California Department of Health Care Access and Information (HCAI)

Office of Health Care Affordability (OHCA)

Total Health Care Expenditures Data Submission Guide

Version 3.0

Updated: April 2026

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Version History

Version	Date	Summary of Changes
3.0	April 2026	• Changed data submission deadline from September 1 to the first business day of September • Added Section 1.4 References • Reorganized Submitter Registration (Section 2) to match the online registration form • Removed Section 3.1.1 Special Requirements for Medi-Cal Data Submission in 2025 • Added special rules for Medi-Cal Managed Care and Medicare Advantage data submissions in Sections 4.3.2 and 4.3.3, respectively, and added OHCA Medi-Cal Payments Addendum • Added Section 4.4.1 Product Types and added Self-Insured products to the list of valid product types • Revised Section 4.8 APM File Payment Allocation for clarity • Added guidance for identification of primary care providers specific to Medi-Cal Managed Care data in Section 4.9.1 • Added Section 4.9.3 Primary Care Member Months • Added new Behavioral Health file (Section 5.10), associated payment allocation methodology (Section 4.10), and OHCA Behavioral Health Addendum • Added attestation statement to the Submitter Questionnaire file (Section 5.7) • Renamed Appendix B: Payment Arrangements and Classification and added subcategory X9 (Fee-for-service only claims) • Removed Appendix E: Primary Care Code Sets and created separate OHCA Primary Care Addendum • Added new Appendix E: Cross-File Data Quality Checks
2.0	April 2025	• Added requirement for health plans, health insurers, or other payers to submit separate registrations

		• Added new Alternative Payment Model (APM) file (Section 5.8), associated payment allocation instructions (Section 4.8), and condition and procedure types (Appendix D) • Added new Primary Care file (Section 5.9), associated allocation methodology (Section 4.9), and code sets (Appendix E) • Added Section 4.3.1 Exclusions • Updated dual eligibles descriptions in Section 4.4 Market Categories • Revised attribution methodologies and instructions in Section 4.5 Member Attribution • Removed Payment Arrangement field from Statewide TME file • Added Taxpayer Identification Number and National Provider Identifier fields to Attributed TME file • Split Member Responsibility field by claims and capitation payments on Statewide, Attributed, and Regional TME files • Added fields to capture estimated benefit amounts for the Commercial (Partial Benefits) market category to the Submitter Questionnaire file • Updated non-claims payment category descriptions and added subcategory descriptions to Appendix B: Expanded Non-Claims Payments Framework • Removed Los Angeles Service Planning Areas (SPAs) from Appendix C: Regions
1.1	June 2024	• Added RR99 (Unspecified Region) code, added non-spatial Los Angeles ZIP codes, and corrected typographical errors in Appendix C: Regions
1.0	February 2024	

1 Introduction

This Total Health Care Expenditures (THCE) Data Submission Guide (the "Guide") is intended for use by payers and fully integrated delivery systems ("submitters") when extracting and aggregating data for submission to the Office of Health Care Affordability (OHCA). This Guide provides technical specifications, file layouts, reporting schedules, and other instructions to ensure the submission of accurate THCE data in a standardized format. The submitter interactions described in this Guide will occur via the secure THCE Data Portal, which is the platform for submitter registration, data submission, and submission status information.

Payers and fully integrated delivery systems are required to submit data and other information necessary for OHCA to measure THCE and per capita THCE pursuant to Health and Safety Code section 127501.4 of the California Health Care Quality and Affordability Act (the "Act") and its implementing regulations.[1] OHCA's purpose and reporting responsibilities, including types of data collection and submitters, are broadly defined in the Act. OHCA actively maintains a website (https://hcai.ca.gov/ohca/) with information about OHCA's mission, including background, links to state statutes and regulations, a link to this Guide and all addenda, the THCE Data Portal, contact information, and other resources for submitters.

For additional detail on whether a payer or fully integrated delivery system meets OHCA's criteria to submit THCE data on a mandatory basis ("required submitter") versus a voluntary basis ("voluntary submitter"), refer to the Act's implementing regulations, which incorporate this Guide by reference, in Article 2 of Chapter 11.5 of Division 7 of Title 22 of the California Code of Regulations, starting with Section 97445.

1.1 Contact Information

OHCA program and data management vendor staff are available to answer questions regarding the process and mechanics of data submission and technical issues regarding the covered population, contents of data files and elements, and reporting timeframes.

For program questions about OHCA, contact ohca@hcai.ca.gov or visit https://hcai.ca.gov/ohca.

For technical assistance or for questions related to data specifications, mapping, or submission results, contact OHCA's data management vendor, Onpoint, at ohca-support@onpointhealthdata.org or 207-623-2555.

[1] California Health and Safety Code sections 127500 *et seq.* (Health Care Quality and Affordability Act).

1.2 Data Submission Deadlines

Payers and fully integrated delivery systems are required to submit THCE data on or before the first business day of September of each year. Submitters will extract and submit data for the previous two calendar years with each annual submission (*e.g.*, data for benefits received by California residents during calendar years 2024 and 2025 is due by September 1, 2026).

Files may be submitted individually as they are ready; however, a submission will not be deemed complete until all required files are received and pass the cross-file data quality checks outlined in Appendix E: Cross-File Data Quality Checks.

1.3 Changes to this Guide

Consistent with Health and Safety Code section 127501.4(k), prior to making changes to this Guide, OHCA will engage with relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received.

For notice of potential regulatory actions or public meetings, subscribe to OHCA's email listservs at https://hcai.ca.gov/mailing-list/.

1.4 References

This Guide references multiple documents incorporated by reference into OHCA's regulations as follows:

Document Name	Dated	Regulation Citation
OHCA Attribution Addendum	April 2026	22 CCR 97445(t)
OHCA Behavioral Health Addendum	April 2026	22 CCR 97445(u)
OHCA Medi-Cal Payments Addendum	April 2026	22 CCR 97445(v)
OHCA Primary Care Addendum	April 2026	22 CCR 97445(w)

2 Submitter Registration

Each year, all submitters must register to submit data to the THCE Data Portal, available from https://hcai.ca.gov/login/. This includes all required submitters and any approved voluntary submitters. Required submitters who previously registered with OHCA will receive an email with a link to register in the THCE Data Portal. Any required submitters who do not receive a link to register and any entities who wish to request approval to submit on a voluntary basis must contact OHCA at ohca@hcai.ca.gov.

Submitters shall complete separate registrations for each health plan, health insurer, or other payer as defined in 22 CCR 97445, for which they will report THCE data. For example, Payer A operates a health plan, licensed by the Department of Managed Health Care, and a health insurer, licensed by the Department of Insurance. Payer A shall complete two registrations: one for the health plan, and one for the health insurer. Only one registration is needed from each entity, and a single registration may identify multiple contacts for the submitter. Submitters shall complete registration annually by the last business day of May.

During the registration process, all submitters will provide the following information:

1. Parent Company Name
2. Submitter (Legal Entity) Name
3. Submitter Code, if previously registered
4. Type of Participant (Voluntary or Mandatory)
5. National Association of Insurance Commissioners (NAIC) Number,[2] if applicable
6. License Issuer and License Number
7. Market Category(ies) for which the submitter will report data. The Market Category(ies) selected at registration must match the contents of the data submission. Refer to Market Categories for more information.
    - Commercial (Full Benefits)
    - Commercial (Partial Benefits)
    - Medi-Cal Managed Care
    - Medicare Advantage
    - Dual Eligibles (Medi-Cal Expenses Only)
    - Dual Eligibles (Medicare Expenses Only)
    - Dual Eligibles (Medi-Cal and Medicare Expenses)
8. For each Market Category selected above, the number of covered lives as of December 31 of the most recent reporting year
9. Submitter Address
10. A business point of contact for submission issues (first and last name, email, phone, organization name, and address)

[2] Registrants shall use the NAIC code required by the California Department of Insurance when filing pursuant to 10 CCR 2308.1.

11. A regulatory point of contact (first and last name, email, phone, organization name, and address)
12. A technical point of contact (first and last name, email, phone, organization name, and address)

Upon approval of the registration, the registering entity will be notified and provided with a unique Submitter Code that will be used in data submission to identify data for which they are responsible. Data files that contain an invalid Submitter Code or no Submitter Code will not be accepted.

2.1 Test File Submission

Test files are not required, though submitters are strongly encouraged to send test files to the THCE Data Portal at their discretion. In addition to confirming file layouts, test files are useful for ensuring file encryption protocols are working as expected. Test files must be indicated in the header record as described below (refer to the Header Record file layout for more information).

3 File Intake Requirements

The following requirements apply to all files submitted to the THCE Data Portal.

3.1 Required Files

A complete submission contains the following eight files:

1. Statewide Total Medical Expense (TME) – total medical expense for covered health benefits during the reporting period broken out by market category, and where applicable, product type.
2. Attributed TME – total medical expense for covered health benefits during the reporting period attributed to physician organizations and broken out by market category, age, and sex.
3. Regional TME – total medical expense for covered health benefits during the reporting period broken out by geographic region and market category.
4. Pharmacy Rebates – statewide medical and retail pharmacy rebate data broken out by market category.
5. Submission Questionnaire – attestations and confirmation that instructions in the Guide were followed when preparing data for submission.
6. Alternative Payment Model (APM) – total medical expense for covered health benefits during the reporting period broken out by market category, and where applicable, product type. Submissions shall include both claims (fee-for-service) and non-claims payments, with non-claims payments broken out by the categories and subcategories described in Appendix B: Payment Arrangements and Classification.
7. Primary Care – total medical expense for covered health benefits during the reporting period, including primary care portions of total medical expense for covered health benefits broken out by market category, and where applicable, product type. Submissions shall include both claims (fee-for-service) and non-claims payments, with non-claims payments broken out by the categories and subcategories described in Appendix B: Payment Arrangements and Classification.
8. Behavioral Health – behavioral health portions of total medical expense for covered health benefits during the reporting period, broken out by market category, and where applicable, product type. Submissions shall include both claims (fee-for-service) and non-claims payments, with non-claims payments broken out by the categories and subcategories described in Appendix B: Payment Arrangements and Classification.

Submitters reporting data for more than one health plan and/or health insurer shall complete separate file submissions for each registered entity. The total medical expense reported for each registered entity shall be mutually exclusive.

For example, Payer A separately registers two entities: a health plan, licensed by the Department of Managed Health Care, and a health insurer, licensed by the Department of Insurance. Payer A receives a unique Submitter Code for each registered entity. Payer A submits a complete set of files reflecting total medical expense for the health plan's lines of business using the health plan's Submitter Code. Payer A separately submits a complete set of files reflecting total medical expense for the health insurer's lines of business using the health insurer's Submitter Code.

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. Refer to Appendix E: Cross-File Data Quality Checks for more information.

3.2 Required Format

File format. Data shall be submitted in a text (.txt) file that is pipe ("|") delimited with one row per record. Only standard ASCII characters are allowed in each file.

Encryption. Files must be encrypted prior to submission using the OpenPGP encryption standard.[3] After annual registration is approved, submitters and Onpoint must exchange public PGP keys. Submitters must encrypt the files using Onpoint's public PGP key with Onpoint identified as the recipient of the file. Submitters must also sign the encryption using the private key that pairs to the public PGP key associated to the submitter's Secure File Transfer Protocol (SFTP) account with the submitter identified as the sender of the file.

No file naming convention requirements. Data in the header record is used to identify key information about the file.

Header and trailer records. Each submission regardless of type (*e.g.*, TME or pharmacy rebates) must begin with a header record and end with a trailer record.

No empty rows. There shall be no empty rows separating either the header or the trailer from the reported data.

Submitting multiple years of data at once. Submitters may report multiple complete years of data with one pair of header and trailer records by indicating the earliest reporting year in the Period Beginning Date field (HD004) and the latest year in the Period Ending Date field (HD005).

Indicating missing data. When indicating missing data, two or more pipes shall appear together showing there is no data for the field. The lack of data between the pipes indicates fields that are unavailable for reporting. There shall be no blank space left

[3] For more information on OpenPGP encryption, refer to https://openpgp.org.

between the two pipes. **Note**: Any amount field with no reportable dollars shall be reported as 0 and not null or missing.

Punctuation. Punctuation shall not be included in the reporting of any names. Decimal points shall not be included in the reporting of financial fields. Amounts shall be rounded to the nearest whole dollar unless otherwise specified. Decimal points shall only be used when reporting standard deviation. Any negative values shall be entered with a hyphen (*e.g.*, -100).

Date formats. Dates, unless otherwise specified, shall be reported using the 8-digit format of YYYYMMDD. For example, January 18, 2024, shall be reported as 20240118.

All data fields shall be reported unless a Data Variance request has been approved by the Office. Unless a Data Variance Request has been requested and approved for a specific field, failure to provide a valid value in a required field will result in rejection of the submitted file (refer to Data Variance Requests for more information).

4 Data Submission Information

4.1 Data Completeness

Submitters shall extract and submit data for the previous two calendar years with each annual submission following guidance in the THCE Data Submission Guide in effect at the time of submission. For each data submission, submitters shall not apply a "paid through date" or otherwise limit the claims run-out, even when reporting data with run-out periods longer than 180 days.

4.1.1 Claims Payments

Submitters shall allow for a claims run-out period of at least 180 days after December 31st of the most recent reporting year (*i.e.*, June 30, 2026 for 2024 and 2025 service dates) to allow for continued claims adjudication. Claims shall be included based on the incurred date or date of service, not the date paid or reconciled. Incurred but not reported (IBNR) or incurred but not paid (IBNP) factors shall not be applied. Refer to Appendix A: Claims Service Category to Bill Code Mapping for more information on claims service categories.

Submitters shall report allowed amounts for covered benefits. Allowed amounts include both the amount paid by the payer or fully integrated delivery system to the provider and the member's financial responsibility owed directly to the provider, regardless of whether the member actually made a payment; this is also known as the negotiated rate, or the contracted rate. The allowed amount is not necessarily the sum of what the provider was paid.

4.1.2 Non-Claims Payments

Submitters shall allow for a non-claims reconciliation period of at least 180 days after December 31st of the most recent reporting year (*i.e.*, June 30, 2026 for 2024 and 2025 service dates) to reconcile non-claims payments. Submitters shall then apply reasonable and appropriate estimations of non-claims liability for each provider (including payments expected to be made to providers not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period. Non-claims shall be reported based on the incurred date or date of service, not the date paid or reconciled. Refer to Appendix B: Payment Arrangements and Classification for more information on non-claims payment categories.

Only costs paid by the submitter for members in capitated arrangements shall be reported; claims and/or encounter data received from a downstream provider shall not be reported to avoid double counting a member's total medical expense. However, claims and/or encounter data may be used to determine a member's financial responsibility owed directly to the provider.

4.1.3 Pharmacy Rebates

Pharmacy rebates are payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefit manager (PBM) to a payer or fully integrated delivery system.

For most members, pharmacy rebate data shall be reported based on actual amounts as of the time of submission without estimates. If pharmacy benefits are carved-out, submitters shall create a reasonable estimate of pharmacy rebates for members in the Commercial (Partial Benefits) market category. Refer to Market Categories for more information.

4.2 Data Variance Requests

Submitters that are unable to submit data files meeting the file intake specifications in this Guide may request a temporary variance to specific data submission requirements from OHCA pursuant to 22 CCR 97449(l). A data variance shall only be requested after a submitted file fails an automated validation in the THCE Data Portal. The request must include an explanation of the issue, the plan for correction, and the anticipated date of correction.

OHCA will respond to temporary variance requests within 5 business days of the date the request was submitted. Data variance requests will be reviewed on a case-by-case basis. Data variance requests granted by OHCA will be limited in duration and will not carry over to future data submission years.

4.3 Included Population

Data must include all health care spending for covered benefits on behalf of, or by, members who are California residents covered by Medicare, Medi-Cal, or commercial insurance, and receive care from any provider in or outside of California. When reporting spending by geographic region, members shall be assigned to a region based on their residence address.

Data shall only be reported by the primary payer on the claim, as secondary coverage expenses would generally double count a portion of the allowed amount reported by the primary payer.

