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OFFICE OF HEALTH CARE AFFORDABILITY
FINDING OF EMERGENCY FOR PROPOSED EMERGENCY REGULATIONS

HEALTH CARE SPENDING TARGETS;
TOTAL HEALTH CARE EXPENDITURES (THCE) DATA COLLECTION

SUBJECT MATTER OF PROPOSED REGULATIONS

This rulemaking updates total health care expenditures (THCE) data collection pursuant to Health and Safety Code sections 127501 *et seq.* (spending targets program), in the California Code of Regulations (CCR) at Title 22, Division 7, Article 2, sections 97445 and 97449.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

The Office of Health Care Affordability (OHCA or the Office) within the Department of Health Care Access and Information (HCAI) is statutorily required to increase cost transparency through public reporting of per capita total health care spending and factors contributing to cost growth. (Health & Saf. Code, § 127501, subd. (c)(1).) OHCA is also statutorily required to advance standards for promoting the adoption of alternative payment models and to measure and promote systemwide investment in primary care and behavioral health care. (Health & Saf. Code, § 127501, subds. (c)(8) and (c)(9).)

OHCA is required to adopt emergency regulations to carry out these functions and the adoption of these regulations is statutorily deemed to be an emergency for purposes of administrative rulemaking. (Health & Saf. Code, § 127501.2, subd. (a).) As directed by statute, OHCA specifically finds these emergency regulations necessary for the immediate preservation of public health and safety, and general welfare of the citizens of California. (*Id.*)

Regulations implementing THCE data collection (hereinafter, the "THCE data collection regulations") became effective on March 4, 2024 and were previously amended effective April 17, 2025. (Cal. Code Regs., tit. 22, § 97445, *et seq.*) The THCE data collection regulations require specified payers and fully integrated delivery systems (collectively hereinafter, "submitters") to annually register and submit health care spending data to OHCA on an ongoing basis. (Cal. Code Regs., tit. 22, § 97449, subds. (e) through (h).) The THCE data collection regulations also incorporate two documents by reference: the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0)*, dated April 2025 ("THCE Data Submission Guide" or the "Guide"); and the *OHCA Attribution Addendum*, dated April 2025 ("OHCA

Attribution Addendum" or "Attribution Addendum"). Submitters use the instructions in the Guide and Attribution Addendum to extract and aggregate THCE data in a standardized format before submission to OHCA.

OHCA has determined certain clarifying amendments to the THCE data collection regulations and updates to the documents incorporated by reference are necessary. Among other things, this regulatory proposal makes necessary changes to the data acceptance and corrections process. This regulatory proposal also adds a new Behavioral Health file to enable OHCA to meet its statutory mandate to measure and report on behavioral health spending and growth in its first annual report. (Health & Saf. Code, § 127505, subds. (a) and (b).) Finally, this regulatory proposal incorporates by reference three new documents containing standardized medical code sets and instructions regarding Medi-Cal specific payments submitters will use to identify, categorize, and report data in the Alternative Payment Model (APM) file, Primary Care file, and proposed Behavioral Health file.

Pursuant to Health and Safety Code section 127501.4(k), OHCA must engage relevant stakeholders, hold a public meeting to solicit input, and "provide a response to input received" prior to adopting data collection regulations. The Health Care Affordability Board (hereinafter, the "Board") is also required to discuss proposed emergency regulations during at least one Board meeting prior to OHCA's adoption. (Health & Saf. Code, § 127501.2, subd. (c).) For purposes of this regulatory proposal, OHCA held regularly scheduled meetings with its THCE Data Submitter workgroup to solicit feedback and inform regulation development on the following dates:

- April 23, 2025
- May 21, 2025
- June 25, 2025
- October 22, 2025
- January 21, 2026
- March 18, 2026

Additionally, the specifications for the new Behavioral Health file were informed by OHCA's Investment and Payment Workgroup, which consists of stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans. OHCA's Investment and Payment Workgroup began regularly scheduled monthly meetings in June 2023 and transitioned to quarterly meetings in September 2025.

OHCA posted a draft of these proposed revisions on its public website on January 5, 2026, with a 25-day window for submission of written comments. OHCA received one email with substantive comments from a health plan and two letters with substantive comments from industry lobby groups. Additionally, during this comment period, OHCA discussed the proposed revisions at the January 28, 2026 Board meeting (in-person

and virtual). There was one public comment by an industry lobby group regarding the revisions at the Board meeting.

OHCA provided a summary of the public comments regarding the January 2026 draft of these regulations to the Board at its March 25, 2026 meeting. Following thorough consideration of input received from all stakeholders, OHCA made responsive changes to these proposed revisions.

OHCA collects THCE data annually by September 1. Because payers and fully integrated delivery systems need sufficient time to extract and aggregate THCE data in accordance with the requirements outlined in this rulemaking prior to September 1, 2026, OHCA must adopt these regulations as soon as possible. (Health & Saf. Code, § 127501.4, subd. (d)(2); Cal. Code Regs., tit. 22, § 97449, subd. (h)(2).)

AUTHORITY AND REFERENCE

Pursuant to Health and Safety Code sections 127501(c)(16), 127501.2, and 127501.4(k), OHCA shall adopt, amend, or repeal, in accordance with the Administrative Procedure Act, rules and regulations as may be necessary to enable it to carry out the laws relating to the collection of data and other information from health care entities under the California Health Care Quality and Affordability Act (Health and Safety Code, section 127500, *et seq*. (Act).)

These regulations implement, interpret, or make specific Health and Safety Code sections 127500.2, 127500.5, 127501.4, 127504, and 127505.

INFORMATIVE DIGEST

Existing Law

OHCA's existing THCE data collection regulations:

- Define terms used in the regulations. (Section 97445.)
- Specify who is a required submitter and how voluntary submitters may request to participate. (Section 97449(a) through (c).)
- Outline how submitters should coordinate data submission with their subcontracted health plans and affiliates. (Section 97449(d).)
- Set deadlines for submitter registration and data file submission. (Section 97449(e) through (h).)
- Describe other requirements related to data file specifications, test files, data acceptance and correction, and variance requests. (Section 97449(i) through (l).)

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OHCA's existing THCE data collection regulations also incorporate by reference:

- The *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0),* dated April 2025 ("THCE Data Submission Guide" or the "Guide"). The Guide contains requirements related to the extraction and aggregation of data for submission to OHCA. The Guide also provides technical specifications, file layouts, reporting schedules, and other instructions to ensure submission of accurate THCE data in a standardized format. The Guide is available on, and may be downloaded from, the HCAI website.

