OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Total Health Care Expenditures (THCE) Data Submitter Workgroup

October 22, 2025

HCAI

Department of Health Care Access and Information

Agenda

1. Proposed Data Submission Guide (DSG) Changes for 2026
2. New: Behavioral Health Spending Data Submission File
3. Payer Previews
4. Submitter Round Table
5. Next Steps

Proposed DSG Changes for 2026

Data Submission Guide 3.0

- DSG 3.0 outlines requirements for submission of 2024-2025 data in 2026
- Draft will be shared for public comment on proposed changes in January 2026
- Annual registration due May 29, 2026
- Data submission due September 1, 2026

DSG 3.0 Proposed Changes

- New Behavioral Health file and payment allocation instructions
- Medi-Cal data will be required in all files
- Separate reporting of self-insured member months and spending in Statewide TME file only
- Copies of filed MLR reports must be emailed to OHCA with data submission

DSG 3.0 Proposed Changes

APM File	PRC File
• Revised language to improve clarity of instructions (e.g., member months attribution)	
• *Medi-Cal MCPs only*: Updated the June 2025 supplemental information clarifying which Medi-Cal payments to include or exclude and incorporated into the reporting requirements	
• APM File Payment Allocation section revised with streamlined APM file instructions; includes a new process map	• Updates to Primary Care code sets (e.g., expansion of Physician Assistant taxonomy)
	• *Medi-Cal MCPs only*: Revised Step 2 in primary care attribution methodology for claims payments to use 274 files submitted to DHCS in the Annual Network Certification to determine whether a provider on a claim is designated as a PCP (for physicians, nurse practitioners, and physician assistants)

Behavioral Health Spending Data Submission File

Behavioral Health Data Collection

Focus Areas for Promoting High Value

Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Behavioral Health Investment Benchmark

- OHCA Board deferred setting a behavioral health investment benchmark this year.
- Board will revisit in summer 2026, with additional data and experience to inform deliberations.
- Behavioral health spending data submitted to OHCA in September 2026 will be used only for measurement and reporting, not comparison to a benchmark, for at least one year.

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 will be in DSG 3.0; to be reviewed at future workgroup meeting

Measuring Behavioral Health Spending

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health spending

Denominator

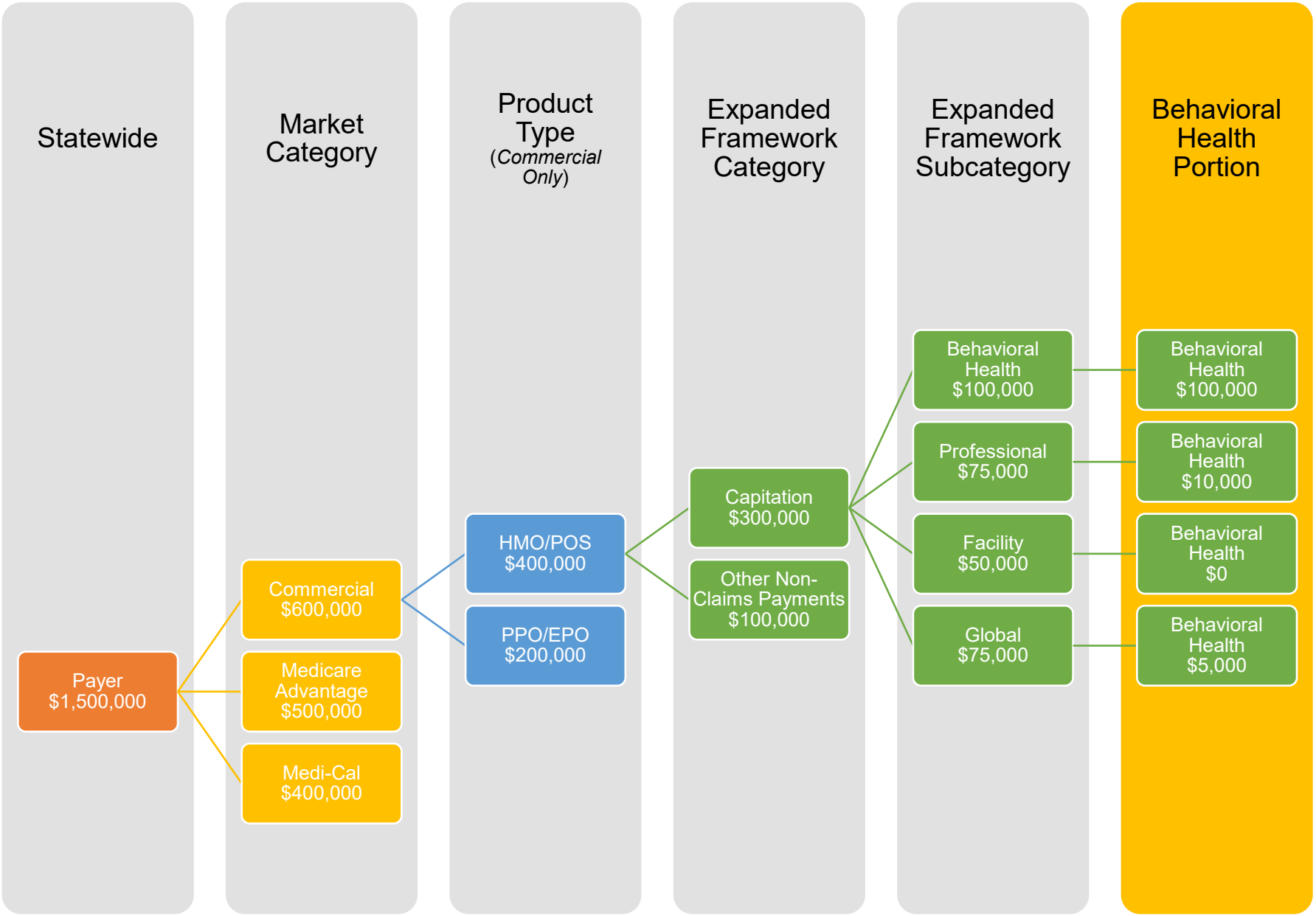
Total claims-based payments + Total non-claims-based payments = Total medical expense