When calculating total medical expense and member months, submitters shall include all members, including those with no utilization, for whom the submitter is directly contracted with a group purchaser, individual subscriber, or public agency to arrange for the provision of health care services.

4.3.1 Exclusions

Claims paid for residents of states other than California who receive care from California providers shall not be included. Total medical expense and member months for members with whom the submitter is not directly contracted (*i.e.*, members "from other plans") shall not be included.

The following lines of business shall be excluded from data submissions:

- Accident policies
- Acupuncture-only insurance
- Chiropractic-only insurance
- Dental-only insurance
- Disability policies
- Hospital indemnity policies
- Long-term care insurance
- Medicare supplemental insurance (Medigap)
- Specific disease policies
- Stand-alone prescription drug plans (PDPs)
- Stop-loss plans
- Supplemental and/or indemnity insurance that pays deductibles, copays, or coinsurance
- Vision-only insurance
- Workers' compensation

Submitters shall also exclude the following items from data submissions:

- Reinsurance recoveries or premiums
- Centers for Medicare & Medicaid Services (CMS) reconciliation payments, such as Medicare sweep or Part D
- Premiums
- Affordable Care Act (ACA) risk transfer payments
- PBM administrative fees

4.3.2 Special Rules for Medi-Cal Managed Care Data Submission

Medi-Cal Managed Care plans shall exclude certain payments specific to the Medi-Cal program when reporting data in the APM, Primary Care, and Behavioral Health files for the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories. For more information, refer to the OHCA Medi-Cal Payments Addendum.

4.3.3 Special Rules for Medicare Advantage Data Submission

Medicare Advantage plans shall include all Medicare Advantage benefits covered by the Medicare Advantage plan under the contract (*i.e.*, basic benefits and mandatory and optional supplemental benefits described in 42 CFR 422.100(c)) when reporting data in all files for the Medicare Advantage, Dual Eligibles (Medicare Expenses Only) and/or Dual Eligibles (Medi-Cal and Medicare Expenses) market categories.

4.4 Market Categories

Market categories are a segment within the public or private health insurance market for the purpose of reporting total medical expense. The seven market categories are:

1. Commercial (Full Benefits) – The Commercial (Full Benefits) market category shall be used when a submitter is able to report information on all claims and/or capitation paid on behalf of a member and the submitter is responsible for all covered benefits including pharmacy. In this scenario, the submitter has a complete picture of the member's total medical expense, even in the case where a capitated, delegated organization pays downstream claims.
2. Commercial (Partial Benefits) – If the submitter does not have all of the information on claims and/or capitation paid on behalf of the member (*e.g.*, self-funded pharmacy), the submitter shall use their Commercial (Full Benefits) population spend to create an estimate of expenses for those members on a PMPM basis. The estimate will be added to the spending for members for whom certain benefits are carved-out (*e.g.*, pharmacy). The total medical expense for these members shall be reported in the Commercial (Partial Benefits) market category to indicate a portion of spending has been estimated, and the estimated amounts must be reported in the Submission Questionnaire File.
3. Medi-Cal Managed Care
4. Medicare Advantage
5. Dual Eligibles (Medi-Cal Expenses Only) – Use this market category to report total medical expense for dual eligible members when the submitter is only administering Medi-Cal benefits.
6. Dual Eligibles (Medicare Expenses Only) – Use this market category to report total medical expense for dual eligible members when the submitter is only administering Medicare benefits.
7. Dual Eligibles (Medi-Cal and Medicare Expenses) – Use this market category to report total medical expense for dual eligible members when the submitter is administering both Medicare and Medi-Cal benefits (*e.g.*, Medicare Medi-Cal (Medi-Medi) Plans).

Reporting Dual Eligibles members: Member months for dual eligibles shall be mutually exclusive across the three market categories. A member's total medical expense shall only be reported in one market category for any given month based on the benefits administered by the submitter.

4.4.1 Product Types

Within the Statewide TME file, spending in the Commercial (Full Benefits) and Commercial (Partial Benefits) market categories shall be disaggregated by the following product types:

- Fully insured health maintenance organization (HMO) or point of service (POS) products, which require a primary care provider to manage the member's care.
- Fully insured preferred provider organization (PPO) or exclusive provider organization (EPO) products, which allow members to schedule visits without a referral.
- Other fully insured products, which do not fit the descriptions above.
    - If the Other product type is used, the products must be described in the Other Product Type field (SQS025) of the Submission Questionnaire File.
- Self-Insured products, regardless of benefit design.

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.

Within the APM, Primary Care, and Behavioral Health files, spending in the Commercial (Full Benefits) and Commercial (Partial Benefits) market categories shall be disaggregated by the following product types:

- HMO or POS products, which require a primary care provider to manage the member's care.
- PPO or EPO products, which allow members to schedule visits without a referral.
- Other products, which do not fit the descriptions above.
    - If the Other product type is used, the products must be described in the Other Product Type field (SQS025) of the Submission Questionnaire File.

4.5 Member Attribution in the Attributed TME File

In the Attributed TME File, submitters shall attribute member-level expenses to physician organizations listed on the OHCA Attribution Addendum (incorporated at 22 CCR 97445) according to the methods described below. Members shall only be attributed to physician organizations and not to other payers or fully integrated delivery systems (*i.e.*, not based on a "plan-to-plan contract" as defined at 22 CCR 97445(k)). Attribution shall be calculated on a monthly basis and reported in terms of member months.

Members must only be attributed to one physician organization for any given month. If a member is attributed to more than one physician organization during a reporting year, their total medical expense shall be allocated to each physician organization on a mutually exclusive basis (*i.e.*, expenses shall be allocated based on the respective member months allocated to each physician organization).

Data reported for each physician organization must include the total medical expense for the attributed members, including spending on care from providers outside of the attributed physician organization.

In addition, submitters shall report the identifier(s) (*i.e.*, Taxpayer Identification Number (TIN) and/or National Provider Identifier (NPI)) used to identify the physician organization on the OHCA Attribution Addendum within their data.

Member attribution shall be performed in the following order:

1. First, identify members for whom utilization management and claims payment functions have been delegated to a physician organization listed on the OHCA Attribution Addendum through a capitated payment arrangement. Report data for these members using the **Capitated, Delegated Arrangement** attribution method.
2. Next, attribute remaining members to a total cost of care Accountable Care Organization (ACO) arrangement that includes a physician organization listed on the OHCA Attribution Addendum. Report data for these members using the **ACO Arrangement** attribution method.
3. Any members who **cannot** be attributed using one of the above methods may be attributed to a physician organization listed on the OHCA Attribution Addendum using a submitter-developed, rules-based approach for assigning total medical expense. Report data for these members using the attribution method **Payer-Developed Attribution**.

> **Attributing members to other physician organizations**: The list of physician organizations in the OHCA Attribution Addendum is not comprehensive. Data for members who can be attributed using the above steps to a physician organization **not** listed on the OHCA Attribution Addendum shall be reported with '7777' in the Organization Code field (ATT003). Include the full legal name in the Organization Name field (ATT004).
>
> Report data in separate records for each physician organization with at least 1,000 attributable members. The 1,000-member count shall be calculated across all market categories as of December 31 of the most recent reporting year.

4. Not all members will be attributed. Data for members who cannot be attributed to any physician organization using any of the attribution methods shall be reported using the **Not Attributed** attribution method with '9999' in the Organization Code field (ATT003).

4.6 Self-Insured Plans

For self-insured lines of business, the administrative costs and profits portion of THCE is calculated using additional payer-submitted data on the income from fees from any self-insured accounts.

OHCA requests submitters with self-insured lines of business report aggregate information on the fees earned from their self-insured accounts (*e.g.*, "fees from uninsured plans") as part of the THCE data submission. Submitters shall follow the instructions for Part 1, Line 12 on the NAIC Supplemental Health Care Exhibit (SHCE) for their California-situs self-insured accounts. The amount is entered on the Submission Questionnaire File in the Administrative Costs and Profits for Self-Insured Plans field (SQS023).

4.7 Standard Deviation

Standard deviation shall be calculated for all members, including those with no utilization, and reported as a PMPM value. Standard deviation must be calculated for the applicable market category and reporting year on the Statewide TME File, and for the applicable market category, physician organization, and reporting year on the Attributed TME File. Standard deviation shall be based on PMPM spending and calculated after any estimates for specialized or carved-out services have been applied. Non-claims expenses shall be excluded from the calculation of standard deviation.

4.7.1 Statewide TME File

The following steps detail how submitters can calculate standard deviation values for each reporting year on the Statewide TME File data submission.

- **Step 1**: For each market category, the submitter must calculate the average monthly spending amount for each member using claims-based allowed amounts. Submitters shall calculate the average claims-based allowed amount after partial claims adjustments. Non-claims expenses shall be excluded from this average.

  Note: The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.

- **Step 2**: For each market category, divide Claims: Total amount by total member months (across all members) to produce a PMPM dollar amount specific to that market category.

- **Step 3**: With the average claims expenses value for each market category, submitters can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\Sigma(x_i - \bar{x})^2}{N}}$$

Where:
x_i = value of the one observation
$\bar{x}$ = mean value of all observations
N = number of observations (count of members)

Validating results: Using the Microsoft Excel function STDEV.P() or other standard deviation commands in any other statistical software program, submitters can calculate the standard deviation of the PMPM costs for a given market category.

Note that when calculating standard deviation, submitters shall use the formula for population standard deviation (divided by N). Submitters shall NOT use the formula for sample standard deviation (divided by N-1).

- **Step 4**: Report the standard deviation value in the Standard Deviation field within the Statewide TME File. Each row shall correspond to a specific market category and reporting year.

4.7.2 Attributed TME File

The following steps detail how submitters can calculate standard deviation values for each reporting year on the Attributed TME File data submission.

- **Step 1**: Attribute members to the appropriate physician organization for a specific market category.

- **Step 2**: For each market category, for each physician organization, the submitter must calculate the average monthly spending amount for each member using claims-based allowed amounts. Submitters shall calculate the average claims-based allowed amount after partial claims adjustments. Non-claims expenses shall be excluded from this average.

  Note: The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.

- **Step 3**: For each market category, for each physician organization, divide Claims: Total amount by total member months (across all members) to produce a PMPM dollar amount specific to that given market category and physician organization.

- **Step 4**: With the average claims expenses value for each physician organization, submitters can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\Sigma(x_i - \bar{x})^2}{N}}$$

Where:
x_i = value of the one observation
$\bar{x}$ = mean value of all observations
N = number of observations (count of members)

Validating results: Using the Microsoft Excel function STDEV.P() or other standard deviation commands in any other statistical software program, submitters can calculate the standard deviation of the PMPM costs for a given market category.

Note that when calculating standard deviation, submitters shall use the formula for population standard deviation (divided by N). Submitters shall NOT use the formula for sample standard deviation (divided by N-1).

- **Step 5**: Report the standard deviation value in the Standard Deviation field within the Attributed TME File. Each row shall correspond to a physician organization, market category, and reporting year.

4.8 APM File Payment Allocation

In the APM File, submitters shall allocate member-level expenses and member months to the payment categories and subcategories described in Appendix B: Payment Arrangements and Classification.

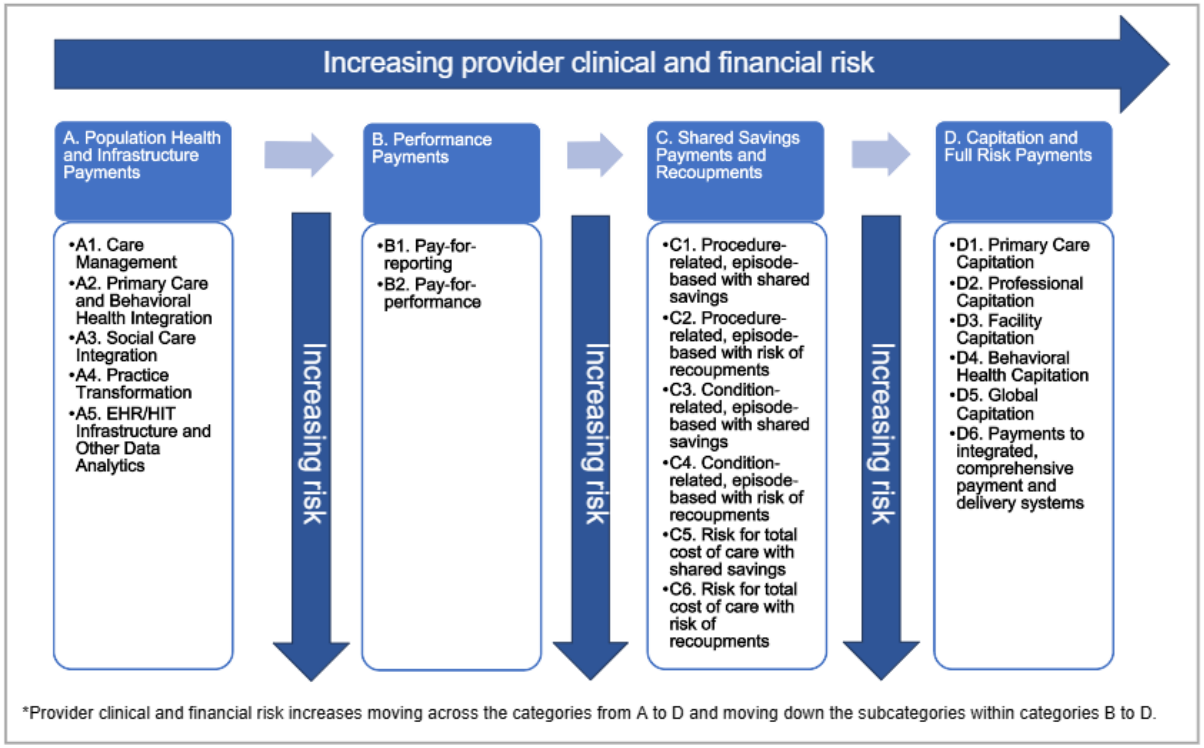
Submitters shall report aggregate data for each payment subcategory, disaggregated by market category and product type. Submitters shall further disaggregate data into each relevant payment subcategory and indicate whether payment arrangements on behalf of the member are linked to quality or not linked to quality.

The steps below detail how submitters shall allocate member-level expenses and member months in the Total Amount Allowed field (APM008) and the Member Months field (APM009) for each Payment Subcategory field (APM006) for each reporting year in the APM File. The steps are also illustrated in Figure 2 in a process map at the end of this section.

- **Step 1**: Using the payment category and subcategory descriptions in Appendix B: Payment Arrangements and Classification, and the hierarchy of non-claims payment subcategories illustrated in Figure 1, below, assign members and their

total medical expense (both claims and non-claims payments) to the applicable payment subcategory furthest along the continuum of provider clinical and financial risk. To assign members to subcategories, first identify the highest applicable category along the continuum (A-D). Then, identify the highest applicable subcategory (*i.e.*, greatest level of provider clinical and financial risk). Use the Payment Category field (APM005) to report the applicable category and the Payment Subcategory field (APM006) to report the applicable subcategory.

Figure 1. Continuum of Provider Clinical and Financial Risk for Non-Claims Payments



- **All the member's total medical expense and member months are allocated to a single payment subcategory, even if the member was covered by multiple payment arrangements during the reporting year.** For example, a member who was included in the determination of a pay-for-performance payment (payment subcategory B2) to a provider and who was also included in a total cost of care shared savings arrangement (payment subcategory C5) would have *all* of their claims and non-claims payments and member months in the total cost of care shared savings arrangement line and *none* in the pay-for-performance line.
- **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.**

If none of the subcategories listed in Figure 1 are applicable to a member, assign the member to category X (fee-for-service only) and subcategory X9.

- **Step 2**: Determine whether payment arrangements on behalf of a member are considered “linked to quality.” Payment arrangements on behalf of a member are considered “linked to quality” if any payments in either subcategory B2 or categories C or D made on their behalf to any provider would be adjusted based on specific predefined goals for quality. The link to quality is established based on *eligibility* for payment in recognition of quality performance, not actual payment of any quality incentive.