- The *Office of Health Care Affordability: Attribution Addendum*, dated April 2025 ("OHCA Attribution Addendum" or "Attribution Addendum"). The Attribution Addendum contains a list of physician organizations with unique identifiers submitters must use when attributing total medical expenses. OHCA periodically updates the names and identifying information in the Attribution Addendum as physician organizations reorganize, enter, and exit the health care market. The Attribution Addendum is available on, and may be downloaded from, the HCAI website.

General Policy Statement

In 2022, the Act (Senate Bill (SB) 184, Chapter 47, Statutes of 2022) established OHCA within HCAI. Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, the Legislature expressed its intent to:

> …have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care, with the goal of improving affordability, access, and equity of health care for Californians. (Health & Saf. Code, § 127500.5, subd. (b).)

In enacting SB 184, the Legislature charged OHCA with doing all of the following:

(1) Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs.
(2) Addressing cost increases in excess of health care cost targets through public transparency, opportunities for remediation, and other progressive enforcement actions to achieve cost targets that optimize value in health care spending.

(3) Referring transactions that may reduce market competition or increase costs to the Attorney General for further review. (Health & Saf. Code, § 127500.5, subds. (o)(1) through (o)(3).)

When fully implemented in 2028, OHCA's spending targets program will collect, analyze, and publicly report THCE data and progressively enforce health care spending targets set by the Board. (Health & Saf. Code, § 127501, subd. (b).)

This rulemaking amends regulations contained in Title 22 of the CCR that implement SB 184 with regard to collecting data and measuring total health care spending.

This proposal will:

- Amend section 97445 to update version numbers and dates of documents incorporated by reference through this regulatory action.
- Amend section 97445 to incorporate by reference three new addenda.
- Amend section 97449 to change the annual data submission deadline from September 1 to the first business day of September.
- Amend section 97449 to require submitters to respond to requests for information regarding data submission errors within three business days of notification by OHCA.
- Amend section 97449 to extend the existing five-day file resubmission deadline to 10 business days.
- Amend section 97449 to clarify OHCA may make multiple requests for information regarding data submission errors.

This proposal also incorporates by reference:

- An updated version of the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 3.0)*, dated April 2026 (hereinafter, the "Guide Version 3.0"). The Guide Version 3.0 contains requirements related to the extraction and aggregation of data for submission to OHCA. The Guide Version 3.0 also provides technical specifications, file layouts, reporting schedules, and other instructions to ensure submission of accurate THCE data in a standardized format. Each update to the Guide Version 3.0 is described in the *Total Health Care Expenditures Data Submission Guide (Version 3.0)* section of this Finding of Emergency, below.

  The Guide Version 3.0 will be available on, and may be downloaded from, the HCAI website.

- An updated version of the *Office of Health Care Affordability: Attribution Addendum*, dated April 2026 ("OHCA Attribution Addendum" or "Attribution Addendum"). This document contains a list of physician organizations with unique identifiers submitters must use when attributing total medical expenses.

Each update to the Attribution Addendum is described in the *OHCA Attribution Addendum* section of this Finding of Emergency, below.

The updated Attribution Addendum will be available on, and may be downloaded from, the HCAI website.

- The *Office of Health Care Affordability: Behavioral Health Addendum*, dated April 2026 ("OHCA Behavioral Health Addendum" or "Behavioral Health Addendum"). This document contains an up-to-date, standardized list of medical codes submitters will use to identify, categorize, and report behavioral health spending in the Behavioral Health file. As with the Guide Version 3.0 and the Attribution Addendum, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

  The Behavioral Health Addendum will be available on, and may be downloaded from, the HCAI website.

- The *Office of Health Care Affordability: Medi-Cal Payments Addendum*, dated April 2026 ("OHCA Medi-Cal Payments Addendum" or "Medi-Cal Payments Addendum"). This document provides submitters in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories with standardized instructions for excluding and including certain Medi-Cal specific payments in the APM file, Primary Care file, and Behavioral Health file. As with the Guide Version 3.0 and the Attribution Addendum, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

  The Medi-Cal Payments Addendum will be available on, and may be downloaded from, the HCAI website.

- The *Office of Health Care Affordability: Primary Care Addendum*, dated April 2026 ("OHCA Primary Care Addendum" or "Primary Care Addendum"). This document consolidates appendices in the existing Guide into an up-to-date, standardized list of medical codes submitters will use to identify, categorize, and report primary care spending in the Primary Care file. As with the Guide Version 3.0 and the Attribution Addendum, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

  The Primary Care Addendum will be available on, and may be downloaded from, the HCAI website.

SPECIFIC PURPOSE AND NECESSITY FOR EACH REGULATION

Amend section 97445 of Division 7 of Title 22, Definitions.

Subsection (s)

OHCA amends the version number of the Guide to "3.0" and the version date of the Guide to "April 2026." As explained above, required submitters use the Guide to extract and aggregate THCE data in a standardized format. These amendments ensure required submitters use the most recent version of the Guide when submitting data to OHCA. The specific changes to the Guide are discussed in the *Total Health Care Expenditures Data Submission Guide (Version 3.0)* section of this Finding of Emergency, below.

Subsection (t)

OHCA amends the version date of the Attribution Addendum to "April 2026." As explained above, required submitters will use the Attribution Addendum to extract and aggregate THCE data in a standardized format. This amendment ensures required submitters use the most recent version of the Attribution Addendum when submitting data to OHCA.[1]

Subsection (u)

OHCA replaces the existing definition of "voluntary submitter" in subsection (u) with this definition introducing the reference document for reporting behavioral health data. This definition is necessary because it incorporates by reference the *OHCA Behavioral Health Addendum*, dated April 2026 (Behavioral Health Addendum) and directs the reader to where it may be obtained.[2] As explained above, required submitters will use the Behavioral Health Addendum to identify, categorize, and report behavioral health spending in the Behavioral Health file.

Subsection (v)

OHCA adds this definition introducing the reference document for reporting Medi-Cal payments data. This definition is necessary because it incorporates by reference the *OHCA Medi-Cal Payments Addendum*, dated April 2026 (Medi-Cal Payments Addendum) and directs the reader to where it may be obtained.[3] As explained above,

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[1] The specific changes to the Attribution Addendum are discussed in the *OHCA Attribution Addendum* section of this Finding of Emergency.
[2] The specific purpose and necessity of the Behavioral Health Addendum is described in the *OHCA Behavioral Health Addendum* section of this Finding of Emergency.
[3] The specific purpose and necessity of the Medi-Cal Payments Addendum is described in the *OHCA Medi-Cal Payments Addendum* section of this Finding of Emergency.

required submitters in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories will use the Medi-Cal Payments Addendum when reporting total medical expense in the APM file, Primary Care file, and Behavioral Health file.

