed within the same reporting year and market category.

1. Member Months
  - a. The sum of Member Months (SWT005) by Market Category (SWT003) in the Statewide TME File is equal to:
    - i. The sum of Member Months (ATT011) by Market Category (ATT008) in the Attributed TME File, and
    - ii. The sum of Member Months (RET005) by Market Category (RET004) in the Regional TME File, and
    - iii. The sum of Member Months (APM009) by Market Category (APM003) in the APM File
2. Claims Payments
  - a. For each service category, the sum of claims payments in the Statewide TME, Attributed TME, and Regional TME files shall match:
    - i. Claims: Hospital Inpatient (SWT006) = (ATT012) = (RET008)
    - ii. Claims: Hospital Outpatient (SWT007) = (ATT013) = (RET007)
    - iii. Claims: Professional (SWT008) = (ATT014) = (RET008)
    - iv. Claims: Long-Term Care (SWT009) = (ATT015) = (RET009)
    - v. Claims: Retail Pharmacy (SWT010) = (ATT016) = (RET010)
    - vi. Claims: Other (SWT011) = (ATT017) = (RET011)
  - b. The total claims amount shall match across all three TME files and the Primary Care File:
    - i. Claims: Total (SWT012) = (ATT018) = (RET012) = (PRC007) where Payment Category (PRC005) = X
    - ii. Due to the rules for inclusion or exclusion of specific Medi-Cal payments provided in the [OHCA Medi-Cal Payments Addendum](#), this validation does not apply to data in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories.
3. Non-Claims Payments
  - a. The sum of Capitation and Full Risk Payments in the Statewide TME, Attributed TME, and Regional TME files shall match: (SWT014) = (ATT020) = (RET014)
  - b. The sum of all other non-claims payment categories in the Statewide TME, Attributed TME, and Primary Care files shall match:

# Data Submission Process

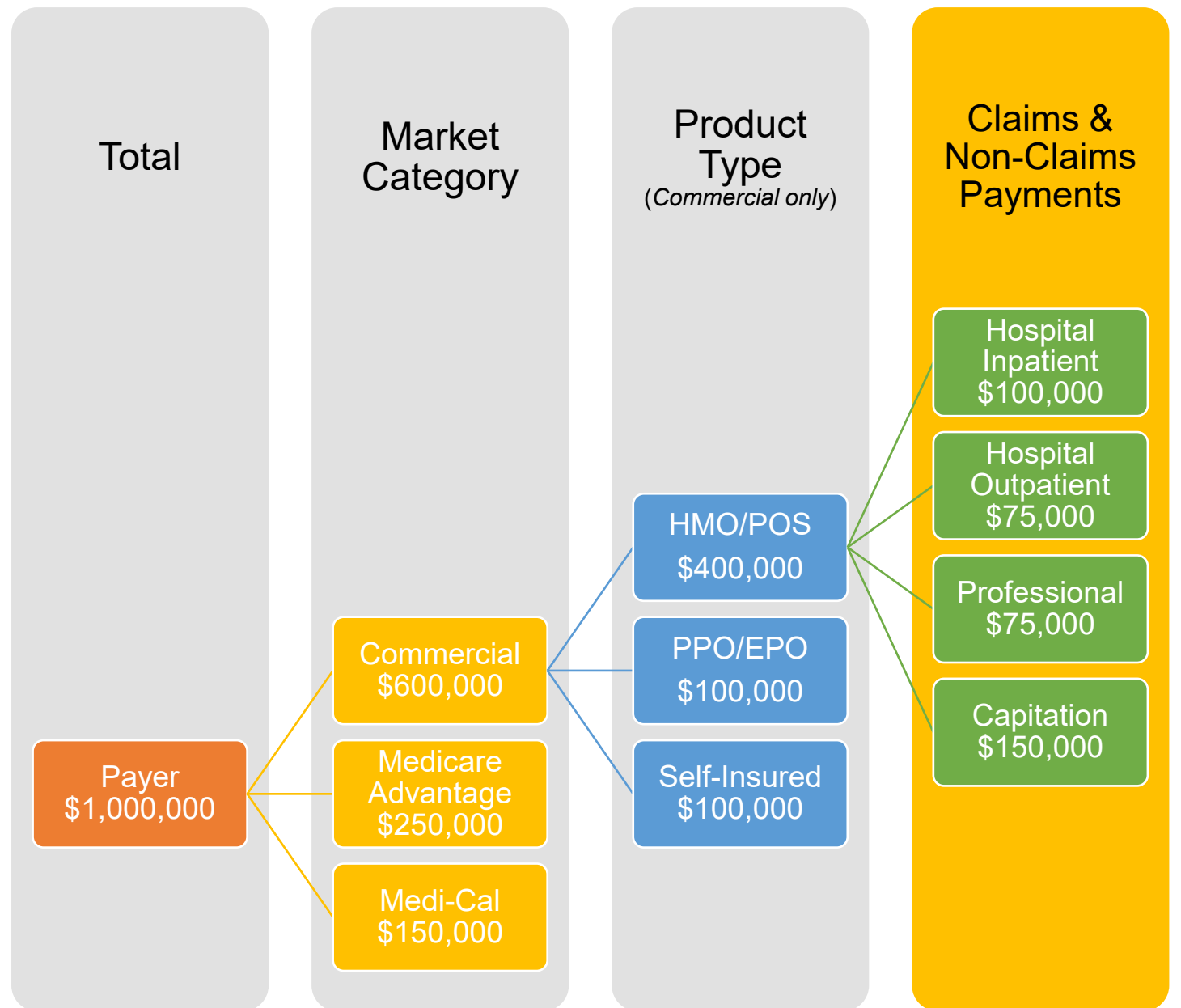
- Excel versions of the OHCA addenda can be found on the Documentation page in the THCE Data Portal.