X 100% = Behavioral health spending as a % of total medical expense

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.

Draft Behavioral Health File Layout

Behavioral Health File



Required for Market Categories:
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)

Draft 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	Use this field to report the market category code. Refer to Market Categories for more information. Valid values include: • 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) **Note**: The Market Category(ies) selected at registration must match the contents of the data submission.
4	BHV004	Product Type	Integer	1	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: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For other Market Categories, valid value includes: • 0 = Not applicable

Draft Behavioral Health File Layout

Col. #	Field ID	Field Name	Type	Max	Description
5	BHV005	Payment Category	Text	1	Use this field to report the payment category. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include: • 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	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: • 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

Draft Behavioral Health File Layout

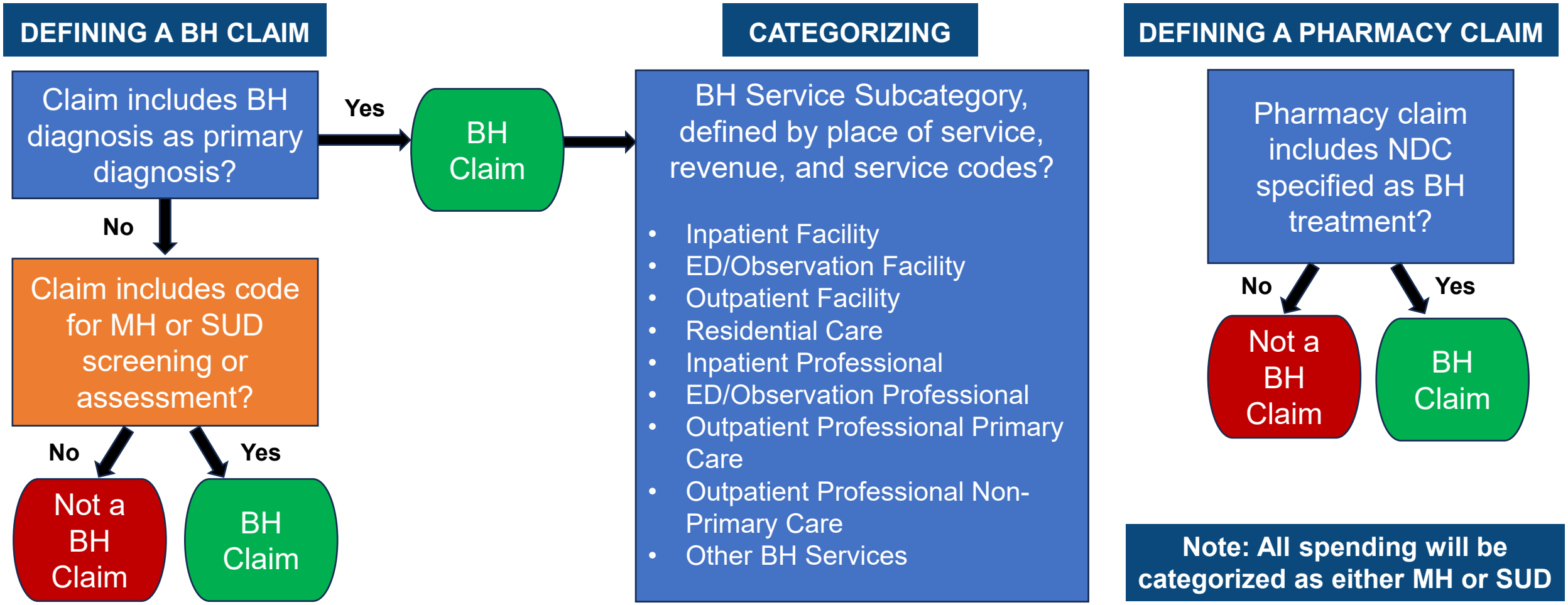
Col. #	Field ID	Field Name	Type	Max	Description
7	BHV007	Diagnosis Category	Text	1	Use this field to report the diagnosis category- mental health or substance use disorder. Refer to the OHCA Behavioral Health Code Set for guidance. When Payment Subcategory (BHV006) is 'X9', valid values include: • M = Mental Health • S = Substance Use Disorder When Payment Subcategory (BHV006) is **not** 'X9', valid value includes: • N = Not Designated
8	BHV008	Service Subcategory	Text	1	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: • 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 When Payment Subcategory (BHV006) is **not** 'X9', valid value includes: • N = Not Categorized
9	BHV009	Amount Paid for Behavioral Health	Integer	12	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. **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.
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 Payment Allocation

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



Note: All spending will be categorized as either MH or SUD

The Milbank Memorial Fund, April 2024. Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Proposed Behavioral Health Reporting Categories

Reporting Categories	Service Subcategories