Subsection (w)

OHCA adds this definition introducing the reference document for reporting primary care data. This definition is necessary because it incorporates by reference the *OHCA Primary Care Addendum*, dated April 2026 (Primary Care Addendum) and directs the reader to where it may be obtained.[4] As explained above, submitters will use the Primary Care Addendum to identify, categorize, and report primary care spending in the Primary Care file.

Subsection (x)

OHCA non-substantively relocates the definition of "voluntary submitter" from existing subsection (u) to a new subsection (x). This amendment ensures the definitions in section 97445 remain in alphabetical order.

Amend section 97449 of Division 7 of Title 22, Total Health Care Expenditures Data Submission.

Subsection (h)

OHCA strikes "September 1" and replaces it with "the first business day of September" for clarity. During the September 2025 data submission period, September 1 fell on the Labor Day holiday. As a result, some submitters were unsure whether the data submission deadline was moved up to the last business day before the holiday weekend or if it was extended to September 2.

Amending the deadline date to the first business day of September is necessary to avoid any confusion in future years when September 1 falls on a weekend or state holiday.

Subsection (k)(2)

OHCA strikes "submit remediated files through the data portal" and replaces it with "respond to the Department with additional information regarding the initially unidentified errors." OHCA also strikes "five" and replaces it with "three" and further strikes "[t]he Office may make multiple requests for corrections or resubmissions." Together, these revisions require a submitter to respond to a request for information regarding data

[4] The specific purpose and necessity of the Primary Care Addendum is described in the *OHCA Primary Care Addendum* section of this Finding of Emergency.

submission errors within three business days of notification by OHCA. OHCA relocates the stricken language to proposed subsections (k)(3) and (k)(4).

These amendments are necessary because communications with submitters regarding identified errors do not always require file resubmission. In some instances, due to the complexity of the data, OHCA and a submitter may engage in a back-and-forth dialogue to confirm whether the error exists and whether a data variance request is more appropriate to resolve the error than a file resubmission. Based on OHCA's experience with the data file submission in September 2025, a three business day response time is appropriate in these scenarios to ensure submitters remain engaged in the discussion and expediently provide the information OHCA needs to determine the best course of action.

Subsection (k)(3)

Subsection (k)(3) requires submitters to submit remediated files through the Data Portal within ten business days of notification by OHCA that previously accepted files contain errors requiring resubmission. This requirement is relocated from existing subsection (k)(2). This requirement also extends the existing five business day resubmission timeframe. OHCA selected 10 business days for the resubmission timeframe based on feedback received during the informal comment period for this regulation. Specifically, a health plan industry group indicated the existing 5-business day turnaround time is insufficient, but 10 business days would be appropriate.

This amendment is necessary to clearly delineate two potential notification scenarios, each with a different response timeframe. As discussed above, a notification requesting information under proposed subsection (k)(2) has a three business day response timeframe and provides OHCA with an opportunity to gather information and confirm whether file resubmission is necessary. A notification requiring resubmission under proposed subsection (k)(3) has a 10 business day response timeframe and is unambiguous regarding OHCA's expectation that the submitter will remediate the identified errors and resubmit the file.

Subsection (k)(4)

Subsection (k)(4) clarifies that OHCA may make multiple requests for information or require multiple file resubmissions under subsections (k)(2) and (k)(3), respectively. This clarifying language is relocated in part from existing subsection (k)(2) and amended to extend to requests for information. This amendment is necessary because, as explained above, OHCA and a submitter may engage in a back-and-forth dialogue regarding an identified error in order to determine whether file resubmission is necessary or if a data variance request is appropriate.

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Total Health Care Expenditures Data Submission Guide (Version 3.0)

OHCA's existing THCE data collection regulations incorporate by reference the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0)*, dated April 2025 (the "THCE Data Submission Guide" or the "Guide"). OHCA proposes through this regulatory action to replace this version of the Guide with an updated version, the *Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 3.0)*, dated April 2026 (hereinafter, the "Guide Version 3.0"). For purposes of this regulatory proposal, OHCA identifies the updates from the existing Guide to the Guide Version 3.0 using green underline text for additions and red strikethrough text for deletions. If this regulatory proposal is approved, the final Guide Version 3.0 will include the identified updates and appear as a "clean" unmarked document.

Proposed subsection 97445(s) incorporates the Guide Version 3.0 by reference. Like the existing Guide, the Guide Version 3.0 provides submitters with detailed technical specifications for the extraction, aggregation, and submission of THCE data in a standardized format. The proposed updates to the Guide Version 3.0 are informed by OHCA's experience with the September 2025 THCE data submission, including feedback received from submitters during and after the data submission process.

As described more fully below, in addition to updates to existing required files, the Guide Version 3.0 adds one new required file: the Behavioral Health (BHV) file. This additional file was developed after extensive consultation with OHCA's contracted experts in behavioral health payment measurement. The specifications for the BHV file were also informed by input from OHCA's Investment and Payment Workgroup, which began regular meetings in June 2023, and brings together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans.

The Guide Version 3.0 will be available on, and may be downloaded from HCAI's website, located at: https://hcai.ca.gov/about/laws-regulations/#total-health-care-expenditures-thce-data-submission.

The following descriptions provide the specific purpose and necessity of updates to the Guide Version 3.0, incorporated by reference in this regulatory proposal.

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OHCA revises "total medical expenses" to the non-plural "total medical expense" and makes conforming changes to surrounding words affected by the revision throughout the document for grammatical reasons.

OHCA also removes single quotation marks surrounding references to payment arrangement categories and subcategories throughout the document. The single

quotation marks are unnecessary and are not uniformly applied in the existing Guide. OHCA proposes this change for consistency.

These are non-substantive changes, as no obligation is changed.

Cover Page, Footers, "Table of Contents," and "Version History"

OHCA updates the version number of the Guide to "Version 3.0" and the date of the Guide to "April 2026" throughout the document, including on the cover page and in all headers.

OHCA updates footnote numbers to reflect new and deleted footnotes in the text of the Guide Version 3.0 and corresponding footers.

OHCA updates the "Table of Contents" to reflect revised section titles, new and deleted sections, a revised appendix title, a deleted appendix, and accurate page numbers.

OHCA adds a row for Version 3.0 in the "Version History" table. This new row includes a bulleted summary of changes reflected in the Guide Version 3.0. OHCA also relocates the June 2024 and April 2025 rows to organize the table from most recent version to least recent version.

Each of these updates is necessary for accuracy and to ensure users can effectively navigate the Guide Version 3.0.

Section 1, "Introduction."