ID	Name	Type
81	<a href="#">OHCA Behavioral Health Addendum April 2026</a>	Document
71	<a href="#">OHCA THCE Data Submission Guide v3.0</a>	Document
70	<a href="#">OHCA Attribution Addendum April 2026</a>	Document
64	<a href="#">User Guide for Onpoint CDM</a>	Document
60	<a href="#">OHCA Medi-Cal Payments Addendum April 2026</a>	Document
59	<a href="#">OHCA Primary Care Addendum April 2026</a>	Document
56	<a href="#">OHCA THCE Appendix C Regions Excerpt</a>	Document
27	<a href="#">Quick Start Guide to Registering with Onpoint CDM</a>	Document

# OHCA Files Overview

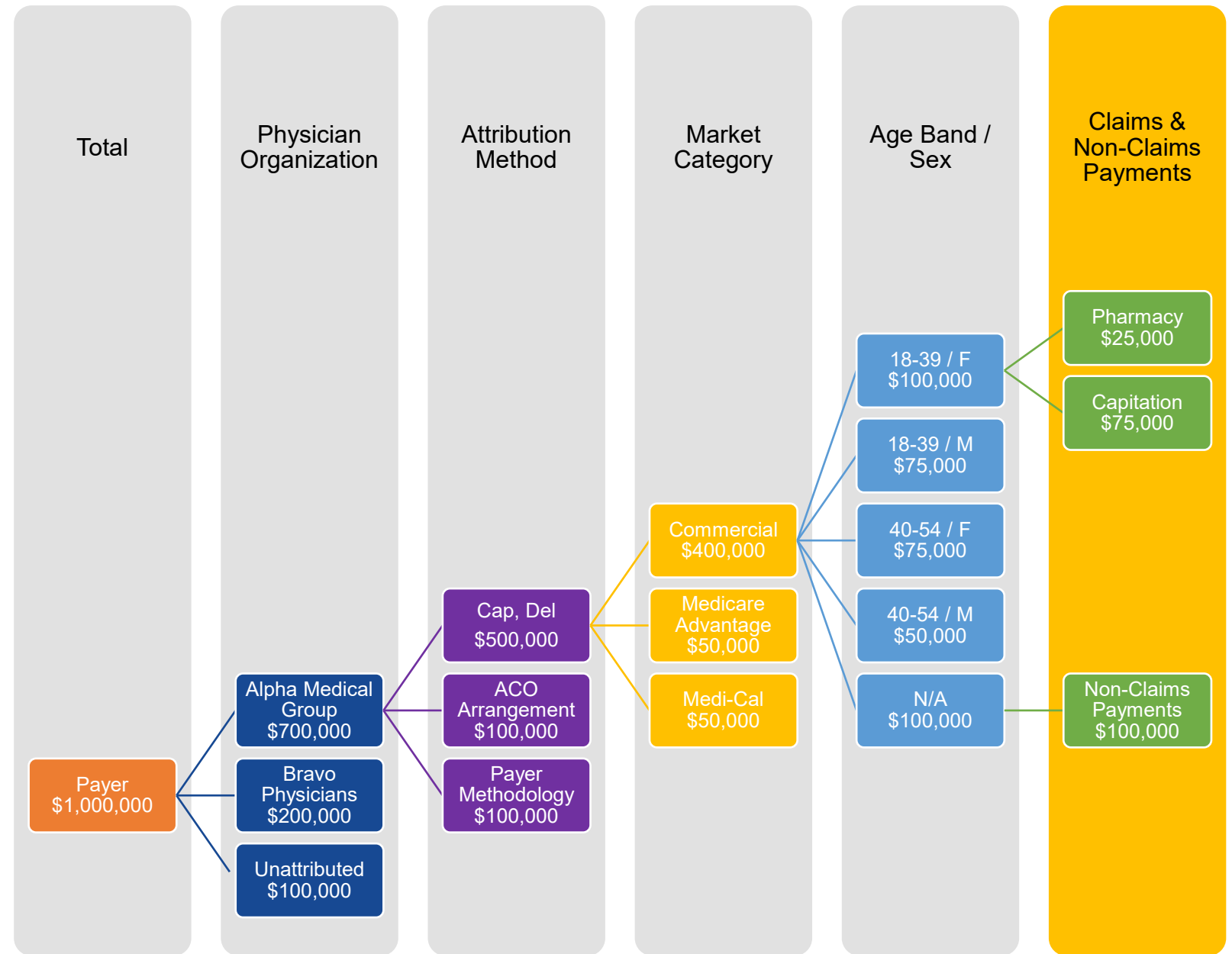
# Statewide TME File

Self-insured spending is only reported separately in the Statewide TME File. Within all other files, self-insured spending shall be included with fully insured spending and reported in the Commercial market category.