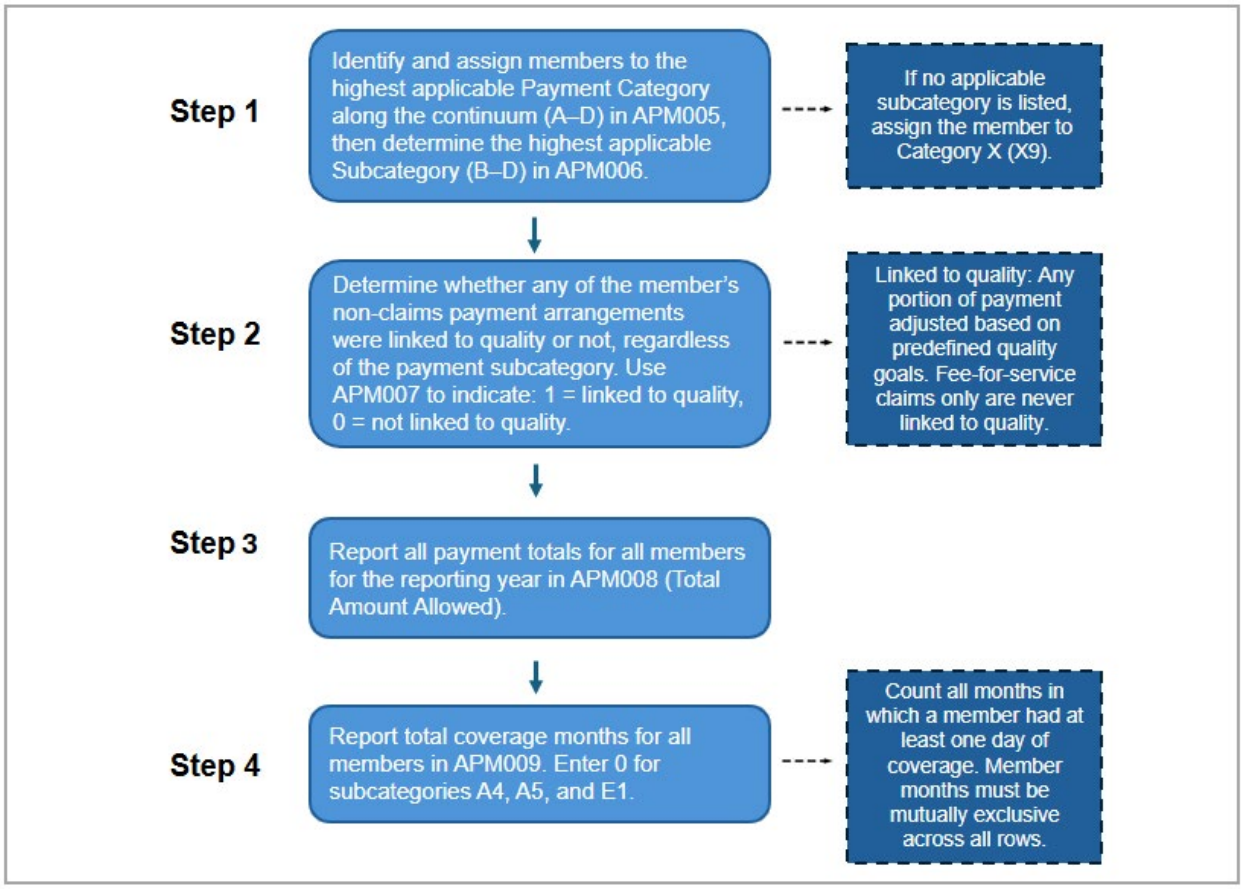
  For example, if a member is attributed to a provider eligible for a pay-for-performance payment (payment subcategory B2) in recognition of quality performance, and also has a professional capitation payment (payment subcategory D2) made on their behalf to any provider that is **not** adjusted based on specific predefined quality goals, then all of the member’s total medical expense and member months should be reported in subcategory D2 and indicated as “linked to quality.”

  Use the Quality Indicator field (APM007) to indicate whether payment arrangements on behalf of a member were linked to quality. Fee-for-service only claims are never considered "linked to quality”; this includes payment arrangements that pay quality-related rewards in the form of an increased claims fee schedule. Data for payment arrangements linked to quality and those that are not linked to quality are reported discretely.

- **Step 3**: Report total medical expense for all members assigned to the payment subcategory, including all claims payments, non-claims payments, and members’ financial responsibility across all providers during the reporting year (*i.e.*, total medical expense) in the Total Amount Allowed field (APM008).

- **Step 4**: Report the total member months in the reporting year for members assigned to the payment subcategory in Member Months (APM009). Report the total number of months of coverage for all members assigned to the payment subcategory, including members with no utilization and/or $0 claims and non-claims expenditures. All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows. Member months shall be reported as zero when Payment Subcategory (APM006) is A4, A5, or E1.

Figure 2. Allocating Member-Level Expenses in the APM File



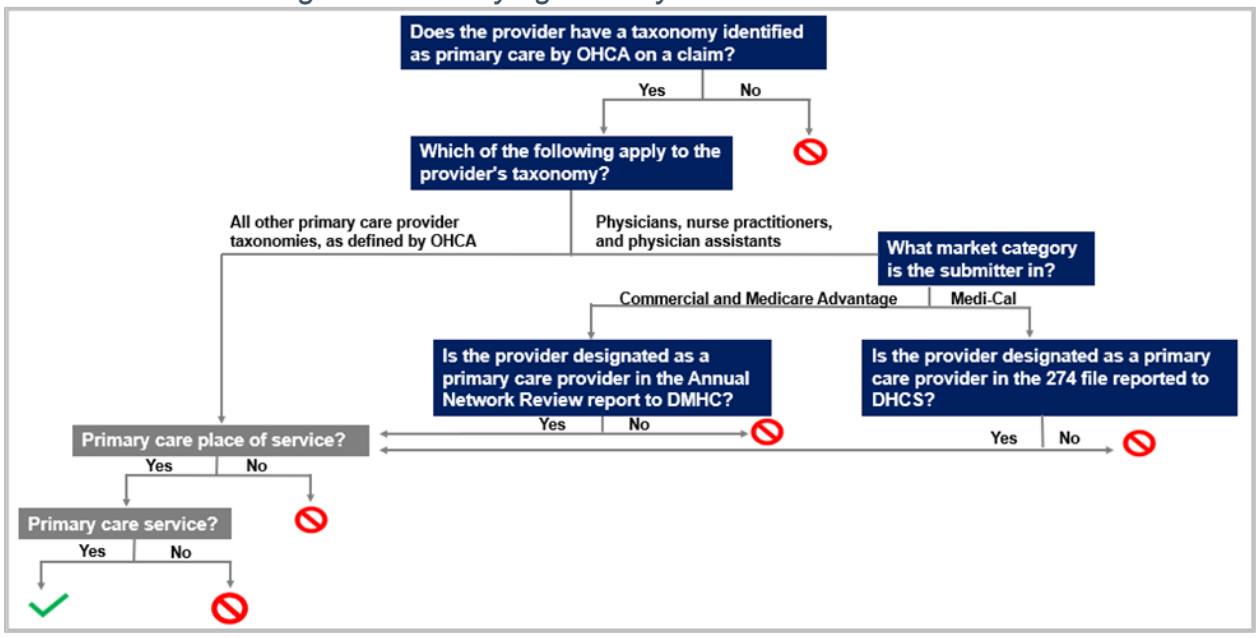
4.9 Primary Care Allocation Methodology

The Primary Care File requires submitters to report the primary care claims and non-claims portion of total medical expense using the methodologies outlined in this section.

4.9.1 Primary Care Paid via Claims

Primary care claims payments are a subset of all professional claims (*i.e.*, the subset of professional claims that meet OHCA's primary care definition). The OHCA Primary Care Addendum defines what spending shall be identified as primary care based on the provider taxonomy, place of service, and service codes included on the claim. Figure 3 below shows the order for identifying primary care paid via claims.

Figure 3. Identifying Primary Care Paid via Claims



- **Step 1**: The first step is to determine whether the claim was rendered by a provider with a taxonomy defined as primary care by OHCA (see OHCA Primary Care Addendum). If the claim was not rendered by a provider with a taxonomy listed in the OHCA Primary Care Addendum, then the claim shall not be included as primary care spending. If the rendering provider has a taxonomy included in the list, proceed to the second step. If the rendering provider field is incomplete, use billing provider's taxonomy. The National Provider Identifier (NPI) shall not be used to identify primary care providers.

- **Step 2**: The second step is based on the provider's taxonomy identified in Step 1:
    - For the Commercial, Medicare Advantage, Dual Eligibles (Medicare Expenses Only) and Dual Eligibles (Medi-Cal and Medicare Expenses) market categories:
        - For physicians, nurse practitioners, and physician assistants (these taxonomies are marked with an asterisk (*) in the OHCA Primary Care Addendum), crosswalk the provider from the claim with the payer's Annual Network Review data submission to the California Department of Managed Health Care (DMHC) for the respective market (*e.g.*, Medicare, Commercial) and product type (*e.g.*, PPO, HMO).
            - If the payer does not have an Annual Network Review submission to DMHC, proceed to Step 3.

- If the provider on the claim is identified as a primary care physician or primary care non-physician medical practitioner (NPMP) in the DMHC Annual Network Review data submission, proceed to Step 3.
- If the provider on the claim is not identified as a primary care physician or practitioner, the claim shall not be included as primary care spending.

▪ For all other primary care provider types as defined by OHCA (*e.g.*, nurses, pharmacists, Federally Qualified Health Center), proceed to Step 3.

○ For the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories:

▪ For physicians, nurse practitioners, and physician assistants (these taxonomies are marked with an asterisk (*) in the OHCA Primary Care Addendum, crosswalk the provider from the claim with the payer's 274 file submitted to the Department of Health Care Services (DHCS). Medi-Cal managed care plans (MCPs) that submit Annual Network Review data to DMHC shall only use the network filings submitted to DHCS in their primary care spending attribution methodology and shall not use data submitted to DMHC. MCPs shall use the monthly 274 file submitted in January for the previous reporting year. For example, the monthly 274 file submitted in January 2025 would be used to attribute primary care spending for the reporting year 2024 and the monthly 274 file submitted in January 2026 would be used to attribute primary care spending for the reporting year 2025.

- If the provider on the claim is identified as a primary care physician or primary care non-physician medical practitioner (NPMP) in the specified DHCS 274 file, proceed to Step 3.
- If the provider on the claim is not identified as a primary care physician or NPMP, the claim shall not be included as primary care spending.

▪ For all other primary care provider types as defined by OHCA (*e.g.*, nurses, pharmacists, Federally Qualified Health Centers), proceed to Step 3.

- **Step 3**: The third step is to determine whether the claim represents a service provided at a care setting that OHCA defines as primary care. The list of place of service codes that OHCA defines as primary care settings can be found in the OHCA Primary Care Addendum. If the place of service code is on the list, proceed to the fourth and final step. If the place of service code is not on the list,

the claim shall not be included as primary care spending.

- **Step 4**: The fourth step confirms whether the service on the claim provided by a primary care provider at a primary care place of service is for a primary care service as defined by OHCA. If the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code on the claim is included in the list of service codes in the OHCA Primary Care Addendum, the claim shall be included in Amount Paid for Primary Care (PRC008). If the claim has a service not included in the list, then the claim shall not be included in Amount Paid for Primary Care (PRC008).
    - UB-04 payments with the facility type code 71 (Clinic, Rural), 73 (Freestanding Clinic), or 77 (Freestanding Provider-Based FQHC) that meet the primary care provider taxonomy and HCPCS/CPT service code requirements shall be included in Amount Paid for Primary Care (PRC008).
    - 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).
        - For claim lines with CPT code 90734 or 90619, for recipients 2 months to 10 years of age, only claim lines with both SK and SL modifiers shall be included in Amount Paid for Primary Care (PRC008).
        - For claim lines with these codes for recipients 11 to 18 years of age, only claim lines with a modifier of SL shall be included in Amount Paid for Primary Care (PRC008).

- **Step 5**: The final step is to report claims spending, including member responsibility, that meets the criteria described in Steps 1 to 4 in Payment Subcategory (PRC006) = X9 (Fee-for-service only) in Amount Paid for Primary Care (PRC008). The Amount Paid for Primary Care (PRC008) is calculated at the claim line level, not the claim level. The entire claim does not need to be identified as primary care spending in accordance with the methodology outlined in Steps 1 through 4 above.

4.9.2 Primary Care Paid via Non-Claims

Submitters shall identify the primary care portion of non-claims payments by payment category and subcategory. Refer to Appendix B: Payment Arrangements and Classification for descriptions of non-claims payments categories and subcategories.

Non-claims payments shall be categorized as primary care based on the purpose of the payment outlined in data submitter and provider organization contracts and the payment subcategory description.

Allocation of payments in subcategories A1, A3, A4, A5, B1, B2, C3, and C4 to behavioral health or primary care must be mutually exclusive. To avoid duplicative reporting of spending in these subcategories, submitters must complete the Primary Care File prior to completing the Behavioral Health File.

Category A. Population Health and Practice Infrastructure Payments

Subcategory A1. Care management/care coordination/population health/medication reconciliation and Subcategory A3. Social care integration

- Identify payments with A in Payment Category (PRC005) and A1 or A3 in Payment Subcategory (PRC006), respectively.
    - Include these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
    - Only include subcategory A1 and A3 payments to multi-specialty practices and health systems as primary care spending in Amount Paid for Primary Care (PRC008) if paid for a primary care program as identified by the payer.

Subcategory A2. Primary care and behavioral health integration

- Identify payments with A in Payment Category (PRC005) and A2 in Payment Subcategory (PRC006).
    - Include all subcategory A2 payments as primary care spending in Amount Paid for Primary Care (PRC008).

Subcategory A4. Practice transformation payments

- Identify payments with A in Payment Category (PRC005) and A4 in Payment Subcategory (PRC006).
    - Include all subcategory A4 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
    - Determine the portion of these payments paid in support of primary care when paid to multi-specialty practices and health systems. Allocate only this portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008).
    - Limit practice transformation payments allocated to primary care under payment subcategory A4 to a maximum of 1% of total medical expense as determined by adding all Total Amount Allowed (PRC007) in the submission.

Subcategory A5. EHR/HIT infrastructure and other data analytics payments

- Identify payments with A in Payment Category (PRC005) and A5 in Payment Subcategory (PRC006).
    - Include all subcategory A5 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
    - Determine the portion of these payments paid in support of primary care when paid to multi-specialty practices and health systems. Allocate only this portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008).
    - Limit EHR/HIT infrastructure and other data analytics payments allocated to primary care under payment subcategory A5 to a maximum of 1% of total medical expense as determined by adding all Total Amount Allowed (PRC007) in the submission.

Category B. Performance Payments

Subcategory B1. Retrospective/prospective incentive payments: pay-for-reporting

- Identify payments with B in Payment Category (PRC005) and B1 in Payment Subcategory (PRC006).
    - Include all subcategory B1 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
    - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to multi-specialty practices and health systems. Limit the portion of pay-for-reporting payments included to only those for patients attributed to primary care providers.

Subcategory B2. Retrospective/prospective incentive payments: pay-for-performance

- Identify payments with B in Payment Category (PRC005) and B2 in Payment Subcategory (PRC006).
    - Include all subcategory B2 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
    - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to multi-specialty practices and health systems. Limit the portion of pay-for-performance payments included to only those for patients attributed to primary care providers.