OHCA adds "all addenda" in paragraph two of this section. OHCA's website includes links to the existing Guide Version 2.0 and Attribution Addendum. Following adoption of the changes proposed in this regulatory action, OHCA's website will include links to the Guide Version 3.0; the Attribution Addendum, dated April 2026; and three additional addenda OHCA proposes to incorporate by reference.

This change is necessary for accuracy and completeness.

Section 1.2, "Data Submission Deadlines."

Paragraphs 1 and 2

OHCA strikes the first paragraph of this section because the information it contains will no longer be relevant to users in April 2026, which is OHCA's proposed date for release of the Guide Version 3.0. OHCA also strikes the second paragraph of this section. The second paragraph contains a narrative regarding the contents of OHCA's first annual report, expected on or before June 1, 2027. This information is not a requirement for users of the Guide Version 3.0, and its inclusion potentially deemphasizes the important requirements in this section that begin in existing paragraph three.

These revisions do not change any requirements for submitters and make the Guide Version 3.0 more usable by improving its relevance and conciseness.

Paragraphs 3 and 4

OHCA strikes "For purposes of ongoing annual reporting…" and revises "will be" to "are" in the first sentence of paragraph three. These revisions, which do not change any requirements for submitters, are necessary to make the language more direct and grammatically correct.

OHCA revises the data submission deadline in the first sentence of paragraph three to "…the first business day of September of each year" and also strikes the second sentence of the paragraph for clarity and consistency with OHCA's proposed revisions to 22 CCR 97449(h). OHCA incorporates the reasons it provides for the proposed revisions to 22 CCR 97449(h) here.

OHCA adds a parenthetical to the last sentence in paragraph three clarifying by way of example the existing requirement to extract and submit data for the previous two calendar years with each data submission. This revision does not change any requirements for submitters and is included to illustrate implementation of the new first business day of September deadline.

OHCA adds "…and pass the cross-file data quality checks outlined in Appendix E: Cross-File Data Quality Checks" to paragraph four. The language is consistent with proposed Section 3.1 of the Guide Version 3.0, which specifies a "complete" submission must pass both the Data Portal's automated validations and OHCA's manual cross-file data quality checks. This amendment is necessary to clarify that submission of THCE data is not deemed complete until each required file passes OHCA's data quality validations described in the Appendix E, "Cross File Data Quality Checks" section of this Finding of Emergency.

<u>Section 1.4, "References."</u>

As explained elsewhere in this Finding of Emergency, OHCA relocates the contents of existing Appendix E and information relevant to the proposed Behavioral Health file to three new addenda incorporated by reference.

This section is necessary to ensure submitters can readily identify the version dates of each of the addenda referenced in the Guide Version 3.0.

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Section 2, “Submitter Registration.”

Paragraph 1

OHCA replaces “identified by” with “who previously registered with” in paragraph one of this section. During the September 2024 and September 2025 data submissions, OHCA used publicly available enrollment data to identify likely required submitters and then sent each entity a Data Portal registration link. For the upcoming September 2026 data submission, OHCA plans to send the annual Data Portal registration link to entities that previously registered in the most recent data submission year. OHCA will continue to monitor health plan and health insurer enrollment to identify any new market entrants potentially meeting the required submitter enrollment thresholds and will reach out to those entities regarding registration, where applicable. Accordingly, this amendment is necessary to ensure the Guide Version 3.0 accurately describes OHCA’s annual Data Portal registration process.

Paragraph 2

OHCA adds the following example illustrating the “license-level” registration requirement in paragraph two:

> 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.

This additional language does not change any existing requirements for submitters. However, based on OHCA’s experience during the September 2025 data submission, this illustrative example is necessary to ensure submitters begin the registration process with an understanding of OHCA’s expectations for “license-level” registration and the information they will need to enter into the Data Portal.

Paragraph 3

OHCA makes multiple revisions to the list of required information provided during registration in the Data Portal for clarity and consistency.

First, OHCA relocates the items “Parent Company Name,”
“National Association of Insurance Commissioners (NAIC) Code(s)…,” and “For each Market Category selected above...,” from existing required item numbers 4, 3, and 6 to proposed numbers 1, 5, and 8 to reflect the field order used in the Data Portal during registration. These are non-substantive changes, as no obligation is changed.

Second, OHCA relocates “Legal entity name and address” from existing required item number 1 to proposed numbers 2 and 9 with the revised names “Submitter (Legal

Entity) Name" and "Submitter Address" to reflect the field order and naming conventions used in the Data Portal during registration. This is a non-substantive change, as no obligation has changed.

Third, OHCA relocates "License Type and License Number" from existing required item number 2 to proposed item number 6 with the revised name "License Issuer and License Number." This change improves the accuracy and clarity of the question because OHCA is asking the submitter to identify the entity that issued the submitter's license to offer health plan or health insurance products. This change also reflects the field order and naming convention used in the Data Portal during registration. This change is necessary because OHCA tracks submitter registrations and enrollment at the license-level. This change ensures OHCA receives accurate and useful identifying information from submitters during registration.

Fourth, OHCA adds a required field for "Submitter Code, if previously registered" as proposed item number 3. This additional field is necessary for OHCA to track submitter registrations across multiple registration years. Additionally, OHCA plans to assign returning submitters the same submitter code used in the prior year for the convenience of the submitter.

Fifth, OHCA adds a required field for "Type of Participant (Voluntary or Mandatory)" as proposed item number 4. This additional field is necessary for OHCA to track which submitters are providing data on a voluntary versus mandatory basis.

Sixth, OHCA relocates "Market Category(ies) for which the submitter…" from existing required item number 5 to proposed item number 7 to reflect the field order used in the Data Portal during registration. This is a non-substantive change, as no obligation is changed. OHCA also adds the following sentence to proposed item number 7: "The Market Category(ies) selected at registration must match the contents of the data submission." This additional requirement is necessary because a submitter's indicated number of market categories affects the number of rows in each required file. Accordingly, the Data Portal uses the market category information provided during registration to perform automatic validation of file completeness during data submission.

Seventh, OHCA relocates "A regulatory contact…," "A business contact…," and "A technical contact…" from existing required item numbers 7, 8, and 9, respectively, to proposed item numbers 10, 11, and 12 with revised names to reflect the field order and naming conventions used in the Data Portal during registration. These are non-substantive changes, as no obligation is changed.

Finally, OHCA strikes existing footnotes 3 and 4. These footnotes provide information that is no longer applicable following completion of the September 2025 data submission.

Section 3.1, “Required Files.”

OHCA revises “seven” to “eight” in reference to the number of required files in a complete submission. This reflects the proposed addition of one new file type, as follows:

…

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.