# Attributed TME File

In the Attributed TME File, all of a member's expenses are attributed to the identified physician organization, regardless of rendering provider.



# Member Attribution Methodology

1.  
Capitated,  
Delegated  
Arrangement

- 1234 Alpha Medical Group
- 2345 Bravo Physicians
- 7777 New PO not currently listed on the OHCA Attribution Addendum



2.  
ACO  
Arrangement

- 3456 Charlie IPA



3.  
Payer-  
Developed  
Attribution

- 4567 Delta Network



4.  
Not Attributed

- 9999 Members could not be attributed to any PO

Payers attribute members to physician organizations identified in the OHCA Attribution Addendum according to the hierarchical order of operations illustrated here.

The 2026 Addendum lists 139 POs. However, payers may also attribute members to POs not listed on the Addendum and OHCA may add those POs to future iterations.

When possible, match the PO name and TIN in the Addendum to your data. Otherwise, match on the name only.

# Adding New Physician Organizations

- When attributing members to a physician organization **not** listed on the OHCA Attribution Addendum, the following must be true:
  - The submitter must have at least 1,000 attributable members, and
  - The physician organization must meet the definition in HSC § 127500.2(r).

## Physician Organizations include:

Risk-Bearing Organizations (RBOs)  
Independent Practice Associations (IPAs)  
Medical Groups  
Physician-led foundations or networks

## Physician Organizations do **not** include:

Hospitals and clinics  
Skilled nursing facilities  
Pharmacies, labs, imaging centers  
Individual or small (<25) physician practices



# Member Attribution Example

Member's Payments	Amount
Sierra Medical Group primary care capitation	\$1,200
Tango Behavioral Health specialty care	\$600
Uniform PBM pharmacy claims	\$400
Victor Hospital ER claim	\$150
<b>Member's Total Medical Expense</b>	<b>\$2,350</b>

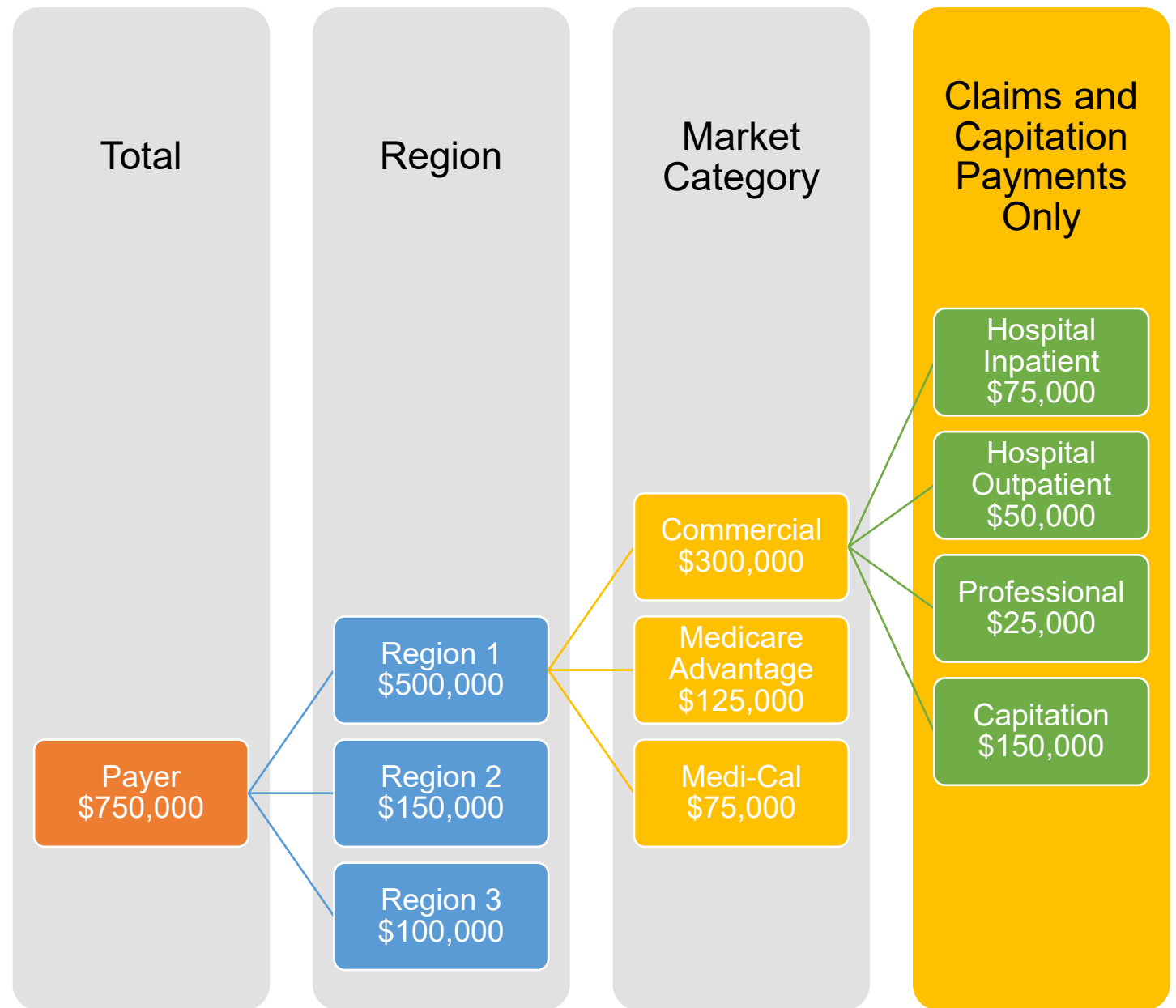
In this example, the plan has paid four organizations on behalf of the member during the reporting year.