Category C. Shared Savings Payments and Recoupments

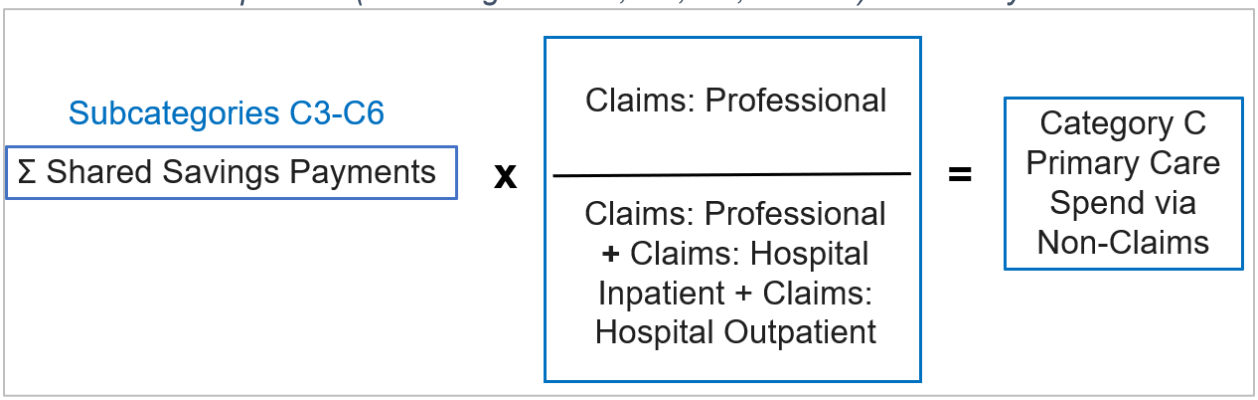
Subcategory C1. Procedure-related, episode-based payments with shared savings and Subcategory C2. Procedure-related, episode-based payments with risk of recoupments

- Report Total Amount Allowed (PRC007) for payments in subcategories C1 and C2, but do not include any portion of these payments in Amount Paid for Primary Care (PRC008).

Subcategory C3. Condition-related, episode-based payments with shared savings, Subcategory C4. Condition-related, episode-based payments with risk of recoupments, Subcategory C5. Risk for total cost of care (e.g., ACO) with shared savings, and Subcategory C6. Risk for total cost of care (e.g., ACO) with risk of recoupments

- Identify payments with C in Payment Category (PRC005) and C3, C4, C5, or C6 in Payment Subcategory (PRC006).
    - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008). Limit the portion of the shared savings (or recoupment) to a maximum of the ratio of Claims: Professional to the sum of Claims: Professional, Claims: Hospital Inpatient, and Claims: Hospital Outpatient multiplied by the shared savings payment as shown in Figure 4 below.

Figure 4. Equation for the Maximum Portion for Allocation of Shared Savings and Recoupments (Subcategories C3, C4, C5, and C6) to Primary Care



Category D. Capitation and Full Risk Payments

There are two amounts that are added together to calculate primary care spending within capitation:

1. All payments for subcategory D1. Primary Care Capitation
2. A portion of payments for subcategories D2. Professional Capitation, D5. Global Capitation, and D6. Payments to Integrated, Comprehensive Payment and Delivery Systems.

Subcategory D1. Primary Care Capitation

- Identify payments with D in Payment Category (PRC005) and D1 in Payment Subcategory (PRC006).
    - Allocate all subcategory D1 payments as primary care spending in Amount Paid for Primary Care (PRC008).

Subcategory D2. Professional Capitation, Subcategory D5. Global Capitation, and Subcategory D6. Payments to Integrated, Comprehensive Payment and Delivery Systems

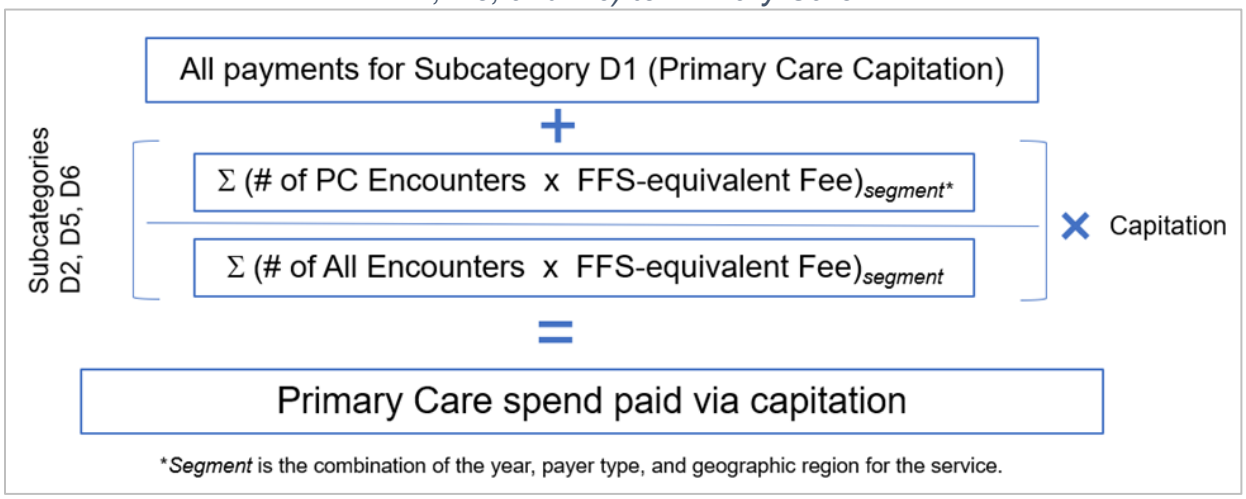
- Identify payments with D in Payment Category (PRC005) and D2, D5, or D6 in Payment Subcategory (PRC006).
    - For subcategories D2, D5, and D6, allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008). For each capitation payment, take the ratio of (a) the sum of primary care encounters within that capitation payment multiplied by their fee-for-service equivalent fee divided by (b) the sum of all encounters within that capitation payment multiplied by their fee-for-service equivalent fee.
        - Encounters included in the numerator sum are those that include a service code from the primary care definition, are provided by a primary care provider taxonomy, and include a primary care place of service code as defined by OHCA (see OHCA Primary Care Addendum).
        - Encounters included in the denominator sum are all encounters included in the relevant capitation payment (*e.g.*, for subcategory D2, all encounters included in professional capitation).
        - The fee-for-service equivalents shall also be for primary care services, delivered by a primary care provider in a primary care place of service, using OHCA's definition.
        - The fee-for-service equivalent fee shall be determined by the submitter and vary by year, market category, and geography (as indicated by “segment” in Figure 5), if appropriate. If the submitter does not have an associated fee-for-service equivalent fee, then they may use the Medicare Physician Fee Schedule if available.[4] If the Medicare Physician Fee Schedule does not have a fee for the HCPCS/CPT service code, then submitters shall use fees for the codes based on Medi-Cal rates.[5]
        - A unique ratio shall be developed for each capitation payment included in a provider contract, and each ratio shall be applied to its

[4] Medicare Physician Fee Schedule can be found at https://www.cms.gov/medicare/physician-fee-schedule/search
[5] Medi-Cal rates can be found at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates

corresponding capitation payment. A single ratio shall not be applied across an entire payment subcategory.

- Next, multiply the ratio by the capitation amount for each respective type of capitation arrangement (*e.g.*, for subcategory D2, the professional capitation amount) as shown in Figure 5 below.

Figure 5. Equation for Allocating Capitation and Full Risk Payments (Subcategories D1, D2, D5, and D6) to Primary Care



Subcategory D3. Facility Capitation and Subcategory D4. Behavioral Health Capitation

- Report Total Amount Allowed (PRC007) for payments in subcategories D3 and D4, but do not include any portion of these payments in Amount Paid for Primary Care (PRC008).

Category E. Other Non-Claims Payments

Report Total Amount Allowed (PRC007) for payments in subcategory E1, but do not include any portion of these payments in Amount Paid for Primary Care (PRC008).

4.9.3 Primary Care Member Months

In the Primary Care file only, member months are not mutually exclusive across the payment subcategories. A given member may have payments in multiple payment subcategories (*e.g.*, professional capitation, subcategory D2, and pay-for-performance, subcategory B2) during any given month, in which case a member month shall be assigned to each subcategory in which payments were made during that month.

In the Primary Care file, member months shall only be reported for the months of coverage during which payment was made on behalf of a member in the corresponding payment subcategory. Months of coverage during which there were no payments for that payment subcategory, even though the member is covered, shall not be reported. If Total Amount Allowed (PRC007) is zero, Member Months (PRC009) shall also be zero.

When Total Amount Allowed (PRC007) is zero and Member Months (PRC009) is zero for a payment subcategory, this payment subcategory is not required to be reported in the Primary Care file.

Member months shall be reported as zero when Payment Subcategory is A4, A5, or E1.

4.10 Behavioral Health Payment Allocation Methodology

The Behavioral Health File requires submitters to report the behavioral health claims and non-claims portion of total medical expense using the methodologies outlined in this section.

4.10.1 Behavioral Health Paid via Claims

Four types of claims are included in behavioral health spending measurement:

1. **Medical Claims *With* a Primary Behavioral Health Diagnosis**: All medical claims with a primary behavioral health diagnosis, as identified in the Diagnosis Codes table of the OHCA Behavioral Health Addendum.
2. **Medical Claims *Without* a Primary Behavioral Health Diagnosis**: Claim lines for behavioral health screening and assessment services, as identified in the identified in the Screening and Assessment Service Codes table of the OHCA Behavioral Health Addendum, regardless of the diagnosis on the claim.
3. ***Medi-Cal* Medical Claims *Without* a Primary Behavioral Health Diagnosis for Members Under 21 Years of Age**: For members under 21 years of age, claim lines for behavioral health services, as identified in the Medi-Cal Only Behavioral Health Services for Members Under 21 table of the OHCA Behavioral Health Addendum, regardless of the diagnosis on the claim. This behavioral health claim type is only applicable to the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories.
4. **Pharmacy Claims for Behavioral Health Treatments**: Pharmacy claims for behavioral health treatments, as identified in the National Drug Codes table of the OHCA Behavioral Health Addendum.

For each claim type, submitters shall follow the steps detailed in the corresponding processes below to identify, designate, and categorize claims to be included in behavioral health spending measurement.

Process 1: Medical Claims *With* a Primary Behavioral Health Diagnosis (see Figure 6)

- **Step 1.1**: Identify all medical claims with a behavioral health primary diagnosis based on the list of International Classification of Diseases, Tenth Revision, (ICD-10) codes provided in the Diagnosis Codes table of the OHCA Behavioral Health Addendum.

- **Step 1.2**: Designate all claims identified in Step 1.1 as either mental health (MH) or substance use disorder (SUD) based on the classification listed for the **primary** diagnosis in the MH/SUD column of the Diagnosis Codes table, in the Diagnosis Category field (BHV007). Do not consider any other diagnoses that may be listed on the claim.

- **Steps 1.3 through 1.11**: To create discrete, mutually exclusive service subcategories, claims identified in Step 1.1 shall be assigned to one service subcategory. Categorize all claims (Steps 1.3 through 1.7) and claim lines (Steps 1.8 through 1.11) designated as MH or SUD in Step 1.2 into service subcategories, as shown in Figure 6, in the Service Subcategories field (BHV008). Claims shall be assigned to one subcategory only, in descending order, as shown in Figure 6 and Steps 1.3 through 1.11. The criteria for categorizing claims into service subcategories are described in the Service Subcategories table of the OHCA Behavioral Health Addendum.
    - **Steps 1.3-1.7: Categorizing Claims**
        - **Step 1.3**: Identify all claims meeting the Inpatient Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize all claim lines for these claims as Inpatient Facility in the Service Subcategories field (BHV008). Do not assign claims assigned to Inpatient Facility to any other Subcategory in Steps 1.4-1.11, even if they also meet criteria for another subcategory.
        - **Step 1.4**: Identify all claims meeting the Emergency Department/ Observation Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize all claim lines for these claims as Emergency Department/Observation Facility in the Service Subcategories field (BHV008). Do not assign claims assigned to Emergency Department/Observation Facility to any other Subcategory in Steps 1.5-1.11, even if they also meet criteria for another subcategory.
        - **Step 1.5**: Identify all claims meeting the Outpatient Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize all claim lines for these claims as Outpatient Facility in the Service Subcategories field (BHV008). Do not assign claims assigned to Outpatient Facility to any other Subcategory in Steps 1.6-1.11, even if they also meet criteria for another subcategory.
        - **Step 1.6**: Identify all claims meeting the Residential Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize all claim lines for these claims as Residential Care in the Service Subcategories field (BHV008). Do

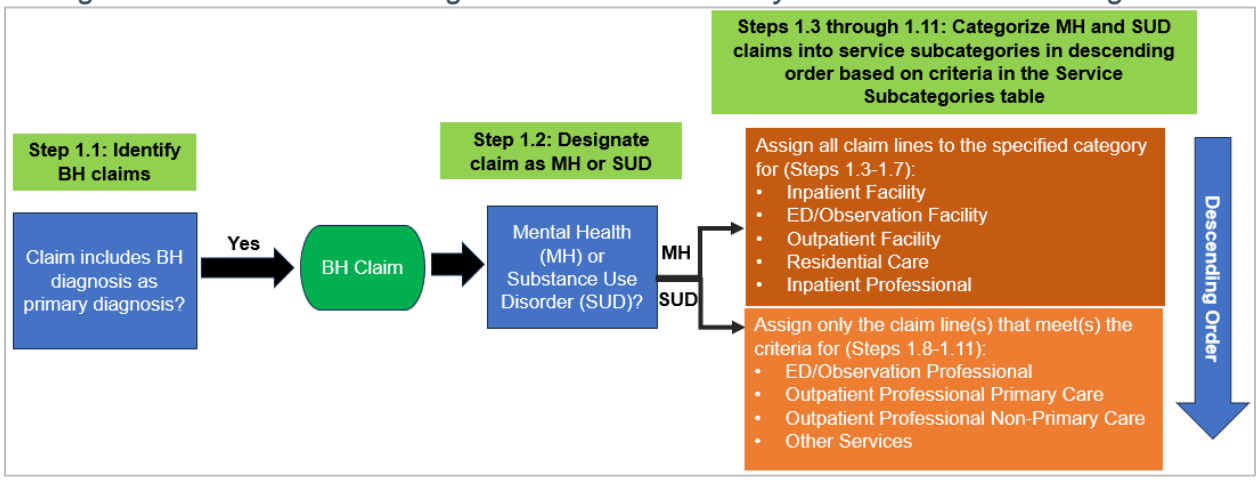
not assign claims assigned to Residential Care to any other Subcategory in Steps 1.7-1.11, even if they also meet criteria for another subcategory.

- **Step 1.7**: Identify all claims meeting the Inpatient Professional criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize all claim lines for these claims as Inpatient Professional in the Service Subcategories field (BHV008). Do not assign claims assigned to Inpatient Professional to any other Subcategory in Steps 1.8-1.11, even if they also meet criteria for another subcategory.

- **Steps 1.8-1.11: Categorizing Claim Lines**
  - **Step 1.8**: Identify all claim lines meeting the Emergency Department/Observation Professional criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Emergency Department/ Observation Professional in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Emergency Department/Observation Professional to any other Subcategory in Steps 1.9-1.11, even if they also meet criteria for another subcategory.
  - **Step 1.9**: Identify all claim lines meeting the Outpatient Professional Primary Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Professional Primary Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Professional Primary Care to any other Subcategory in Steps 1.10-1.11, even if they also meet criteria for another subcategory.
  - **Step 1.10**: Identify all claim lines meeting the Outpatient Professional Non-Primary Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Professional Non-Primary Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Professional Non-Primary Care to any other Subcategory in Step 1.11, even if they also meet criteria for another subcategory.
  - **Step 1.11**: Categorize all claims and claim lines designated as MH or SUD in Step 1.2 that do not meet criteria for any of the subcategories in the Service Subcategories table of the OHCA Behavioral Health Addendum as Other Services in the Service Subcategories field (BHV008).

- **Step 1.12**: Report claims spending, including member responsibility, in separate rows for each unique combination of Diagnosis Category (BHV007) and Service Subcategory (BHV008) in the Amount Paid for Behavioral Health (BHV009).