The purpose of listing the Behavioral Health file in this section is to identify this new file as a required file in a complete THCE data submission. The Behavioral Health file is necessary to collect THCE data at the level of granularity required for OHCA to measure and report on behavioral health spending and growth in its annual report. (Health & Saf. Code, § 127505, subds. (a) through (b).)

In item 2, OHCA adds the word “physician” in the description of the Attributed TME file. This non-substantive change clarifies that total medical expense for covered health benefits is attributed to physician organizations, as defined in 22 CCR 97445(l), as opposed to organizations generally.

In item 6, OHCA adds the following language to the description of the Alternative Payment Model (APM) file:

…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…

OHCA adds this language to emphasize that the APM file includes both claims (fee-for-service) and non-claims spending. OHCA also strikes the reference to the Expanded Non-Claims Payments Framework and replaces it with “Appendix B: Payment Arrangements and Classification” for consistency with the proposed name change for Appendix B discussed in the Appendix B section of this Finding of Emergency. These non-substantive changes make the language describing the APM file more consistent with the language describing the other required files.

In item 7, OHCA revises the description of the Primary Care file to add “total medical expense for covered health benefits during the reporting period, including…” to the beginning of the description. These non-substantive changes make the language describing the Primary Care file more consistent with the language describing the other required files. OHCA also adds the following language to the end of the Primary Care file description:

> 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.

OHCA adds this language to emphasize that the Primary Care file includes both claims (fee-for-service) and non-claims spending.

Finally, OHCA adds the following language to the end of this section:

> 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.

This information is necessary to ensure submitters are aware that following file submission to the Data Portal, OHCA performs multiple cross-file data quality validations to determine whether the submitted files contain potential inaccuracies or inconsistent data. OHCA incorporates the reasons it provides for these cross-file data quality checks in the Appendix E, "Cross File Data Quality Checks" section of this Finding of Emergency here.

Section 3.1.1, "Special Requirements for Medi-Cal Data Submission in 2025."

OHCA strikes this section because it contains special requirements limited to the September 2025 data submission. These special rules are no longer applicable and their continued inclusion in the Guide Version 3.0 is unnecessary.

Section 3.2, "Required Format."

First, OHCA adds the following language to the "File format" instructions: "Only standard ASCII characters are allowed in each file." American Standard Code for Information Interchange (ASCII) characters are the industry-standard accepted American English characters the Data Portal is encoded to accept and process. OHCA uses the term "ASCII" in the Guide Version 3.0, as opposed to the full name of the code set, because "ASCII" is so widely known and accepted that it is a noun defined in Merriam-Webster's Dictionary.[5]

During the September 2025 data submission, one submitter attempted to submit a file through the Data Portal with a non-ASCII character (specifically, the em dash "—" instead of the hyphen minus "-"). Because the Data Portal is encoded to only accept ASCII characters, the file was initially rejected. Limiting file submissions to ASCII characters is necessary to ensure the files use standardized text easily processed by,

[5] *See* Merrian Webster online, available at: https://www.merriam-webster.com/dictionary/ASCII, last accessed January 30, 2026.

and transferred between, multiple systems. The existing Guide does not include an express requirement to limit files to ASCII characters. OHCA seeks to remedy this oversight through this regulatory proposal.

Second, OHCA replaces “You” with “Submitters” and “submit” with “report” in the “Submitting multiple years of data at once” instructions for grammatical reasons. These are non-substantive changes, as no obligation is changed.

Finally, OHCA replaces “registered” with “requested” and “accepted” with “approved” in the “All data fields shall be reported unless…” instructions for clarity and consistency with the terminology used to outline the data variance request process in 22 CCR 97449(l).

Section 4.1, “Data Completeness.”

OHCA relocates the second paragraph of this section to Section 4.1.1, “Claims Payments.” The purpose of this revision is to clarify that reporting of allowed amounts is applicable to claims payments, whereas reporting of costs paid by the submitter to capitated providers are applicable to non-claims payments. This revision is necessary to ensure complete and accurate submission of THCE data.

Section 4.1.1, “Claims Payments.”

OHCA updates the dates in the parenthetical example included in this section for the convenience of users of the Guide Version 3.0. For the September 2025 data submission, the claims reconciliation period for 2023 and 2024 service dates was June 30, 2025. For the upcoming September 2026 data submission, the claims reconciliation period for 2024 and 2025 service dates is June 30, 2026.

OHCA relocates the second paragraph of this section from existing Section 4.1. OHCA incorporates the reasons it provides for this relocation in the Section 4.1, “Data Completeness,” section of this Finding of Emergency here.

Section 4.1.2, “Non-Claims Payments.”

OHCA updates the dates in the parenthetical example included in this section for the convenience of users of the Guide Version 3.0. For the September 2025 data submission, the non-claims payment reconciliation period for 2023 and 2024 service dates was June 30, 2025. For the upcoming September 2026 data submission, the non-claims payment reconciliation period for 2024 and 2025 service dates is June 30, 2026.

OHCA revises the title of “Appendix B,” referenced in this section from “Appendix B: Expanded Non-Claims Payments Framework” to “Appendix B: Payment Arrangements and Classification.” As explained more fully in the “Appendix B, Payment Arrangements and Classification” section of this Finding of Emergency, OHCA updates the title of “Appendix B” to more accurately describe the full range of payment categories and

subcategories (both claims and non-claims) submitters shall use when reporting THCE data to OHCA. The updated text here is a non-substantive change correcting a referenced item.

OHCA adds the following paragraph to the end of this section:

> 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.

This clarifying language is necessary to ensure total medical expense reported by submitters with members in capitated arrangements does not include both the amounts paid by the submitter to the capitated provider and the amounts paid by the capitated provider to other downstream providers for the member's health care services. Inclusion of both amounts would double-count a member's total medical expense because the submitter's initial capitation payment is used by the capitated provider to reimburse downstream claims.

Section 4.2, "Data Variance Requests."

OHCA adds the following language at the end of the first paragraph of this section:

> A data variance request 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.

Operationally, a submitter cannot request a variance in the Data Portal until a file submission attempt is made, and the system's automated validation process identifies a validation failure. This additional language is necessary to clarify this operational constraint in the Data Portal and to ensure consistency with the data variance request requirements specified in 22 CCR 97449(l)(1).

Section 4.3, "Included Population."

OHCA adds the word "members" and relocates the phrase "who are" in the first sentence of this section for clarity and consistency. Although the first sentence already limits reporting to "covered benefits," and membership is a prerequisite for coverage, adding an express reference to "members" is clearer and more consistent with the phrasing used throughout the Guide Version 3.0.

OHCA adds the erroneously omitted word "reported" to the second paragraph of this section for clarity. This revision is necessary because without the omitted word, the existing language suggests the primary payer on a claim may "double count" expenses.