Outpatient/Community Based	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Residential	Residential Care
Other†	Other Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

†All spending for claims with a primary behavioral health diagnosis is included (i.e., spending not in other subcategories goes to "Other").

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, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Portion of Capitation Payments}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*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

Example for a Professional Capitation arrangement:

$$\frac{\Sigma\,(\#\text{ of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\,(\#\text{ of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

x Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Data Submitter Feedback

1. Do submitters have questions about OHCA's approach to measuring behavioral health spending?

2. Are there any questions about the file layout or about specific fields?

Payer Previews

Payer Previews

- OHCA will schedule 30-minute sessions in November and December with registered contacts
- Preview will show TME calculations rolled-up to the parent level
- Preview will also include baseline calculations for Alternative Payment Model and Primary Care
- Opportunity for submitters to share additional information or context around their spending data with OHCA

TME Payer Previews

Time period: January 1, 2023 - December 31, 2024

Table 1. Enrollment (Total members) by Market

Enrollment Information (Total members)	2023	2024	Change (n)	Change (%)
Commercial	200	210	10	5.0%
Medicare Advantage	100	110	10	10.0%

Table 2. Total Medical Expenditures by Market

Aggregate TME Expenditures	2023	2024	Change (n)	Change (%)
Total Medical Expenditures - Commercial	$ 10,000	$ 11,000	$ 1,000	10.0%
Total Medical Expenditures - Medicare Advantage**	$ 20,000	$ 21,000	$ 1,000	5.0%

Table 3. Total Medical Expenditures (PMPY) by Market

TME PMPY	2023	2024	PMPY Unadjusted Change	
	PMPY Unadjusted	PMPY Unadjusted	%	$
Total Medical Expenditures - Commercial	$ 50	$ 52	4.8%	$ 2
Total Medical Expenditures - Medicare Advantage**	$ 200	$ 191	-4.5%	$ (9)

***For Medicare Advantage, market categories 4 (Medicare Advantage), 6 (Dual Eligibles), and 7 (D-SNPs) are combined.*

Submitter Round Table

Next Steps

Next Steps

- OHCA will reach out to schedule 1:1 Payer Preview meetings
- Next workgroup meeting – January 2026
- Send questions to OHCA@HCAI.ca.gov