Figure 6. Process 1: Defining Claims With a Primary Behavioral Health Diagnosis



Process 2: Medical Claims *Without* a Primary Behavioral Health Diagnosis (see Figure 7)

- **Step 2.1**: For claims without a behavioral health primary diagnosis (*i.e.*, all claims not identified as behavioral health in Step 1.1), identify those that include claim lines with HCPCS/CPT codes for screening and assessments for behavioral health conditions, based on the Screening and Assessment Service Codes table of the OHCA Behavioral Health Addendum.

- **Step 2.2**: For claim lines identified in Step 2.1, use the code classification in the OHCA Behavioral Health Addendum (MH/SUD column in the Screening and Assessment Service Codes table) to designate these claim lines as either MH or SUD in the Diagnosis Category field (BHV007).

- **Steps 2.3-2.11**: To create discrete, mutually exclusive service subcategories, claim lines identified in Step 2.1 shall be assigned to one service subcategory. Categorize all claim lines designated as MH or SUD in Step 2.2 into discrete, mutually exclusive service subcategories, as shown in Figure 7, in the Service Subcategory field (BHV008). Claim lines shall be assigned to one subcategory only, in descending order, as shown in Figure 7 and Steps 2.3 through 2.11. The criteria for categorizing claim lines into service subcategories are described in the Service Subcategories table of the OHCA Behavioral Health Addendum.
    - **Step 2.3**: Identify all claim lines meeting the Inpatient Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Inpatient Facility in the Service Subcategories field (BHV008). Do not assign claim lines assigned to

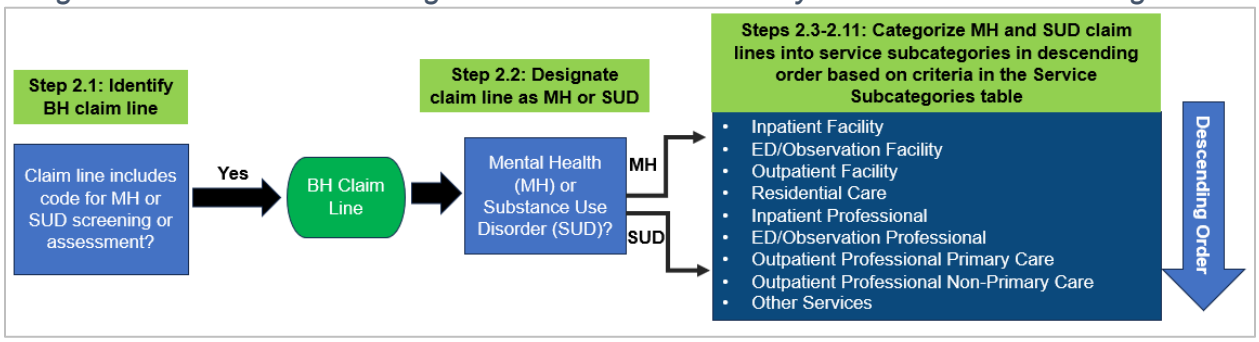
Inpatient Facility to any other Subcategory in Steps 2.4-2.11, even if they also meet criteria for another subcategory.

- **Step 2.4**: Identify all claim lines meeting the Emergency Department/ Observation Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Emergency Department/Observation Facility in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Emergency Department/Observation Facility to any other Subcategory in Steps 2.5-2.11, even if they also meet criteria for another subcategory.
- **Step 2.5**: Identify all claim lines meeting the Outpatient Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Facility in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Facility to any other Subcategory in Steps 2.6-2.11, even if they also meet criteria for another subcategory.
- **Step 2.6**: Identify all claim lines meeting the Residential Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Residential Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Residential Care to any other Subcategory in Steps 2.7-2.11, even if they also meet criteria for another subcategory.
- **Step 2.7**: Identify all claim lines meeting the Inpatient Professional criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Inpatient Professional in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Inpatient Professional to any other Subcategory in Steps 2.8-2.11, even if they also meet criteria for another subcategory.
- **Step 2.8**: Identify all claim lines meeting the Emergency Department/ Observation Professional criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Emergency Department/Observation Professional in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Emergency Department/Observation Professional to any other Subcategory in Steps 2.9-2.11, even if they also meet criteria for another subcategory.
- **Step 2.9**: Identify all claim lines meeting the Outpatient Professional Primary Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Professional Primary Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Professional Primary Care to any other Subcategory in Steps 2.10-2.11, even if they also meet criteria for another subcategory.

- **Step 2.10**: Identify all claim lines meeting the Outpatient Professional Non-Primary Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Professional Non-Primary Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Professional Non-Primary Care to any other Subcategory in Step 2.11, even if they also meet criteria for another subcategory.
- **Step 2.11**: Categorize all claim lines designated as MH or SUD in Step 2.2 that do not meet criteria for any of the subcategories in the Service Subcategories table of the OHCA Behavioral Health Addendum as Other Services in the Service Subcategories field (BHV008).

- **Step 2.12**: Report claim lines spending, including member responsibility, in separate rows for each unique combination of Diagnosis Category (BHV007) and Service Subcategory (BHV008) in the Amount Paid for Behavioral Health (BHV009).

Figure 7. Process 2: Defining Claims Without a Primary Behavioral Health Diagnosis



Process 3: *Medi-Cal* Medical Claims *Without* a Primary Behavioral Health Diagnosis for Members Under 21 Years of Age (see Figure 8)

For Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories only: Follow Steps 3.1-3.12.

For all other market categories: Skip Steps 3.1-3.12. Proceed to Process 4.

- **Step 3.1**: For claims without a behavioral health primary diagnosis (*i.e.*, all claims not identified as behavioral health in Step 1.1), for members under 21 years of age on the date of service, identify claim lines with HCPCS/CPT codes for behavioral health services, based on the Medi-Cal Only Behavioral Health Services for Members Under 21 table of the OHCA Behavioral Health Addendum.

- **Step 3.2**: For claim lines identified in Step 3.1, use the code classification in the OHCA Behavioral Health Addendum (MH/SUD column in the Medi-Cal Only Behavioral Health Services for Members Under 21 table) to designate these

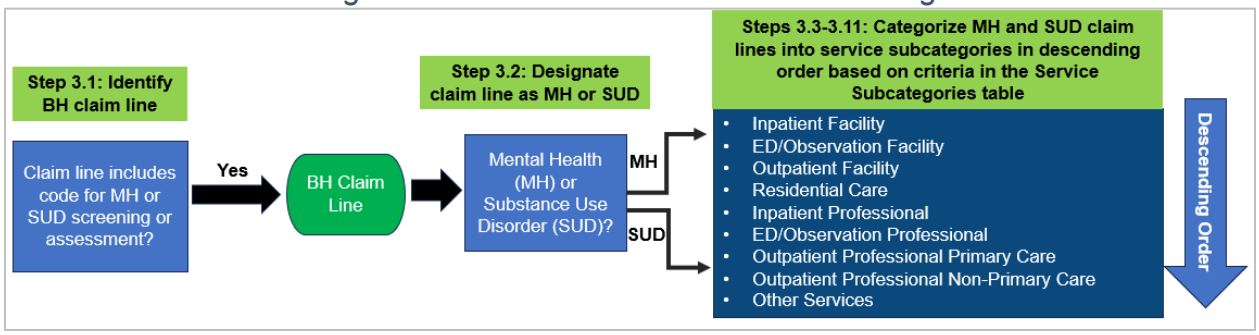
claim lines as either MH or SUD in the Diagnosis Category field (BHV007).

- **Steps 3.3-3.11**: To create discrete, mutually exclusive service subcategories, claim lines identified in Step 3.1 shall be assigned to one service subcategory. Categorize all claim lines designated as MH or SUD in Step 3.2 into discrete, mutually exclusive service subcategories, as shown in Figure 8, in the Service Subcategory field (BHV008). Claim lines shall be assigned to one subcategory only, in descending order, as shown in Figure 8 and Steps 3.3 through 3.11. The criteria for categorizing claim lines into service subcategories are described in the Service Subcategories table of the OHCA Behavioral Health Addendum.
    - **Step 3.3**: Identify all claim lines meeting the Inpatient Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Inpatient Facility in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Inpatient Facility to any other Subcategory in Steps 3.4-3.11, even if they also meet criteria for another subcategory.
    - **Step 3.4**: Identify all claim lines meeting the Emergency Department/ Observation Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Emergency Department/Observation Facility in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Emergency Department/Observation Facility to any other Subcategory in Steps 3.5-3.11, even if they also meet criteria for another subcategory.
    - **Step 3.5**: Identify all claim lines meeting the Outpatient Facility criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Facility in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Facility to any other Subcategory in Steps 3.6-3.11, even if they also meet criteria for another subcategory.
    - **Step 3.6**: Identify all claim lines meeting the Residential Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Residential Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Residential Care to any other Subcategory in Steps 3.7-3.11, even if they also meet criteria for another subcategory.
    - **Step 3.7**: Identify all claim lines meeting the Inpatient Professional criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Inpatient Professional in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Inpatient Professional to any other Subcategory in Steps 3.8-3.11, even if they also meet criteria for another subcategory.

- **Step 3.8**: Identify all claim lines meeting the Emergency Department/ Observation Professional criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Emergency Department/Observation Professional in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Emergency Department/Observation Professional to any other Subcategory in Steps 3.9-3.11, even if they also meet criteria for another subcategory.
- **Step 3.9**: Identify all claim lines meeting the Outpatient Professional Primary Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Professional Primary Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Professional Primary Care to any other Subcategory in Steps 3.10-3.11, even if they also meet criteria for another subcategory.
- **Step 3.10**: Identify all claim lines meeting the Outpatient Professional Non-Primary Care criteria in the Service Subcategories table of the OHCA Behavioral Health Addendum and categorize these claim lines as Outpatient Professional Non-Primary Care in the Service Subcategories field (BHV008). Do not assign claim lines assigned to Outpatient Professional Non-Primary Care to any other Subcategory in Step 3.11, even if they also meet criteria for another subcategory.
- **Step 3.11**: Categorize all claim lines designated as MH or SUD in Step 3.2 that do not meet criteria for any of the subcategories in the Service Subcategories table of the OHCA Behavioral Health Addendum as Other Services in the Service Subcategories field (BHV008).

- **Step 3.12**: Report claim lines spending, including member responsibility, in separate rows for each unique combination of Diagnosis Category (BHV007) and Service Subcategory (BHV008) in the Amount Paid for Behavioral Health (BHV009).

Figure 8. Process 3: Defining Medi-Cal Claims Without a Primary Behavioral Health Diagnosis for Members Under 21 Years of Age



Some service subcategories require multiple codes to be present for the claim line to be included while others do not. The Service Subcategory table of the OHCA Behavioral Health Addendum includes guidance on when a claim line requires a place of service (POS) and/or revenue code **and** a CPT/HCPCS code to be included in the Service Subcategory (BHV008), *e.g.*, Inpatient Professional. The table also includes guidance on when a claim line requires either a place of service (POS) and/or revenue code **or** a CPT/HCPCS code to be included in the Service Subcategory (BHV008), *e.g.*, Residential Care.

Process 4: Pharmacy Claims for Behavioral Health Treatments (see Figure 9)

- **Step 4.1**: For pharmacy claims, submitters shall identify all claims with a prescription drug National Drug Code (NDC) listed in the National Drug Codes table of the OHCA Behavioral Health Addendum. There is no restriction on inclusion of pharmacy claims by diagnosis, only by NDC.

- **Step 4.2**: Designate these claims as either MH or SUD in the Diagnosis Category field (BHV007) based on the classification listed in the MH/SUD Column of the National Drug Codes table of the OHCA Behavioral Health Addendum.

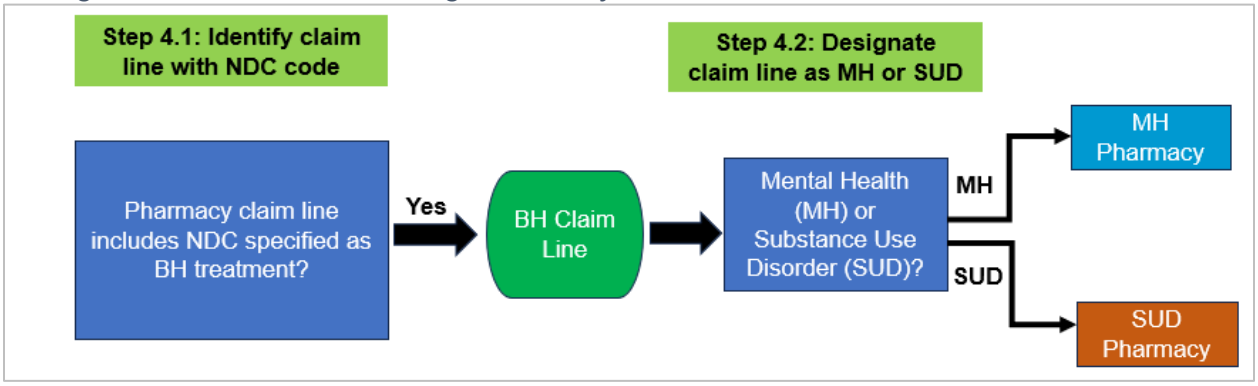
- **Step 4.3**: Categorize claims designated MH in Step 4.2 as MH Pharmacy and claims designated SUD in step 4.2 as SUD Pharmacy, in the Service Subcategory field (BHV008).

- **Step 4.4**: Report pharmacy claims spending, including member responsibility, in separate rows for each unique combination of Diagnosis Category (BHV007) and Service Subcategory (BHV008) in the Amount Paid for Behavioral Health field (BHV009).

For compound drug claims (*i.e.*, claims with multiple NDCs and one payment amount), all NDCs on the claim must be included in the National Drug Codes table of the OHCA Behavioral Health Addendum. Spend for these claims shall be allocated equally to each NDC on the claim and the NDC shall be designated as MH or SUD

based on the MH/SUD column of the National Drug Codes table in the OHCA Behavioral Health Addendum.

Figure 9. Process 4: Defining Pharmacy Claims for Behavioral Health Treatments



4.10.2 Behavioral Health Paid via Non-Claims

Submitters shall identify the behavioral health portion of non-claims payments by payment category and subcategory. Refer to Appendix B: Payment Arrangements and Classification for descriptions of non-claims payments categories and subcategories. Non-claims payments shall be categorized as behavioral health based on the purpose of the payment outlined in data submitter and provider organization contracts and the payment subcategory description.

Allocation of payments in subcategories A1, A3, A4, A5, B1, B2, C3, and C4 to behavioral health or primary care must be mutually exclusive. To avoid duplicative reporting of spending in these subcategories, submitters must complete the Primary Care File prior to completing the Behavioral Health File.

Category A. Population Health and Practice Infrastructure Payments

Subcategory A1. Care management/care coordination/population health/medication reconciliation and Subcategory A3. Social care integration

- Identify payments with A in Payment Category (BHV005) and A1 or A3 in Payment Subcategory (BHV006), respectively.
    - Include these payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009) when paid to a behavioral health provider or provider organization.
    - Subcategory A1 and A3 payments that were reported as Amount Paid for Primary Care (PRC008) in the Primary Care File shall **not** be included in Amount Paid for Behavioral Health (BHV009).

Subcategory A2. Primary care and behavioral health integration

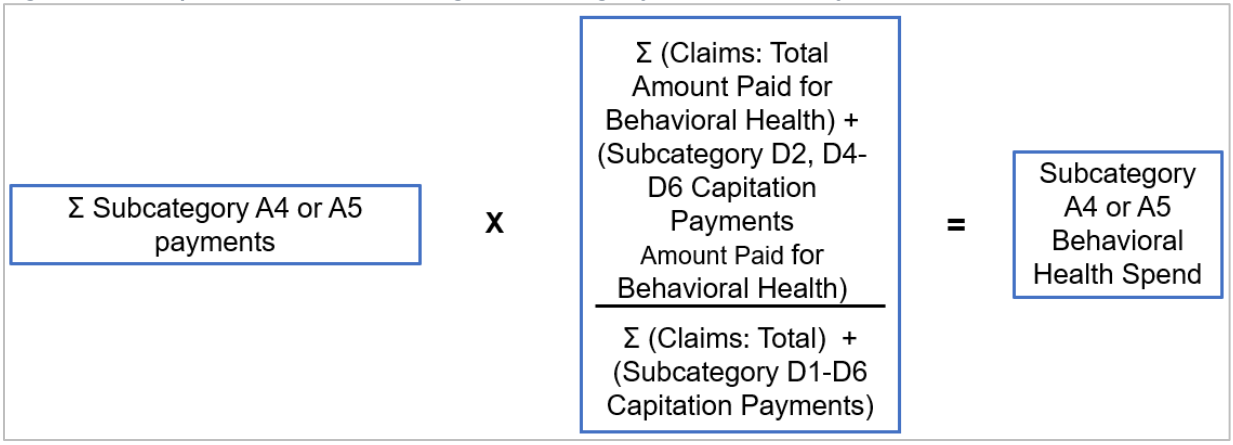
- Identify payments with A in Payment Category (BHV005) and A2 in Payment Subcategory (BHV006).