This is nonsensical based on how benefits are coordinated between primary and secondary payers. Accordingly, this revision is necessary to rectify the omission and clarify the meaning of the paragraph.

OHCA adds the phrase “including those with no utilization” to the third paragraph of this section in response to questions received from submitters. Specifically, during the September 2025 data submission, at least one submitter asked whether non-claims payments on behalf of members with no utilization should be included in total medical expense. Additionally, at least one submitter asked whether member months should be reported for members with no utilization. This revision clarifies that total medical expense and member months shall include all members, including those with no utilization. This revision is necessary to ensure submitters report complete and accurate THCE data.

Section 4.3.1, “Exclusions.”

OHCA proposes three clarifying amendments to this section in response to questions received from submitters.

First, OHCA adds the acronym “(PDPs)” to the existing bulleted item excluding stand-alone prescription drug plans. During the September 2025 data submission, a submitter asked whether stand-alone prescription drug plans include “PDPs.” Because the acronym “PDPs” is arguably better recognized in the health care industry than term of art it abbreviates, this revision is necessary for abundant clarity. OHCA also adds “Centers for Medicare & Medicaid Services” to the bulleted item for CMS reconciliation payments for clarity because it was erroneously omitted from the first mention of this acronym in the existing Guide.

Second, OHCA adds “and/or indemnity” to the existing bulleted item excluding supplemental insurance that pays deductibles, copays, or coinsurance. During the September 2025 data submission, a submitter asked whether OHCA’s data submission specifications intend to exclude indemnity health plans that supplement other health insurance coverage. The purpose of this revision is to emphasize that submitters should exclude all forms of supplemental insurance, including indemnity health insurance, if the supplemental insurance pays deductibles, copays, or coinsurance. This revision is necessary to ensure submitters report consistent and accurate THCE data.

Third, OHCA adds a bulleted item clarifying that “PBM administrative fees” are excluded from data submissions. During the September 2025 data submission, a submitter asked whether administrative fees paid to pharmacy benefit managers (PBMs) should be included in total medical expense. Administrative fees paid to PBMs are necessarily excluded from total medical expense because they are not payments made to providers for covered health care services. Instead, administrative fees paid to PBMs are captured in the administrative costs and profits portion of a submitter’s THCE as an administrative expense. Accordingly, this revision does not change any existing

requirements for submitters, but is necessary for emphasis, and to ensure submitters report complete and accurate THCE data.

Section 4.3.2, “Special Rules for Medi-Cal Managed Care Data Submission.”

Proposed Section 4.3.2 informs submitters that certain Medi-Cal-specific payments are excluded from data submission in the APM, Primary Care, and Behavioral Health files. Because these additional exclusions are limited to submitters reporting data for the Medi-Cal Managed Care and Dual-Eligibles (Medi-Cal Expenses Only) market categories, the specific information regarding the exclusions is not relevant to most users of the Guide Version 3.0. Accordingly, OHCA refers affected submitters to a separate document, the *OHCA Medi-Cal Payments Addendum*, dated April 2026, which OHCA proposes to incorporate by reference through this regulatory action.

Additionally, the special rules for Medi-Cal Managed Care data submission are contained in a separate document incorporated by reference because OHCA anticipates the list of excluded Medi-Cal-specific payments will need to be updated periodically based on federal and state changes to Medicaid financing and policy. The specific purpose and necessity of the Medi-Cal Payments Addendum is discussed in the *OHCA Medi-Cal Payments Addendum* section of this Finding of Emergency.

Section 4.3.3, “Special Rules for Medicare Advantage Data Submission.”

Proposed Section 4.3.3 instructs submitters to include spending for the full scope of Medicare Advantage covered benefits when reporting total medical expense in all files. OHCA proposes adding this section in response to questions from submitters during the September 2025 data submission regarding whether to include or exclude certain Medicare Advantage supplemental benefits from data submission. Based on feedback received from a stakeholder during the informal comment period for this regulatory proposal, OHCA includes a citation to the section of the Code of Federal Regulations defining the types of Medicare Advantage benefits, including supplemental benefits.

This proposed section is necessary to emphasize the existing requirement that submitters include all health care spending for covered benefits on behalf of, or by, members who are California residents. OHCA does not intend to exclude spending for any specific health care benefits, unless expressly indicated in the Guide Version 3.0. OHCA includes this clarifying language in a separate section to mirror the format of proposed Section 4.3.2.

Section 4.4, “Market Categories.”

OHCA removes the note within the text box following market category “2” in this section and relocates the information in the box to a new Section 4.4.1, “Product Types.” OHCA adopts the reasons provided for this change in Section 4.4.1 of this Finding of Emergency here.

OHCA revises the title of the note within the text box at the end of this section to: "Reporting Dual Eligibles members." OHCA proposes this change to make the note title more descriptive. The revised title also places emphasis on "members" because member months are calculated at the member-level prior to reporting on a mutually exclusive basis across the three Dual Eligibles market categories. This is a non-substantive change, as no obligation is changed.

Section 4.4.1, "Product Types"

OHCA relocates and revises the information in the existing note within a text box following market category "2" in Section 4.4 to this proposed Section 4.4.1. The purpose of this new section is to improve the usability of the Guide Version 3.0 by including information related to disaggregation by product type within a single, easy to locate section.

The first paragraph of this section and its accompanying bullet points require submitters to disaggregate total medical expense for self-insured product types from fully insured product types in the Statewide TME file only. This new requirement will enable OHCA to more accurately calculate THCE at the statewide level because OHCA uses two different data sources for the administrative costs and profits portion of the THCE calculation. For self-insured lines of business, OHCA uses the Administrative Costs and Profits for Self-Insured Plans field (SQS023) from the Submission Questionnaire file. For fully insured lines of business, OHCA uses Federal Medical Loss Ratio (MLR) information obtained from the Centers for Medicare and Medicaid Services (CMS). Disaggregation by self-insured and fully insured product types will enable OHCA to better align the total medical expense reported by submitters and these administrative costs and profits data sources. This change is necessary to improve the reliability of per capita THCE calculations and give OHCA greater insight into data completeness.

The second paragraph of this section and its accompanying bullet points clarify the existing requirement that in the APM, Primary Care, and Behavioral Health files, disaggregation by product type does not differentiate between self-insured and fully insured product types.

Additionally, OHCA adds a requirement that submitters using the "Other" product type category provide a description of the product type in the Other Product Type field of the Submission Questionnaire file (SQS025). OHCA adds this requirement based on its experience in the September 2025 data submission. Specifically, some submitters erroneously included insurance products that are excluded from data submission in the "Other" category (*e.g.*, supplemental insurance products). This additional requirement is necessary for OHCA to validate that products listed in the "Other" category are appropriately captured in total medical expense reporting. It also gives OHCA greater insight into evolving benefit designs that may inform future changes to the product type category descriptions.