Attributed Phys Org	Member Months	Total Medical Expense
Sierra Medical Group	12	\$2,350

In the Attributed TME File, all of the member's expense should be attributed to the medical group where the plan has delegated the member's care.

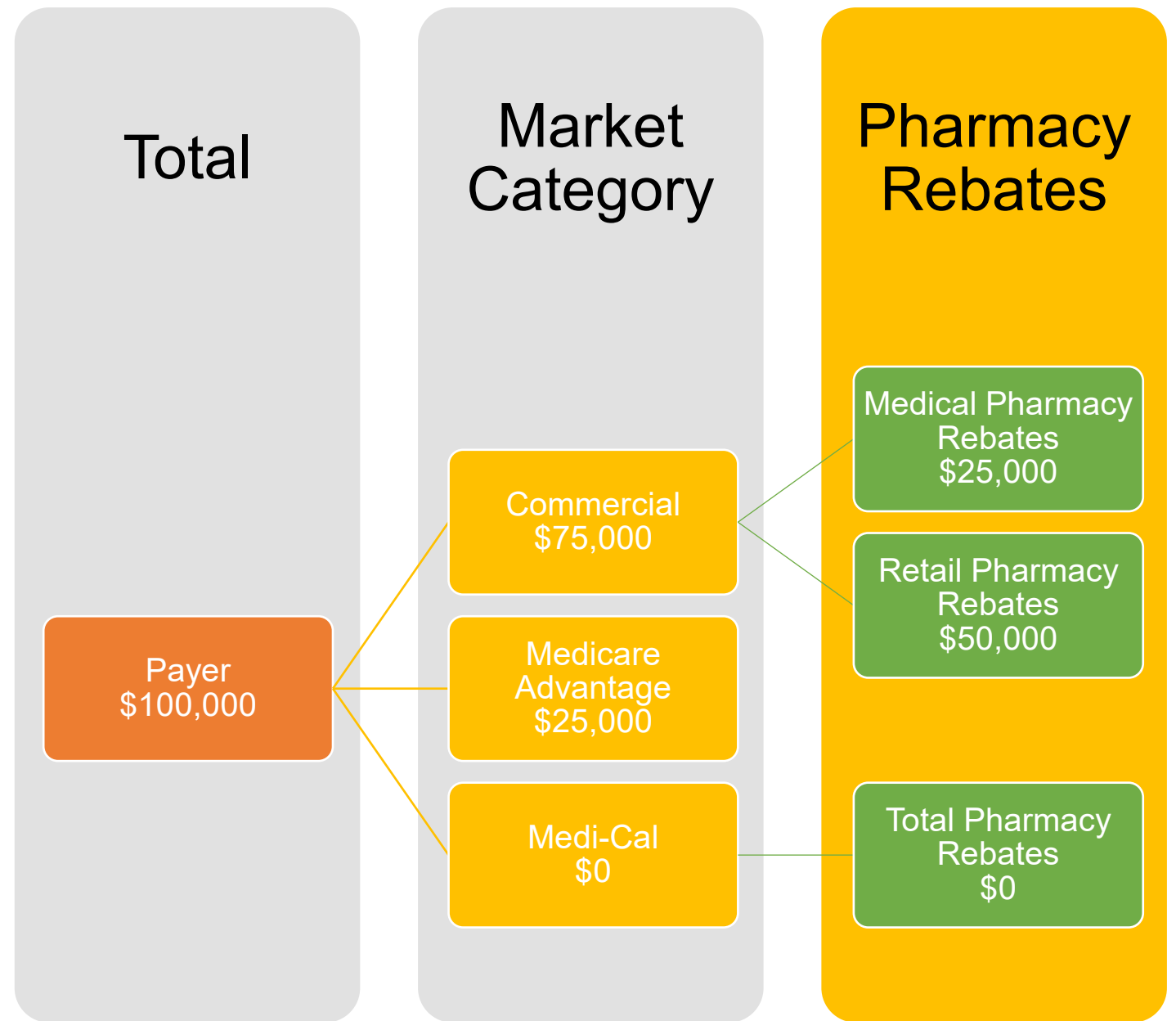
# Regional TME File

The Regional TME File captures claims and capitation payments only; other non-claims payment categories are not reported. Region is assigned based on the member's residence address.