- Allocate all subcategory A2 payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009).
- Subcategory A2 payments shall be reported as **both** Amount Paid for Primary Care (PRC008) in the Primary Care File and Amount Paid for Behavioral Health (BHV009).

Subcategory A4. Practice transformation payments and Subcategory A5. EHR/HIT infrastructure and other data analytics payments

- Identify payments with A in Payment Category (BHV005) and A4 or A5 in Payment Subcategory (BHV006).
  - Allocate only a portion of these payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009). For this allocation, determine the portion of these payments paid in support of behavioral health. Limit the portion of payments allocated to behavioral health to a maximum of the ratio of the sum of total behavioral health claims and capitation payments to the sum of total claims and capitation payments as shown in Figure 10 below.
  - Subcategory A4 and A5 payments that were reported as Amount Paid for Primary Care (PRC008) in the Primary Care File shall **not** be included in Amount Paid for Behavioral Health (BHV009).

Figure 10. Equation for Allocating Subcategory A4 or A5 Payments to Behavioral Health



Category B. Performance Payments

Subcategory B1. Retrospective/prospective incentive payments: pay-for-reporting and Subcategory B2. Retrospective/prospective incentive payments: pay-for-performance

- Identify payments with B in Payment Category (BHV005) and B1 or B2 in Payment Subcategory (BHV006), respectively.
  - Include all of these payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009) when paid to a behavioral health provider or provider organization.

- Subcategory B1 and B2 payments that were reported as Amount Paid for Primary Care (PRC008) in the Primary Care File shall **not** be included in Amount Paid for Behavioral Health (BHV009).

Category C. Shared Savings Payments and Recoupments

Subcategory C1. Procedure-related, episode-based payments with shared savings, Subcategory C2. Procedure-related, episode-based payments with risk of recoupments, Subcategory C5. Risk for total cost of care (e.g., ACO) with shared savings, and Subcategory C6. Risk for total cost of care (e.g., ACO) with risk of recoupments

- Do **not** allocate payments in subcategories C1, C2, C5, or C6 to behavioral health spending.

Subcategory C3. Condition-related, episode-based payments with shared savings, Subcategory C4. Condition-related, episode-based payments with risk of recoupments

- Identify payments with C in Payment Category (BHV005) and C3 or C4 in Payment Subcategory (BHV006), respectively.
  - Allocate only spending for service bundles for behavioral health-related episodes of care shared savings or recoupment arrangements in submitter contracts with providers as behavioral health spending in Amount Paid for Behavioral Health (BHV009).
  - Subcategory C3 and C4 payments that were reported as Amount Paid for Primary Care (PRC008) in the Primary Care File shall **not** be included in Amount Paid for Behavioral Health (BHV009).

Category D. Capitation and Full Risk Payments

There are two amounts that are added together to calculate behavioral health spending within capitation:

1. All payments for subcategory D4. Behavioral Health Capitation
2. A portion of payments for subcategories D2. Professional Capitation, D5. Global Capitation, and D6. Payments to Integrated, Comprehensive Payment and Delivery Systems.

Subcategory D1. Primary Care Capitation and Subcategory D3. Facility Capitation

- Do **not** allocate payments in subcategory D1 or D3 to behavioral health spending.

Subcategory D4. Behavioral Health Capitation

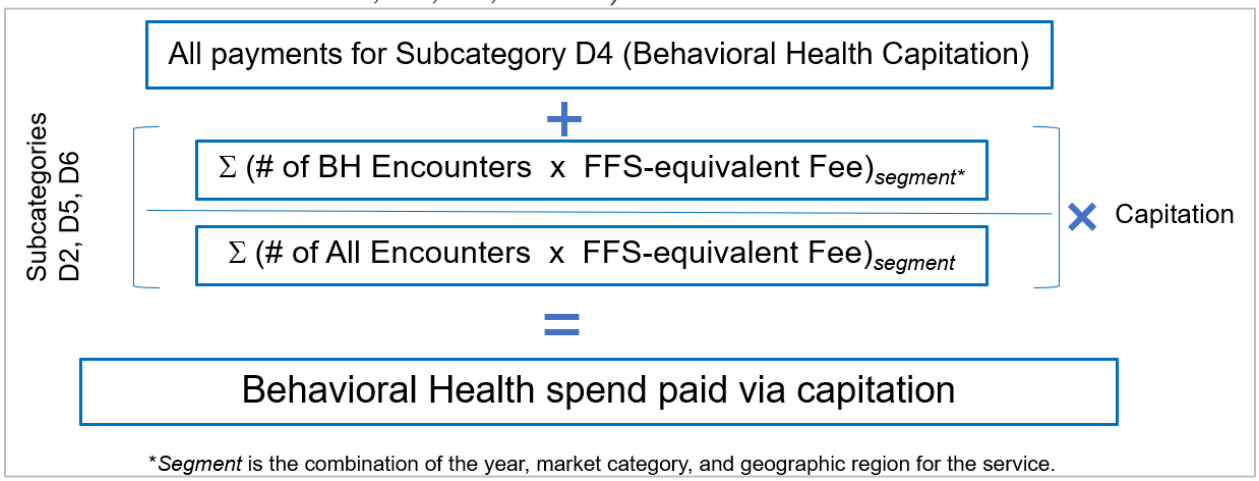
- Identify payments with D in Payment Category (BHV005) and D4 in Payment Subcategory (BHV006).
  - Allocate all subcategory D4 payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009).

Subcategory D2. Professional Capitation, Subcategory D5. Global Capitation, and Subcategory D6. Payments to Integrated, Comprehensive Payment and Delivery Systems

- Identify payments with D in Payment Category (BHV005) and D2, D5, or D6 in Payment Subcategory (BHV006), respectively.
    - For subcategories D2, D5, and D6, allocate only a portion of these payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009). For each capitation payment, take the ratio of (a) the sum of encounters with a behavioral health primary diagnosis included in the Diagnosis Codes table of the OHCA Behavioral Health Addendum multiplied by their fee-for-service equivalent fee divided by (b) the sum of all encounters within that capitation payment multiplied by their fee-for-service equivalent fee.
        - Encounters included in the numerator sum are those that include an ICD-10 diagnosis code defined as behavioral health by OHCA.
        - Encounters included in the denominator sum are all encounters included in the relevant capitation payment (*e.g.*, for subcategory D2, all encounters included in the professional capitation).
        - The fee-for-service equivalent fee shall be determined by the submitter based on the care setting included on the encounter and will vary by year, market category, and geography (as indicated by "segment" in Figure 11), if appropriate. If the submitter does not have an associated fee-for-service equivalent fee, then they may use the Medicare Physician Fee Schedule if available.[6] If the Medicare Physician Fee Schedule does not have a fee for the HCPCS/CPT service code, then submitters shall use fees for the codes based on Medi-Cal rates.[7]
- A unique ratio shall be developed for each capitation payment included in a provider contract, and each ratio shall be applied to its corresponding capitation payment. A single ratio shall not be applied across an entire payment subcategory.
- Next, multiply the ratio by the capitation amount for each respective type of capitation arrangement (*e.g.*, for subcategory D2, the professional capitation amount) as shown in Figure 11 below.

[6] Medicare Physician Fee Schedule can be found at https://www.cms.gov/medicare/physician-fee-schedule/search
[7] Medi-Cal rates can be found at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates

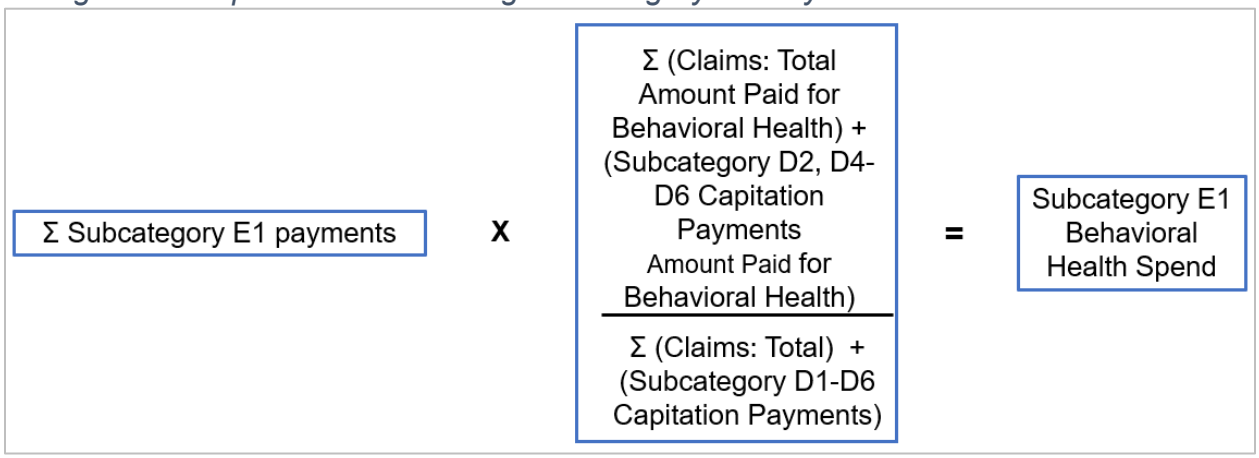
Figure 11. Equation for Allocating Capitation and Full Risk Payments (Subcategories D2, D4, D5, and D6) to Behavioral Health



Category E. Other Non-Claims Payments

- Identify payments with E in Payment Category (BHV005) and E1 in Payment Subcategory (BHV006).
    - Allocate only a portion of these payments as behavioral health spending in Amount Paid for Behavioral Health (BHV009). For this allocation, determine the portion of these payments paid in support of behavioral health. Limit the portion of payments allocated to behavioral health to a maximum of the ratio of the sum of total behavioral health claims and capitation payments to the sum of total claims and capitation payments as shown in Figure 12.

Figure 12. Equation for Allocating Subcategory E1 Payments to Behavioral Health



5 File Layouts and Field Specifications

5.1 Header Record

Col. #	Field ID	Field Name	Type	Max	Description
1	HD001	Record Type	Text	2	This field must be coded 'HD' to indicate the start of the header record.
2	HD002	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
3	HD003	File Type	Text	3	Use this field to report the code that indicates the type of data being submitted. The only valid codes for this field are: • SWT = Statewide TME • ATT = Attributed TME • RET = Regional TME • RXR = Pharmacy Rebates • SQS = Submission Questionnaire • APM = Alternative Payment Model • PRC = Primary Care • BHV = Behavioral Health
4	HD004	Period Beginning Date	Integer	6	Use this field to report the earliest reporting year year/month included in the submission in YYYYMM format.
5	HD005	Period Ending Date	Integer	6	Use this field to report the latest reporting year year/month included in the submission in YYYYMM format.
6	HD006	Test File Flag	Text	1	Use this field to report whether this submission is a test or production submission. The only valid codes for this field are: • T = Test • P = Production
7	HD007	Comments	Text	50	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.
8	HD008	Guide Version Number	Decimal	2,1	This field is used to report the THCE Data Submission Guide version used for reporting data. The version number is found on the title page of the document (*e.g.*, 1.1 or 2.0).

5.2 Trailer Record

Col. #	Field ID	Field Name	Type	Max	Description
1	TR001	Record Type	Text	2	This field must be coded 'TR' to indicate the start of the trailer record.
2	TR002	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
3	TR003	File Type	Text	3	Use this field to report the code that indicates the type of data being submitted. The only valid codes for this field are: • SWT = Statewide TME • ATT = Attributed TME • RET = Regional TME • RXR = Pharmacy Rebates • SQS = Submission Questionnaire • APM = Alternative Payment Model • PRC = Primary Care • BHV = Behavioral Health
4	TR004	Extraction Date	Date	8	Use this field to report the date on which the file was created in YYYYMMDD format.
5	TR005	Record Count	Integer	10	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count shall not include the header and trailer records.

5.3 Statewide TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	SWT001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	SWT002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	SWT003	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)

Col. #	Field ID	Field Name	Type	Max	Description
					• 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	SWT004	Product Type	Integer	1	Use this field to designate the product type. Refer to Product Types for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) only (Market Category = 1 or 2), valid values include: • 1 = Fully insured HMO/POS • 2 = Fully insured PPO/EPO • 3 = Other fully insured products • 4 = Self-Insured products, regardless of benefit design For all other Market Categories, regardless of product type, valid value includes: • 0 = Not applicable
5	SWT005	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows. **Note**: This field reported as an integer.
6	SWT006	Claims: Hospital Inpatient	Integer	12	Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include

Col. #	Field ID	Field Name	Type	Max	Description
					physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
7	SWT007	Claims: Hospital Outpatient	Integer	12	Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
8	SWT008	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
9	SWT009	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities,

Col. #	Field ID	Field Name	Type	Max	Description
					residential facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
10	SWT010	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This amount excludes pharmacy rebates. This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
11	SWT011	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
12	SWT012	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (SWT006 through SWT011). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
13	SWT013	Member Responsibility (Claims)	Integer	12	Report the total member responsibility portion (*i.e.*, copay, coinsurance, and deductible) of claims for all members for the reporting year. Include all amounts not paid by the primary

Col. #	Field ID	Field Name	Type	Max	Description
					payer. Include member responsibility amounts from claims paid by the submitter across all categories (SWT006 through SWT011). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
14	SWT014	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
15	SWT015	Member Responsibility (Capitation)	Integer	12	Report the total member responsibility amount (*i.e.*, copay, coinsurance, and deductible) for all members covered by capitation payments for the reporting year. Include all amounts not paid by the primary payer. **Note**: The member responsibility amount shall not have been included in the amount reported in Capitation and Full Risk Payments (SWT014). This is a money field reported in whole dollars. This field may contain a negative value.
16	SWT016	Non-Claims: Population Health and Practice Infrastructure Payments	Integer	12	Report the total amount of prospective, non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. Do not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
17	SWT017	Non-Claims: Performance Payments	Integer	12	Report the total amount of non-claims bonus payments paid to health care providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
18	SWT018	Non-Claims: Shared Savings Payments and Recoupments	Integer	12	Report the net total amount of non-claims payments to health care providers or organizations (or recouped from health care providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care.

Col. #	Field ID	Field Name	Type	Max	Description
					Dollars reported in this category shall reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
19	SWT019	Non-Claims: Other	Integer	12	Report any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
20	SWT020	Standard Deviation	Decimal	12,5	Report the standard deviation of the total claims spending for the members included in this record for the reporting year. Report up to 5 decimal places (*e.g.*, 1234.56789). Refer to the Standard Deviation instructions for more information. **Note**: The same value shall be reported for all rows with the same Reporting Year (SWT002) and Market Category (SWT003) combination.
21	SWT898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
22	SWT899	Record Type	Text	3	Use this field to report the value of 'SWT' to indicate TME reporting at the statewide level.

5.4 Attributed TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	ATT001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	ATT002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	ATT003	Organization Code	Text	4	Use this field to report the unique Organization Code provided by OHCA. Refer to the OHCA Attribution Addendum for valid values.