Section 4.5, “Member Attribution in the Attributed TME File.”

First, OHCA adds “in the Attributed TME File” to the title and first sentence of this section because the language is more specific and more accurately reflects the content of this section. This is a non-substantive change, as no obligation is changed.

Second, OHCA adds the word “physician” in multiple locations throughout this section. This non-substantive change clarifies that in the Attributed TME file total medical expense for covered health benefits is attributed to physician organizations, as defined in 22 CCR 97445(l), as opposed to organizations generally.

Third, for similar reasons, OHCA adds the following sentence to the first paragraph of this section:

> 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)).

This non-substantive change emphasizes that in the Attributed TME file total medical expense for covered health benefits is attributed to physician organizations, not to other payers or fully integrated delivery systems. OHCA includes a parenthetical reference to “plan-to-plan contract” to make it easier for submitters to cross-reference the section of the regulation text defining this term for a common contracting scenario.

Fourth, OHCA replaces “Note” in the text box at the bottom of this section with “Attributing members to other physician organizations” because this language is more specific and improves the navigability of the Guide Version 3.0. This is a non-substantive change, as no obligation is changed.

Finally, OHCA relocates the second to last sentence in the text box to a new paragraph within the text box and adds the following instruction: “The 1,000-member count shall be calculated across all market categories as of December 31 of the most recent reporting year.” The purpose of this instruction is to avoid potential confusion regarding the time parameters for calculating the 1,000-attributable members referenced in the preceding sentence. A time parameter of December 31 of the most recent reporting year is appropriate in this context because it is consistent with the time parameter submitters are required to use when calculating and reporting enrollment to OHCA during Data Portal registration. Accordingly, this instruction is necessary to ensure each submitter’s identification of physician organizations with 1,000-attributable members is standardized and consistent with corresponding submitter enrollment data.

Section 4.6, “Self-Insured Plans.”

OHCA replaces “shall be” with “is” in the second paragraph of this section. The Administrative Costs and Profits for Self-Insured Plans field (SQS023) is requested by

OHCA. The revised language is necessary to avoid any confusion regarding whether the field is currently required.

Sections 4.7, “Standard Deviation” and 4.7.2, “Attributed TME File.”

OHCA adds the word “physician” in multiple locations in these sections. These non-substantive changes clarify that in the Attributed TME file total medical expense for covered health benefits is attributed to physician organizations, as defined in 22 CCR 97445(l), as opposed to organizations generally.

Section 4.8, “APM File Payment Allocation.”

OHCA reorganizes and relocates the existing language in Sections 4.8 and 4.8.1 to a proposed updated Section 4.8. The changes to these sections do not affect any existing requirements or file specifications. Instead, the purpose of the changes is to improve the clarity of the instructions.

Specifically, based on feedback received during the September 2025 data submission, some submitters were unsure whether to include fee-for-service claims payments and/or non-claims payments for members with no utilization in the APM file. Some submitters also requested additional guidance on the order of operations for the APM file payment allocation. Taking this valuable feedback from submitters into account, OHCA proposes reorganized step-by-step instructions and an additional illustrative process map, discussed in turn below.

Introductory paragraphs, Step 1, and Figure 1

OHCA relocates and reorganizes the instructions from the first paragraph of existing Section 4.8 to the introductory paragraphs and Step 1 of proposed Section 4.8. OHCA also integrates existing Figure 1 into proposed Step 1 and revises the title to: “Continuum of Provider Clinical and Financial Risk for Non-Claims Payments.”

The purpose of Step 1 is to provide submitters with instructions for how to categorize their payment models for the APM file. Specifically, this section instructs submitters how to allocate payments and member months to the correct payment categories and subcategories listed in Appendix B, “Payment Arrangements and Classification”[6] (renamed) in the APM file. This section is necessary because OHCA is required to annually report on health care entity progress toward meeting OHCA’s APM Adoption Goals (hereinafter, the “APM Adoption Goals”), which were approved by the Board in June 2024. (Health & Saf. Code, § 127504.)

The purpose of the first sub-bullet in Step 1 is to instruct submitters on how to allocate a member’s expense and member months to a single payment subcategory in the APM

[6] The specific purpose and necessity of Appendix B is discussed in the Appendix B, “Payment Arrangements and Classification” section of this Finding of Emergency.

file and to provide an example of how to categorize payment arrangements with multiple types of non-claims payments. This sub-bullet is necessary because OHCA is required to report on progress toward meeting statewide APM adoption goals, which is focused on members in payment arrangements classified as Expanded Non-Claims Payments Framework categories C and D.[7]

The purpose of the second sub-bullet in Step 1 is to instruct submitters on how a payment subcategory applies to a member if the member was covered by any contracted payment arrangement that meets the subcategory's description, even if the member had not utilized any services resulting in expenses. OHCA adds this sub-bullet in response to questions from submitters regarding whether members with no utilization should be included in the APM file payment allocation. This sub-bullet is necessary to ensure OHCA receives complete data submissions to enable accurate reporting on each submitter's progress towards meeting statewide APM adoption goals.

The purpose of the final sentence in Step 1 is to clarify that members not assigned to subcategories A1-D6 are to be assigned to the fee-for-service only category and subcategory. OHCA adds this sentence in response to questions from submitters regarding whether the APM file payment allocation should include members in fee-for-service-only payment arrangements. This sub-bullet is necessary to ensure OHCA receives complete data submissions to enable accurate reporting on each submitter's progress towards meeting statewide APM adoption goals.

Step 2

OHCA relocates and reorganizes the instructions from Note 2 of existing Section 4.8 to Step 2 of proposed Section 4.8. The purpose of Step 2 is to provide submitters with instructions for how to differentiate between payment arrangements that are linked to quality and those that are not, and how to report on these payment arrangements separately.

Step 2 clarifies that fee-for-service only claims are never considered linked to quality, even in scenarios where fee-for-service fee schedules are increased as a quality-related reward. Step 2 further clarifies that the "link to quality" is based on member attribution to a payment arrangement in subcategory B2 or categories C or D where the participating provider is eligible for an adjusted non-claims payment based on specific predefined goals for quality. A provider does not need to successfully earn an adjusted non-claims payment for the payment arrangement to have a "link to quality".