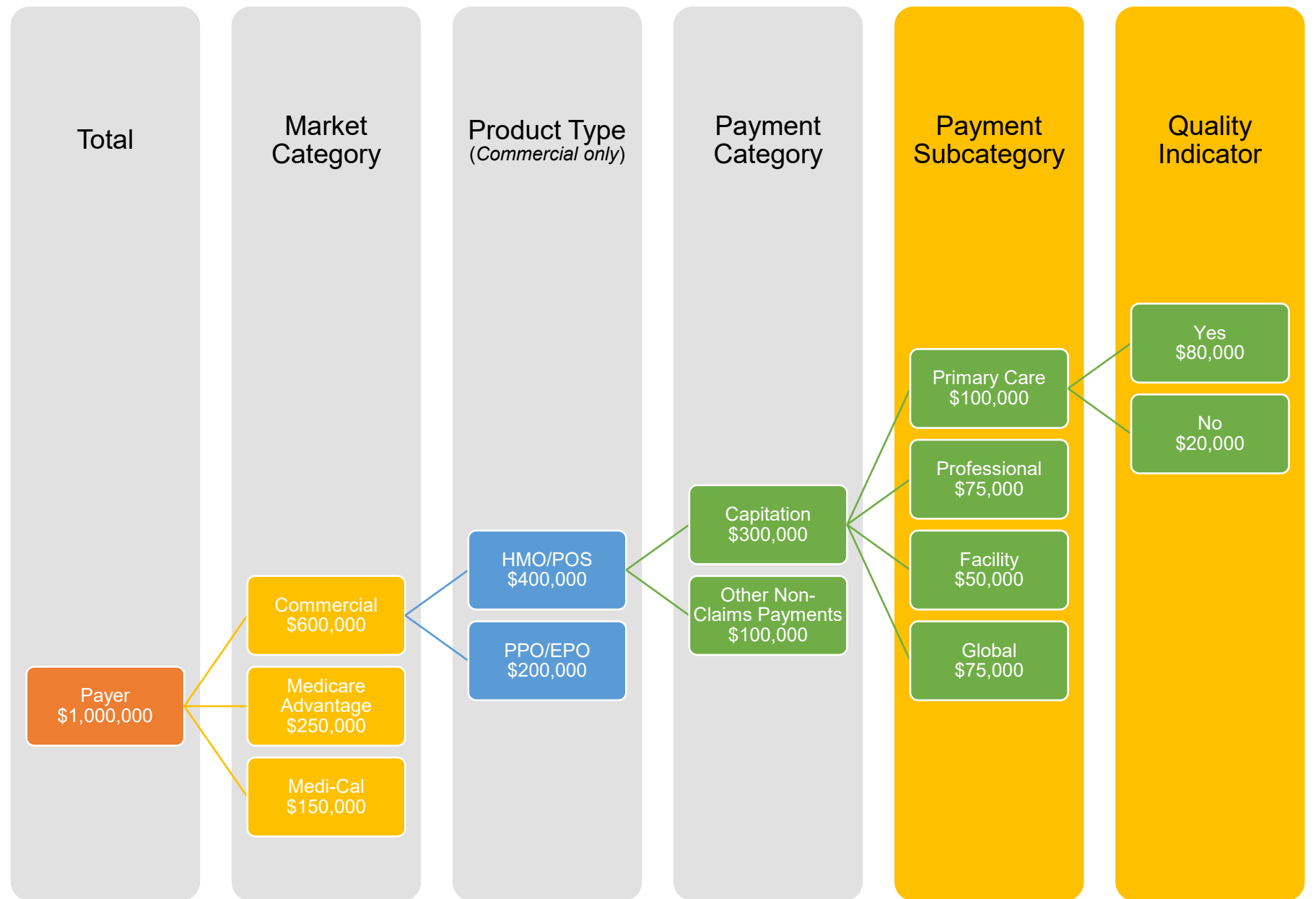
# Pharmacy Rebates File

Even if a payer has no pharmacy rebates to report, they must still submit a Pharmacy Rebates File with \$0 in all fields.