Col. #	Field ID	Field Name	Type	Max	Description
					Note: To report records for other physician organizations with at least 1,000 attributed members, use code '7777'. To report records for members that cannot be attributed, use code '9999'.
4	ATT004	Organization Name	Text	80	Use this field to report the full legal name of the physician organization. **Note**: Leave blank if Organization Code (ATT003) is '9999'.
5	ATT005	Organization Taxpayer Identification Number	Integer	9	Use this field to report the nine-digit Taxpayer Identification Number (TIN) associated with the physician organization identified in Organization Name (ATT004). Do not include a hyphen. **Note**: Leave blank if Organization Code (ATT003) is '9999'.
6	ATT006	Organization National Provider Identifier	Integer	10	Use this field to report the ten-digit organizational, or Type 2, National Provider Identifier (NPI) associated with the physician organization identified in Organization Name (ATT004). **Note**: Leave blank if Organization Code (ATT003) is '9999'.
7	ATT007	Attribution Method	Integer	1	Use this field to report the method as to how these members were attributed. Valid values include: • 1 = Capitated, Delegated Arrangement • 2 = ACO Arrangement • 3 = Payer-Developed Attribution • 4 = Not Attributed **Note**: When Organization Code (ATT003) is reported as '9999' this field shall be reported as '4' (Not Attributed). Refer to the Member Attribution in the Attributed TME File instructions for more information.
8	ATT008	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

Col. #	Field ID	Field Name	Type	Max	Description
					• 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.
9	ATT009	Age Band (in Years)	Integer	1	Use this field to report the appropriate age band (in years) of the members. Age band is assigned based on the age of the member on the last day of the reporting year (December 31st). Valid values include: • 1 = 0-1 • 2 = 2-18 • 3 = 19-39 • 4 = 40-54 • 5 = 55-64 • 6 = 65-74 • 7 = 75-84 • 8 = 85+ In very rare circumstances, a submitter may not have access to the member's age. In that scenario, report claims and/or capitation payments using Age Band '9' (Unknown) and enter a response to the Unknown Age Band question (SQS017) in the Submission Questionnaire file. For reporting non-claims payments only (ATT022 through ATT025), valid value includes: • 0 = Not applicable
10	ATT010	Sex	Text	1	Use this field to report the member's sex as reported by the member. Valid values include: • F = Female • M = Male • U = Unknown or Other

Col. #	Field ID	Field Name	Type	Max	Description
					For reporting non-claims payments only (ATT022 through ATT025), valid value includes: • X = Not applicable
11	ATT011	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows. **Note**: This field reported as an integer. When Age Band (in Years) (ATT009) is '0' and Sex (ATT010) is 'X', Member Months shall be 0.
12	ATT012	Claims: Hospital Inpatient	Integer	12	Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
13	ATT013	Claims: Hospital Outpatient	Integer	12	Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
14	ATT014	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
15	ATT015	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
16	ATT016	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This amount excludes pharmacy rebates. This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting).

Col. #	Field ID	Field Name	Type	Max	Description
					Note: This is a money field reported in whole dollars. This field may contain a negative value.
17	ATT017	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
18	ATT018	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (ATT012 through ATT017). **Note**: This is a money field reported in whole dollars. This field may contain a negative value. When Age Band (in Years) (ATT009) is '0' and Sex (ATT010) is 'X', Claims: Total shall be 0.
19	ATT019	Member Responsibility (Claims)	Integer	12	Report the total member responsibility portion (*i.e.*, copay, coinsurance, and deductible) of claims for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims paid by the submitter across all categories (ATT012 through ATT017). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
20	ATT020	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
21	ATT021	Member Responsibility (Capitation)	Integer	12	Report the total member responsibility amount (*i.e.*, copay, coinsurance, and deductible) for all members covered by capitation payments for the reporting year. Include all amounts not paid by the primary payer.

Col. #	Field ID	Field Name	Type	Max	Description
					Note: The member responsibility amount shall not have been included in the amount reported in Capitation and Full Risk Payments (ATT020). This is a money field reported in whole dollars. This field may contain a negative value.
22	ATT022	Non-Claims: Population Health and Practice Infrastructure Payments	Integer	12	Report the total amount of prospective, non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. Do not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
23	ATT023	Non-Claims: Performance Payments	Integer	12	Report the total amount of non-claims bonus payments paid to health care providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
24	ATT024	Non-Claims: Shared Savings Payments and Recoupments	Integer	12	Report the net total amount of non-claims payments to health care providers or organizations (or recouped from health care providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category shall reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
25	ATT025	Non-Claims: Other	Integer	12	Report any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
26	ATT026	Standard Deviation	Decimal	12,5	Report the standard deviation of the total claims spending for the members included in this record for the reporting year. Report up to 5 decimal places (*e.g.*, 1234.56789). Refer to the Standard Deviation instructions for more information.

Col. #	Field ID	Field Name	Type	Max	Description
					Note: The same value shall be reported for all rows with the same Reporting Year (ATT002), Organization Code (ATT003), and Market Category (ATT008) combination.
27	ATT898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
28	ATT899	Record Type	Text	3	Use this field to report the value of 'ATT' to indicate TME reporting at the attributed organization level.

5.5 Regional TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	RET001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	RET002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	RET003	Region	Text	4	Use this field to report the Rating Region of the member's residence address. Refer to Appendix C: Regions for a list of valid values. **Note**: Report TME for any members whose residence address cannot be assigned to a region using 'RR99' (Unspecified Region).
4	RET004	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.

Col. #	Field ID	Field Name	Type	Max	Description
5	RET005	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows. **Note**: This field reported as an integer.
6	RET006	Claims: Hospital Inpatient	Integer	12	Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
7	RET007	Claims: Hospital Outpatient	Integer	12	Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
8	RET008	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible).

Col. #	Field ID	Field Name	Type	Max	Description
					This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
9	RET009	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
10	RET010	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This amount excludes pharmacy rebates. This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
11	RET011	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year.

Col. #	Field ID	Field Name	Type	Max	Description
					Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
12	RET012	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (RET006 through RET011). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
13	RET013	Member Responsibility (Claims)	Integer	12	Report the total member responsibility portion (*i.e.*, copay, coinsurance, and deductible) of claims for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims paid by the submitter across all categories (RET006 through RET011). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
14	RET014	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
15	RET015	Member Responsibility (Capitation)	Integer	12	Report the total member responsibility amount (*i.e.*, copay, coinsurance, and deductible) for all members covered by capitation payments for the reporting year. Include all amounts not paid by the primary payer. **Note**: The member responsibility amount shall not have been included in the amount reported in Capitation and Full Risk Payments (RET014). This is a money field reported in whole dollars. This field may contain a negative value.
16	RET898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
17	RET899	Record Type	Text	3	Use this field to report the value of 'RET' to indicate TME reporting at the regional level.

5.6 Pharmacy Rebates File

Col. #	Field ID	Field Name	Type	Max	Description
1	RXR001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	RXR002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	RXR003	Market Category	Integer	1	Use this field to report the market category code. 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	RXR004	Medical Pharmacy Rebate Amount	Integer	12	Report the total amount of rebates for drugs covered under the members' medical benefit for the reporting year. For the Commercial (Partial Benefits) market category, if pharmacy benefits are carved out, create a reasonable estimate of pharmacy rebates. For all other market categories, report only actual amounts; do not include estimates. Report pharmacy rebates as a positive number. **Note**: This is a money field reported in whole dollars.
5	RXR005	Retail Pharmacy Rebate Amount	Integer	12	Report the total amount of rebates for drugs covered under the members' retail pharmacy benefit for the reporting year. For the Commercial (Partial Benefits) market category, if pharmacy benefits are carved out, create a reasonable estimate of pharmacy rebates. For all other market categories, report only actual amounts; do not include estimates. Report pharmacy rebates as a positive number. **Note**: This is a money field reported in whole dollars.
6	RXR006	Total Pharmacy Rebate Amount	Integer	12	Report the total amount of pharmacy rebates for the reporting year. For the Commercial (Partial Benefits) market category, if pharmacy benefits are carved out, create a reasonable

Col. #	Field ID	Field Name	Type	Max	Description
					estimate of pharmacy rebates. For all other market categories, report only actual amounts; do not include estimates. This amount shall equal the sum of all reported rebate amounts (RXR004 through RXR005). **Note**: This is a money field reported in whole dollars.
7	RXR898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
8	RXR899	Record Type	Text	3	Use this field to report the value of 'RXR' to indicate reporting pharmacy rebates.

5.7 Submission Questionnaire File

Col. #	Field ID	Field Name	Type	Max	Description
1	SQS001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	SQS002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	SQS003	CA Residents Only	Text	1	Does the spending data include California residents only? Valid values include: • Y = Yes • N = No
4	SQS004	Members	Text	1	Does the spending data represent members in a full-service health care service plan, specialized mental health care service plan, health insurance plan, or specialized behavioral health-only policy? Valid values include: • Y = Yes • N = No
5	SQS005	Primary Payer	Text	1	Does the spending data only include members for whom the payer or fully integrated delivery system is primary payer on the claim? Valid values include: • Y = Yes • N = No
6	SQS006	Allowed Amounts	Text	1	Does the claims spending data include allowed amounts? Valid values include: • Y = Yes • N = No

Col. #	Field ID	Field Name	Type	Max	Description
7	SQS007	Attribution	Text	1	Does the spending data include all data for all attributed members for each month a member was attributed? Valid values include: • Y = Yes • N = No
8	SQS008	Attribution Methodology	Text	500	Briefly describe the approach used to attribute members in the Payer-Developed Attribution method.
9	SQS009	Date Incurred or Served	Text	1	Are spending data submitted based on the incurred date or date of service? Valid values include: • Y = Yes • N = No
10	SQS010	Claims Runout	Date	8	For claims runout, what is the maximum payment date for claims payments? Format = YYYYMMDD
11	SQS011	Non-Claims Runout	Date	8	For non-claims runout, what is the maximum payment date for non-claims payments? Format = YYYYMMDD
12	SQS012	IBNR IBNP	Text	1	Are spending data reported without IBNR/IBNP factors applied? Valid values include: • Y = Yes • N = No
13	SQS013	Pharmacy Rebates	Text	1	Are pharmacy rebate data actuals, without estimates? This question does not apply to data submitted in the Commercial (Partial Benefits) market category. Valid values include: • Y = Yes • N = No
14	SQS014	Standard Deviation	Text	1	Is the standard deviation calculated using the formula for population standard deviation? Valid values include: • Y = Yes • N = No
15	SQS015	Standard Deviation Members	Text	1	In calculating standard deviation, is spending included for every month the member was attributed, regardless of whether the member has paid claims? Valid values include: • Y = Yes • N = No

Col. #	Field ID	Field Name	Type	Max	Description
16	SQS016	Standard Deviation Non-Claims Excluded	Text	1	Does the standard deviation data exclude non-claims spending? Valid values include: • Y = Yes • N = No
17	SQS017	Unknown Age Band	Text	500	Briefly describe why you do not have access to the member age. This field is required when the value in Age Band (in Years) (ATT009) in the Attributed TME File is '9'.
18	SQS018	Estimated Pharmacy Spending	Integer	12	Report the total estimated amount for carved-out pharmacy spending within the Commercial (Partial Benefits) market category. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
19	SQS019	Estimated Behavioral Health Spending	Integer	12	Report the total estimated amount for carved-out behavioral health spending within the Commercial (Partial Benefits) market category. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
20	SQS020	Estimated Other Spending	Integer	12	Report the total estimated amount for other (non-pharmacy and non-behavioral health) carved-out benefits within the Commercial (Partial Benefits) market category. Describe the benefits that have been estimated in your response to Estimate Methodology (SQS021). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
21	SQS021	Estimate Methodology	Text	500	Briefly describe the methodology used to estimate spend in the Commercial (Partial Benefits) market category.
22	SQS022	Self-Insured Plans	Text	1	Does the submission include spending data from self-insured accounts? Valid values include: • Y = Yes • N = No
23	SQS023	Administrative Costs and Profits for Self-Insured Plans	Integer	12	Report aggregate information on the fees earned from self-insured accounts (*e.g.*, "fees from uninsured plans"). Submitters shall follow the instructions for Part 1, Line 12 on the NAIC SHCE for their California-situs self-insured accounts. This field is required when the value in Self-Insured Plans (SQS022) is 'Y'. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
24	SQS024	Procedure and Condition-Specific Episode-based Payment Arrangements	Text	500	List the types of procedure and condition-specific episode-based payment arrangements in place with providers during the reporting year. Use Appendix D: Condition and Procedure Types as a reference to categorize and describe the type of arrangement. This field is required when amounts are reported in the Primary Care File for Payment Subcategory (PRC006) C1, C2, C3, or C4.
25	SQS025	Other Product Type	Text	500	Briefly describe the types of products that could not otherwise be classified as HMO/POS or PPO/EPO in the Statewide TME, APM, Primary Care, and Behavioral Health files.
26	SQS897	Attestation	Text	50	By typing your name in this field, you certify under penalty of perjury under the laws of the State of California that the information provided in your organization's file submission is true and correct to the best of your knowledge.
27	SQS898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
28	SQS899	Record Type	Text	3	Use this field to report the value of 'SQS' to indicate submission questionnaire responses.

5.8 Alternative Payment Model (APM) File

Col. #	Field ID	Field Name	Type	Max	Description
1	APM001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	APM002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	APM003	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)

Col. #	Field ID	Field Name	Type	Max	Description
					Note: The Market Category(ies) selected at registration must match the contents of the data submission.
4	APM004	Product Type	Integer	1	Use this field to designate the product type. Refer to Product Types for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) only (Market Category = 1 or 2), valid values include: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For all other Market Categories, regardless of product type, valid value includes: • 0 = Not applicable
5	APM005	Payment Category	Text	1	Use this field to report the payment category. Refer to Appendix B: Payment Arrangements and Classification 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 **Note**: This field shall correspond to a Payment Subcategory (APM006) that begins with the same character.
6	APM006	Payment Subcategory	Text	2	Use this field to report the payment subcategory based on the initial character in Payment Category (APM005). Refer to Appendix B: Payment Arrangements and Classification 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

Col. #	Field ID	Field Name	Type	Max	Description
					• 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 = Fee-for-service only
7	APM007	Quality Indicator	Integer	1	This field indicates when payment arrangements reported are linked to quality. Submitters will provide data on arrangements linked to quality and those that are not for each Payment Subcategory in APM006. Payment arrangements are considered “linked to quality” if any non-claims payments made on their behalf to any provider would be adjusted based on specific predefined goals for quality. For example, if a member is attributed to a provider organization eligible for a pay-for-performance payment in addition to a shared savings or capitation payment, then the payment would be considered “linked to quality.” Refer to APM File Payment Allocation for more information. Valid values are: • 0 = No • 1 = Yes

Col. #	Field ID	Field Name	Type	Max	Description
					Note: When Payment Subcategory (APM006) is X9, Quality Indicator shall be '0'.
8	APM008	Total Amount Allowed	Integer	12	Report the total of all payments, including all claims payments, non-claims payments, and members' financial responsibility made across all providers during the reporting year (*i.e.*, total medical expense). For non-claims payments, this is the amount paid by the payer or fully integrated delivery system across providers. For fee-for-service claims, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). For capitation, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **The methodology for determining the amount to report in the Total Amount Allowed (APM008) field in each row of the APM file is different from all other files.** Refer to APM File Payment Allocation for the details of this methodology. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
9	APM009	Member Months	Integer	12	Report the total number of months of coverage for members in the arrangement indicated in Payment Category (APM005) and Payment Subcategory (APM006). All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows. **Note**: This field reported as an integer. When Payment Subcategory (APM006) is A4, A5, or E1, Member Months shall be 0.
10	APM898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.

Col. #	Field ID	Field Name	Type	Max	Description
11	APM899	Record Type	Text	3	Use this field to report the value of 'APM' to indicate APM reporting at the submitter level.

5.9 Primary Care File

Col. #	Field ID	Field Name	Type	Max	Description
1	PRC001	Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	PRC002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	PRC003	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.