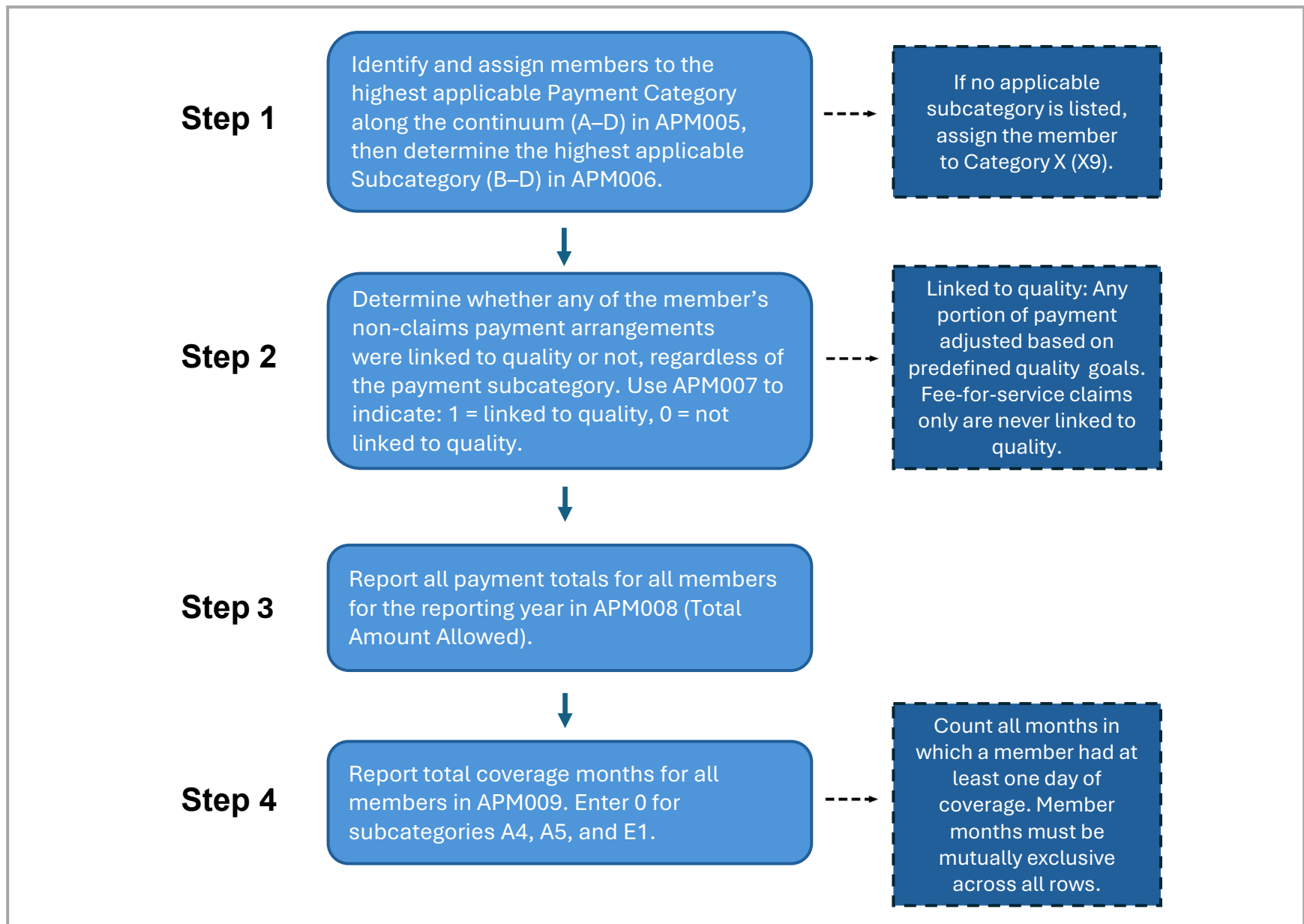
# APM File

In the APM File, all of a member's expenses and all months of coverage are reported in a single payment subcategory furthest along the continuum of clinical and financial risk, regardless of payment type.



# 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.



# APM 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)	\$400
<b>Member's Total Medical Expense</b>	<b>\$2,100</b>

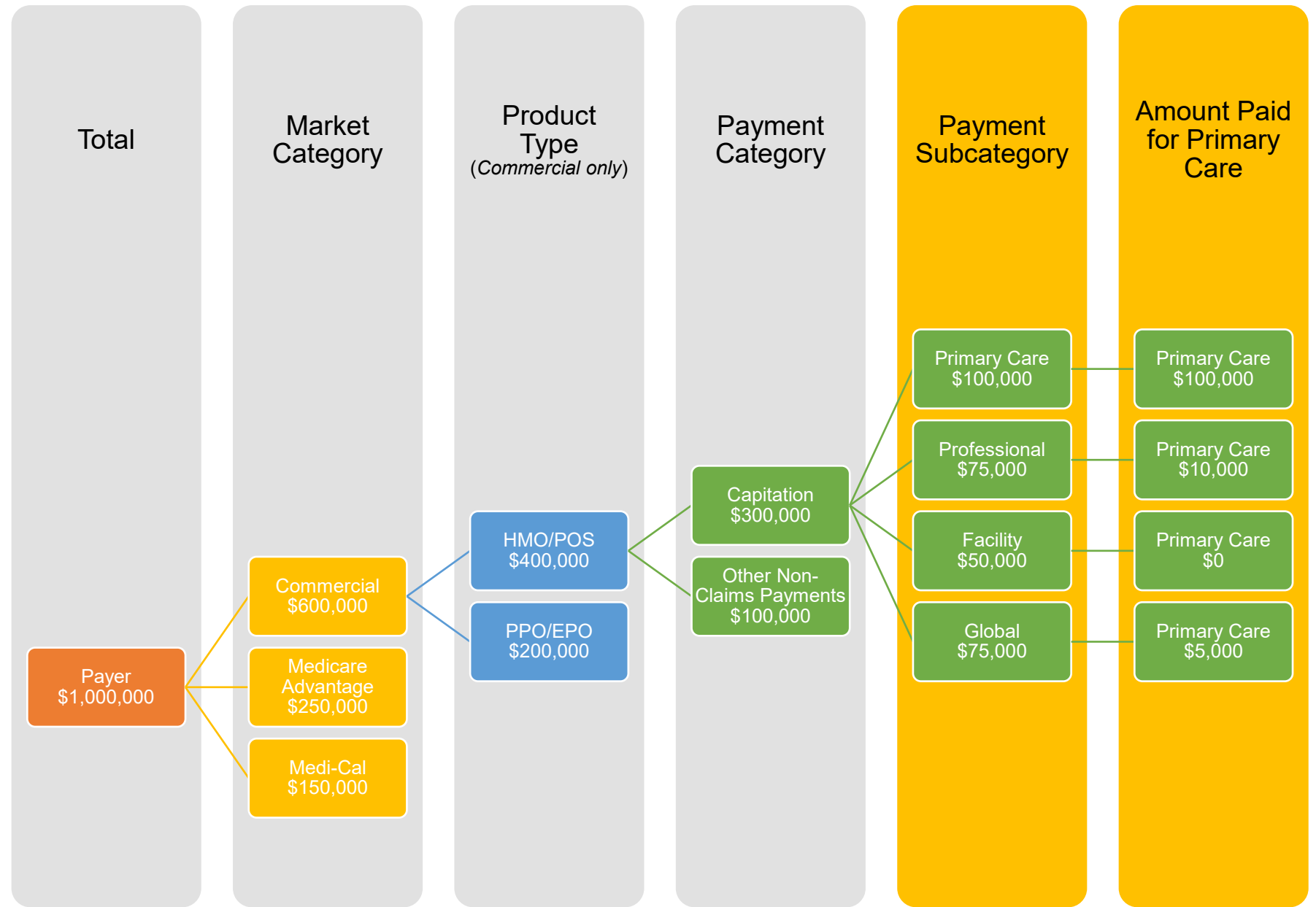
In this example, the plan made three different types of payments on behalf of the member during the reporting year.

Payment Subcategory	Linked to Quality?	Total Amount Allowed	Member Months
D1	Yes	\$2,100	12

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

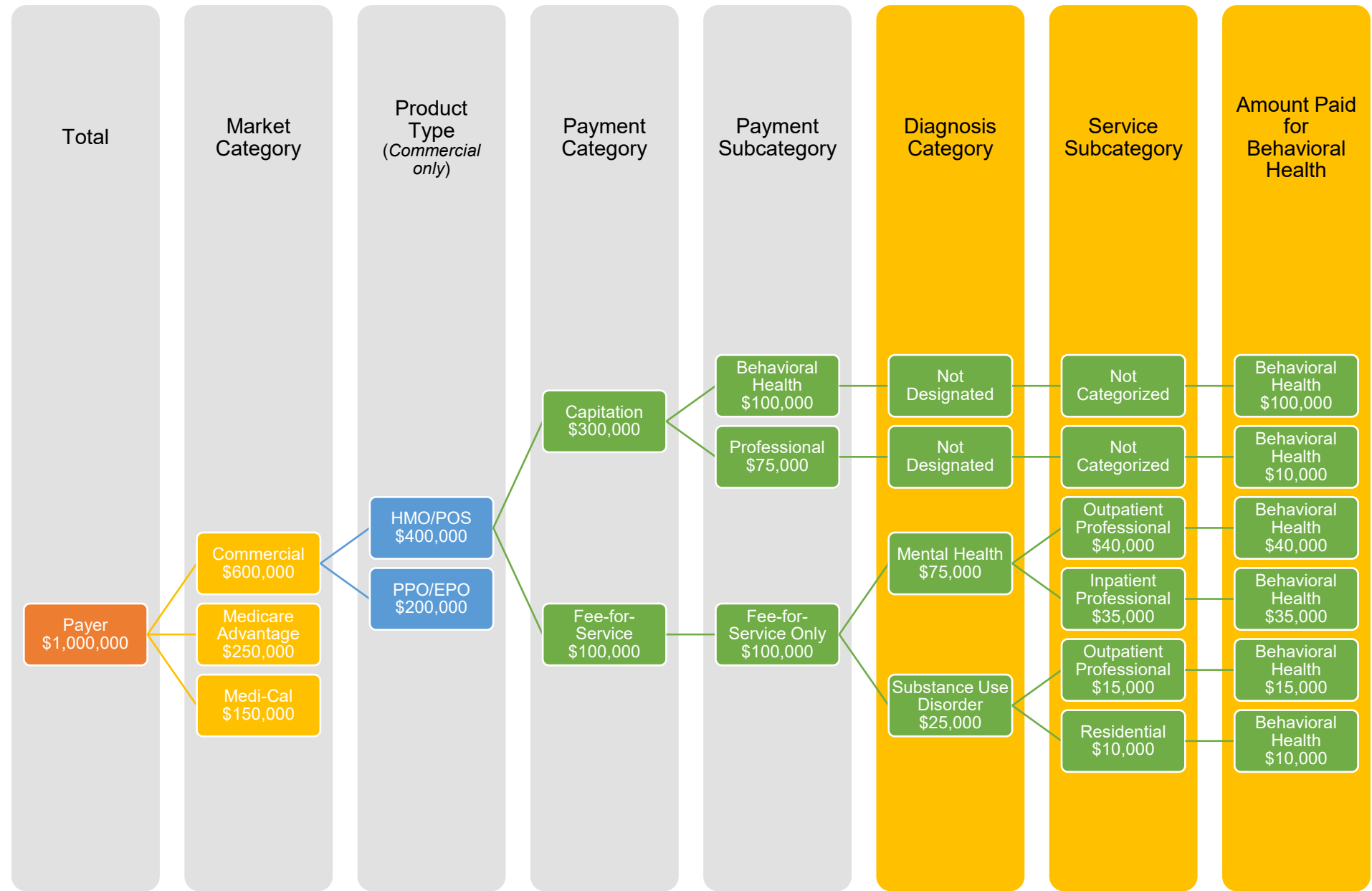
# Primary Care File

In the Primary Care File, member months are reported for any month in which a payment was made and are **not** mutually exclusive across payment subcategories. Months of coverage where no payment was made are **not** reported.



# Behavioral Health File

To avoid duplicate reporting of certain payments, the Primary Care File must be completed before the Behavioral Health File.



# File Layout Differences

Statewide, Attributed, and Regional TME Files	Alternative Payment Model, Primary Care, and Behavioral Health Files
Rows for each market category and product type (SWT), physician organization and age/sex band (ATT), and region (RET).	Rows for each unique combination of market category, product type, and payment subcategory.
Columns for all payment types.	Columns for link to quality (APM), amount paid for primary care (PRC), and amount paid for behavioral health (BHV).
Six categories for claims payments.	One subcategory for all claims payments. BHV Only: One subcategory with columns for diagnosis categories (two) and service subcategories (eleven) combinations.