Col. #	Field ID	Field Name	Type	Max	Description
4	PRC004	Product Type	Integer	1	Use this field to designate the product type. Refer to Product Types for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) only (Market Category = 1 or 2), valid values include: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For all other Market Categories, regardless of product type, valid value includes: • 0 = Not applicable
5	PRC005	Payment Category	Text	1	Use this field to report the payment category. Refer to Appendix B: Payment Arrangements and Classification 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 **Note**: This field shall correspond to a Payment Subcategory (PRC006) that begins with the same character.
6	PRC006	Payment Subcategory	Text	2	Use this field to report the payment subcategory based on the initial character in the Payment Category (PRC005). Refer to Appendix B: Payment Arrangements and Classification 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

Col. #	Field ID	Field Name	Type	Max	Description
					• 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 = Fee-for-service only **Note**: When this field is C1, C2, C3, or C4, a response must be entered in the Procedure and Condition-Specific Episode-based Payment Arrangements (SQS024) field in the Submission Questionnaire File.
7	PRC007	Total Amount Allowed	Integer	12	Report the total of all payments, including member responsibility, made in the payment subcategory across all providers during the reporting year. For non-claims payments, this is the amount paid by the payer or fully integrated delivery system across providers. For fee-for-service claims, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible).

Col. #	Field ID	Field Name	Type	Max	Description
					For capitation, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
8	PRC008	Amount Paid for Primary Care	Integer	12	Report the total of all payments, including member responsibility, made in the payment subcategory across all providers for primary care during the reporting year. For fee-for-service payments follow the instructions in Primary Care Paid via Claims to determine the portion allocated to primary care. For non-claims payments follow the instructions specific to each payment subcategory outlined in Primary Care Paid via Non-Claims. **Note**: This is a money field reported in whole dollars. This field may contain a negative value. When Payment Subcategory (PRC006) is C1, C2, D3, D4, or E1, Amount Paid for Primary Care shall be 0.
9	PRC009	Member Months	Integer	12	Report the total number of months **during which payment was made** on behalf of a member as reported in Total Amount Allowed (PRC007). If Total Amount Allowed (PRC007) is zero, Member Months (PRC009) shall also be zero. Refer to Primary Care Member Months for more information. Member months shall **not** be mutually exclusive across all rows. **Note**: This field reported as an integer. When Payment Subcategory (PRC006) is A4, A5, or E1, Member Months shall be 0.
10	PRC898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
11	PRC899	Record Type	Text	3	Use this field to report the value of ‘PRC’ to indicate primary care reporting at the submitter level.

5.10 Behavioral Health File

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 Product Types for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) only (Market Category = 1 or 2), valid values include: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For all other Market Categories, regardless of product type, valid value includes: • 0 = Not applicable
5	BHV005	Payment Category	Text	1	Use this field to report the payment category. Refer to Appendix B: Payment Arrangements and Classification for more information. Valid values include: • A = Population health and practice infrastructure payments

Col. #	Field ID	Field Name	Type	Max	Description
					• B = Performance payments • C = Shared savings payments and recoupments • D = Capitation and full risk payments • E = Other non-claims payments • X = Fee-for-service **Note**: This field shall correspond to a Payment Subcategory (BHV006) that begins with the same character.
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: Payment Arrangements and Classification 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 • C3 = Condition-related, episode-based payments with shared savings • C4 = Condition-related, episode-based payments with risk of recoupments • D2 = Professional capitation • D4 = Behavioral health capitation • D5 = Global capitation • D6 = Payment to integrated, comprehensive payment and delivery systems • E1 = Other non-claims payments • X9 = Fee-for-service only
7	BHV007	Diagnosis Category	Text	1	Use this field to report the diagnosis category mental health or substance use disorder. Refer to Behavioral Health Paid via Claims for more information. **When Payment Subcategory (BHV006) is X9**, valid values include:

Col. #	Field ID	Field Name	Type	Max	Description
					• 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 Behavioral Health Paid via Claims for more information. **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, including member responsibility, 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.

Col. #	Field ID	Field Name	Type	Max	Description
10	BHV898	Submission Year	Integer	4	Use this field to report the data submission year in YYYY format. For example, data due on September 1, 2026 shall have 2026 in the Submission Year field.
11	BHV899	Record Type	Text	3	Use this field to report the value of ‘BHV’ to indicate behavioral health reporting at the submitter level.

Appendix A: Claims Service Category to Bill Code Mapping

The table below provides guidance on mapping claims service categories to bill codes for the purpose of reporting total medical expense. The codes listed are provided as representative examples but are **not** meant to be an exhaustive list.

Claims Service Category	Description	Example Code Sets
Hospital Inpatient	This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities.	Type of bill codes: • Hospital: 011X • Hospital Swing Bed: 018X • Religious Nonmedical Hospital: 041X
Hospital Outpatient	This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.	Type of bill codes: • Hospital Inpatient, Part B only: 012X • Hospital Outpatient: 013X • Hospital Other Part B: 014X • Religious Nonmedical Hospital: 043X • Critical Access Hospital: 085X
Professional	This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor.	All professional claims (CMS-1500) *excluding*: • Ambulance/transportation services (Place of service codes: 41, 42) • Durable Medical Equipment • Independent Labs (Place of service code: 81) • Optical services (HCPCS codes V2020-2799)

Claims Service Category	Description	Example Code Sets
		• Medical services provided at a pharmacy (Place of service code: 01)
Long-Term Care	This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community.	Type of bill codes: • SNF: 021X • SNF Part B: 022X • SNF Outpatient: 023X • SNF Swing Bed: 028X • ICF: 065X, 066X • Home Health: 032X, 033X • Home Health Part B: 034X • Residential Facilities: 086X
Retail Pharmacy	This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting).	
Other	Claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year.	Examples of claims to include: • Ambulance services (Place of service codes: 41, 42) • Durable Medical Equipment • Independent Labs (Place of service code: 81) • Optical services (HCPCS codes V2020-2799) • Medical services provided at a pharmacy (Place of service code: 01)

Claims Service Category	Description	Example Code Sets
		Institutional Claims Type of Bill Codes: • Clinic: Rural Health: 071X • Clinic: ESRD: 072X • Clinic: Free Standing: 073X • Clinic: Outpatient Rehabilitation Facility (ORF): 074X • Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF): 075X • Clinic: Community Mental Health Center: 076X • Federally Qualified Health Center (FQHC): 077X • Clinic: Other 079X • Hospice: 081X, 082X • Ambulatory Surgical Clinic Non-professional services: 083X • Freestanding birth center: 084X • Freestanding Non-residential Opioid Treatment Program: 087X • Special Facility – Other: 089X

Appendix B: Payment Arrangements and Classification

The table below provides guidance to submitters on mapping payment types to claims (fee-for-service) and non-claims payment categories and subcategories used for data submission.

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
A	Population Health and Infrastructure Payments	Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.	
A1	Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (*e.g.*, practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
A2	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (*e.g.*, funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
A3	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
A4	Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
A5	EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
B	Performance Payments	Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.	
B1	Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B: Pay for Reporting: Bonuses for reporting data or penalties for not reporting data

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
B2	Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C: Pay for Performance: Bonuses for quality performance
C	Shared Savings Payments and Recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category shall reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars shall be reported as a negative value.	
C1	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (*e.g.*, joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality
C2	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (*e.g.*, joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality
C3	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (*e.g.*, diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality
C4	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (*e.g.*, diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
C5	Risk for total cost of care (*e.g.*, ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality
C6	Risk for total cost of care (*e.g.*, ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory shall be based on a fee-for-service architecture. Payment models paid predominantly via capitation shall be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.”	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.”	
D	Capitation and Full Risk Payments	Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time.	
D1	Primary care capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
D2	Professional capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N:

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
			Capitated payments not linked to quality
D3	Facility capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
D4	Behavioral health capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
D5	Global capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B: Comprehensive Population-based Payment: Global budgets or full/percent of premium payments; 4N: Capitated payments not linked to quality

#	Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
D6	Payments to integrated, comprehensive payment and delivery systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C: Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems; 4N: Capitated payments not linked to quality
E1	Other Non-Claims Payments	Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit.	
X9	Fee-for-service only claims	Claims payments in which healthcare providers or organizations are paid for each service performed. Examples of services include tests and office visits.	1: Fee-for-service payments not linked to quality

Appendix C: Regions

Total medical expense shall be reported by region based on the member's residence address. Use the table below to determine which Rating Region to use in the Region field (RET003) on the Regional TME File.

Rating Region	County Name	3-Digit ZIP Code (Los Angeles County only)
RR01	Alpine	
RR01	Amador	
RR01	Butte	
RR01	Calaveras	
RR01	Colusa	
RR01	Del Norte	
RR01	Glenn	
RR01	Humboldt	
RR01	Lake	
RR01	Lassen	
RR01	Mendocino	
RR01	Modoc	
RR01	Nevada	
RR01	Plumas	
RR01	Shasta	
RR01	Sierra	
RR01	Siskiyou	
RR01	Sutter	
RR01	Tehama	
RR01	Trinity	
RR01	Tuolumne	
RR01	Yuba	
RR02	Marin	
RR02	Napa	
RR02	Solano	
RR02	Sonoma	
RR03	El Dorado	
RR03	Placer	
RR03	Sacramento	
RR03	Yolo	
RR04	San Francisco	
RR05	Contra Costa	
RR06	Alameda	
RR07	Santa Clara	
RR08	San Mateo	
RR09	Monterey	

Rating Region	County Name	3-Digit ZIP Code (Los Angeles County only)
RR09	San Benito	
RR09	Santa Cruz	
RR10	Mariposa	
RR10	Merced	
RR10	San Joaquin	
RR10	Stanislaus	
RR10	Tulare	
RR11	Fresno	
RR11	Kings	
RR11	Madera	
RR12	San Luis Obispo	
RR12	Santa Barbara	
RR12	Ventura	
RR13	Imperial	
RR13	Inyo	
RR13	Mono	
RR14	Kern	
RR15	Los Angeles (East)	906 907 908 910 911 912 915 917 918 935
RR16	Los Angeles (West)	900 901 902 903 904 905 913 914 916 932
RR17	Riverside	
RR17	San Bernardino	
RR18	Orange	
RR19	San Diego	
RR99	Unspecified Region	

Appendix D: Condition and Procedure Types

The tables below describe how submitters shall categorize payment arrangements in the Submission Questionnaire File when episode-based payments are reported using Payment Subcategory (PRC006) C1, C2, C3, or C4 in the Primary Care File.

Procedure-related, Episode-based Payments

These shared savings payments or payments with risk of recoupments are built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment. When Payment Subcategory (PRC006) is C1 or C2, report the procedure type(s) in the Procedure and Condition-Specific Episode-based Payment Arrangements (SQS024) field in the Submission Questionnaire File using its corresponding coded value (*e.g.*, '1' for a cardiovascular procedure) using the table below.

#	Type	Description	Examples of Procedures
1	Cardiovascular	Procedures involving the heart and blood vessels.	• Coronary artery bypass graft surgery • Percutaneous coronary intervention • Automatic cardiac defibrillator implant
2	Gastrointestinal	Procedures and surgeries involving the gastrointestinal tract.	• Colonoscopy • Upper gastrointestinal tract endoscopy • Major bowel procedures
3	Orthopedic	Procedures and surgeries involving the musculoskeletal system, including muscles, joints, and the spine.	• Hip replacement • Knee arthroscopy • Spinal fusion • Amputation • Removal of orthopedic devices
4	Transplant	Transplantation procedures of solid organs and bone marrow.	• Kidney transplant • Bone marrow transplant • Partial liver transplant
5	Other Procedures	Other procedure-specific, episode-based payments built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment that do not fall into Types 1-4.	• Cataract surgery • Bariatric surgery • Hysterectomy

Condition-related, Episode-based Payments

These shared savings payments or payments with risk of recoupments are built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment. When Payment Subcategory (PRC006) is C3 or C4, report the condition type(s) in the Procedure and Condition-Specific Episode-based Payment Arrangements (SQS024) field in the Submission Questionnaire File using its corresponding coded value (*e.g.*, '6' for a chronic/outpatient-based condition) using the table below.

#	Type	Description	Examples of Conditions
6	Chronic/Outpatient-Based	Care to treat chronic conditions primarily managed in an outpatient setting, over a defined period of time. Note: chronic care for cancer shall be included in Type 8.	• Diabetes • Asthma • Chronic kidney disease
7	Acute/Hospitalization-Based	Episodes initiated by an inpatient stay, which may be limited to inpatient treatment or may extend into the post-hospitalization period or may include only post-hospitalization care.	• Stroke • Cardiac arrhythmia • Sepsis
8	Oncology	Diagnosis, treatment, and/or prevention of cancer.	• High-risk breast cancer • Lymphoma • Colorectal cancer
9	Pregnancy	Care to support health during pregnancy, childbirth, and/or the postpartum period.	N/A
10	Other Conditions	Other condition-specific, episode-based payments built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment that do not fall into Types 6-9.	N/A

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) = (RET006)
        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:

i. Population Health and Practice Infrastructure Payments (SWT016) = (ATT022) = (PRC007) where Payment Category (PRC005) = A
ii. Performance Payments (SWT017) = (ATT023) = (PRC007) where Payment Category (PRC005) = B
iii. Shared Savings Payments and Recoupments (SWT018) = (ATT024) = (PRC007) where Payment Category (PRC005) = C
iv. Non-Claims: Other (SWT019) = (ATT025) = (PRC007) where Payment Category (PRC005) = E
v. Due to the rules for inclusion or exclusion of specific Medi-Cal payments provided in the OHCA Medi-Cal Payments Addendum, these validations do not apply to data in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories.

4. Member Responsibility
   a. The sum of Member Responsibility (Claims) in the Statewide TME, Attributed TME, and Regional TME files shall match: (SWT013) = (ATT019) = (RET013)
   b. The sum of Member Responsibility (Capitation) in the Statewide TME, Attributed TME, and Regional TME files shall match: (SWT015) = (ATT021) = (RET015)
5. Submission Questionnaire File
   a. Unknown Age Band (SQS017) must be populated if Age Band in Years (ATT009) = ‘9’ in the Attributed TME file
   b. If data is submitted for the Commercial (Partial Benefits) market category, then:
      i. The sum of Estimated Pharmacy Spending (SQS018), Estimated Behavioral Health Spending (SQS019), and Estimated Other Spending (SQS020) must be greater than zero, and
      ii. Estimate Methodology (SQS021) must be populated
   c. Procedure and Condition-Specific Episode-based Payment Arrangements (SQS024) must be populated if Payment Subcategory (PRC006) = C1, C2, C3, or C4 in the Primary Care file
6. APM, Primary Care, and Behavioral Health Files
   a. The same combinations of Market Category and Product Type must be present in the APM, Primary Care, and Behavioral Health files: (APM003 and APM004) = (PRC003 and PRC004) = (BHV003 and BHV004)
   b. Within each market category and reporting year, the sum of Total Amount Allowed (APM008) in the APM file shall equal the sum of Total Amount Allowed (PRC007) in the Primary Care file and equal the sum of (SWT012) and (SWT014) through (SWT019) in the Statewide TME file
      i. 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.

c. The sum of Total Amount Allowed (PRC007) where Payment Category (PRC005) = D in the Primary Care file shall equal the sum of Capitation and Full Risk Payments (SWT014) and Member Responsibility (Capitation) (SWT015) in the Statewide TME file
    i. 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.
d. Within each market category and reporting year, the sum of Total Amount Allowed (PRC007) when Payment Subcategory (PRC006) = A2 in the Primary Care file shall equal the sum of Amount Paid for Behavioral Health (BHV009) when Payment Subcategory (BHV006) = A2
e. Within each market category and reporting year, the sum of Total Amount Allowed (PRC007) when Payment Subcategory (PRC006) = D4 in the Primary Care file shall equal the sum of Amount Paid for Behavioral Health (BHV009) when Payment Subcategory (BHV006) = D4
f. Within each market category and reporting year, the sum of Total Amount Allowed (PRC007) when Payment Subcategory (PRC006) is **not** A2 or D4 shall be greater than the sum of Amount Paid for Behavioral Health (BHV009) for the same Payment Subcategory (BHV006)