Non-claims payments at the category level (e.g., Performance payments, Capitation).	Non-claims payments at the subcategory level (e.g., Pay-for-reporting, Pay-for-performance, Primary care capitation, Facility capitation).

# File Layout Examples

```

HD|CHC9999|SWT|202401|202512|T|SAMPLE SWT FILE|3.0
CHC9999|2024|1|1|12|100000|75000|75000|0|0|0|250000|500|150000|500|0|0|0|0|1.2345|2026|SWT
CHC9999|2025|1|1|12|100000|75000|75000|0|0|0|250000|500|150000|500|0|0|0|0|1.2345|2026|SWT
TR|CHC9999|SWT|20260520|2
    
```

Every row contains the same Submitter Code

Separate rows for each Reporting Year

Report member months and dollar amounts in whole numbers

Report 0 for any numeric field not applicable (n/a or null not allowed)

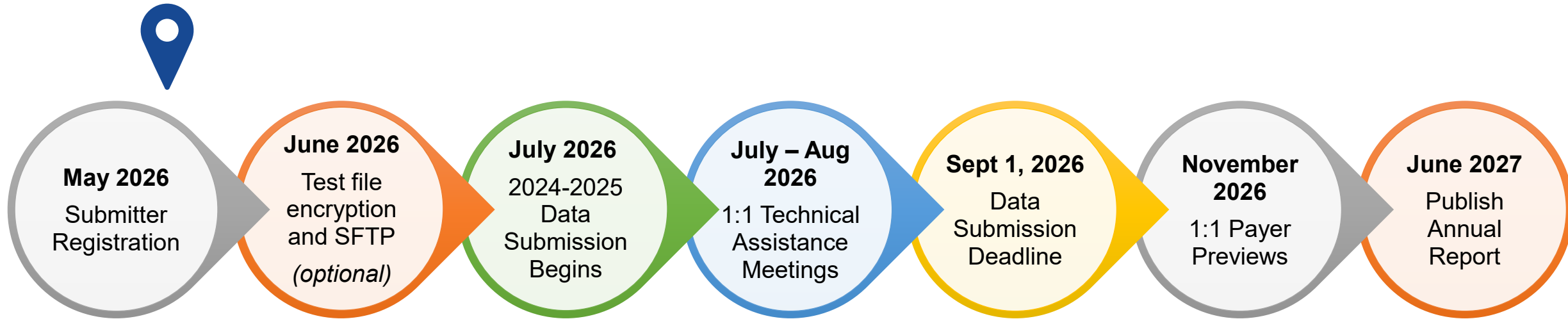
```

HD|CHC9999|PRC|202401|202512|T|SAMPLE PRC FILE|3.0
CHC9999|2024|1|1|D|D1|100500|100500|12|2026|PRC
CHC9999|2024|1|1|D|D3|50000|0|12|2026|PRC
CHC9999|2024|1|1|X|X9|250500|50000|6|2026|PRC
CHC9999|2025|1|1|D|D1|100500|100500|12|2026|PRC
CHC9999|2025|1|1|D|D3|50000|0|12|2026|PRC
CHC9999|2025|1|1|X|X9|250500|50000|6|2026|PRC
TR|CHC9999|PRC|20260520|6
    
```

# Submitter Round Table

# Next Steps

# 2026 Data Collection Timeline



# Next Steps

- Reminder: Annual registration due by **May 29, 2026**
- Next workgroup meeting – June 17, 2026
- Send questions or requests for future workgroup topics to [OHCA@HCAI.ca.gov](mailto:OHCA@HCAI.ca.gov)