OHCA adds specific references to subcategory B2, category C, and category D for clarity and to improve the Guide Version 3.0's ease of use. The existing Guide specifies

[7] *See* Memo Re: OHCA's APM Standards and Adoption Goals at p. 6, available at: https://hcai.ca.gov/wp-content/uploads/2024/07/Board-Adopted-APM-Standards-and-Adoption-Goals-Memo-Final.pdf, last accessed January 20, 2026.

payment arrangements in these categories and subcategory may be considered "linked to quality," but the specification is in existing Appendix B. OHCA proposes relocating this specification to Step 2 of Section 4.8 so information regarding the "link to quality" determination is in one location in the Guide Version 3.0. OHCA makes these clarifications in response to stakeholder comments received during the informal comment period for this proposed regulation.

Step 2 is necessary because the members that count towards OHCA's APM Adoption Goals must belong to a payment arrangement eligible for an adjusted non-claims payment based on specific predefined goals for quality.[8]

Step 3

OHCA relocates and revises the instructions from Step 2 of existing Section 4.8.1 to Step 3 of proposed Section 4.8. The purpose of Step 3 is to instruct submitters how to report total medical expense after allocating members to a payment subcategory. Revised language in Step 3 also clarifies that total medical expense includes "all claims payments, non-claims payments, and members' financial responsibility across all providers during the reporting year…." Step 3 is necessary to ensure OHCA can accurately categorize members included in payment arrangements that count towards OHCA's APM Adoption Goals.[9] This will support OHCA's work to promote the shift from fee-for-service based payment arrangements to alternative payment models. (Health & Saf. Code, § 127504, subd. (a).)

Step 4

OHCA relocates and revises the instructions from Step 3 of existing Section 4.8.1 to Step 4 of proposed Section 4.8. The purpose of Step 4 is to instruct submitters how to report member months after allocating members to a payment subcategory. Revised language in Step 4 also includes additional instructions clarifying how to calculate member months in response to questions received from submitters during the September 2025 data submission. Step 4 is necessary to ensure OHCA can accurately categorize members included in payment arrangements that count towards OHCA's APM Adoption Goals.[10] This will support OHCA's work to promote the shift from fee-for-service based payment arrangements to alternative payment models. (Health & Saf. Code, § 127504, subd. (a).)

Figure 2

OHCA adds the process map in proposed Figure 2 to provide submitters with a visual reference for following the step-by-step instructions in proposed Section 4.8. Based on OHCA's experience during the September 2025 data submission, many submitters

[8] *Id.*
[9] *Id.*
[10] *Id.*

benefit from a visual reference when following data submission instructions. OHCA incorporates the reasons it provides for Steps 1 through 4 of Section 4.8 here.

Section 4.9, “Primary Care Allocation Methodology.”

OHCA replaces “shall contain” with “requires submitters to report” because it is more grammatically appropriate in the sentence. Additionally, OHCA replaces “methodology” with “methodologies” to accurately reflect the two distinct allocation methodologies described in Sections 4.9.1 and 4.9.2—Primary Care Paid via Claims and Primary Care Paid via Non-Claims.

These are non-substantive changes, as no obligation is changed.

Section 4.9.1, “Primary Care Paid via Claims.”

First, OHCA replaces references to “code set,” “Primary Care Providers Taxonomy List,” “Primary Care CMS Places of Service,” and “HCPCS/CPT Primary Care Services” with “OHCA Primary Care Addendum” throughout Section 4.9.1. This change reflects the consolidation of the existing code sets used for reporting spending in the Primary Care file into the “*OHCA Primary Care Addendum*,” dated April 2026, which OHCA proposes to incorporate by reference through this regulatory action. The specific purpose and necessity of the OHCA Primary Care Addendum is described in the *OHCA Primary Care Addendum* section of this Finding of Emergency.

These revisions are necessary to ensure submitters reference the correct document when reporting spending in the Primary Care file.

Second, OHCA strikes existing Figure 2 and replaces it with a new Figure 3. Figure 3 is an updated version of existing Figure 2 incorporating changes to the decision tree for the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories. The changes to the decision tree are necessary for consistency with proposed changes discussed in Step 2, below. OHCA incorporates the reasons it provides for the proposed changes discussed in Step 2, below, here.

Step 1

OHCA replaces “on” with “listed in” in the second sentence of this subsection for grammatical reasons. This is a non-substantive change, as no obligation is changed.

OHCA strikes “Note:” in the third sentence of this subsection because it is unnecessary and adds a “the” to the same sentence for grammatical reasons. These are non-substantive changes, as no obligation is changed.

OHCA adds a sentence at the end of this subsection clarifying that National Provider Identifier (NPI) shall not be used to identify primary care providers. The purpose of this sentence is to emphasize that provider taxonomy shall be used to identify primary care

spending, consistent with the instructions in the preceding sentences. OHCA adds this sentence in response to questions from submitters and common errors OHCA identified during the September 2025 data submission. This sentence is necessary to ensure accurate identification of primary care spending so OHCA can measure claims-based primary care spend as part of the primary care spending benchmark (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

During the informal comment period for this proposed regulation, a stakeholder requested OHCA revise the existing specifications to allow submitters to use the primary provider taxonomy code associated with a provider's NPI to identify primary care providers. OHCA declined this change because the CMS system that assigns unique NPIs to providers does not require taxonomy codes associated with a provider's NPI to be listed in any specific order. As a result, a provider's first listed taxonomy may not be a provider's primary taxonomy in scenarios where a provider has more than one specialty. Therefore, OHCA determined an NPI-based identification approach would likely undercount or overcount primary care providers and related spending.

Step 2

OHCA makes multiple changes to Step 2 in response to feedback received during the September 2025 data submission, specifically from submitters reporting spending in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories (hereinafter, collectively "MCPs"). MCPs are currently required to submit MCP network filings (the "274 files") to the Department of Health Care Services (DHCS), which include, among other things, a list of all Primary Care Providers (PCPs) in the MCPs' network.[11]

MCPs requested that OHCA allow the use of the 274 files to crosswalk primary care providers identified in Step 1, in lieu of the Annual Network Review data most MCPs submit to the Department of Managed Health Care (DMHC). Based on further discussions with the DHCS regarding the MCPs' request, OHCA agrees MCP use of the 274 files will promote consistency between OHCA and DHCS reporting requirements and reduce administrative burden for MCPs.

Accordingly, OHCA revises the first bulleted section of Step 2 to limit the instructions to the Commercial, Medicare Advantage, Dual Eligibles (Medicare Expenses Only) and Dual Eligibles (Medi-Cal and Medicare Expenses) market categories. The purpose of this change is to clarify that the existing requirement to use the Annual Network Review

[11] *See* DHCS All-Plan Letter 23-001, available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2,023/APL23-001.pdf, last accessed February 19, 2026 (providing guidance to Medi-Cal Managed Care Plans regarding requirement to maintain a network of providers, including PCPs).

data to crosswalk primary care providers identified in Step 1 does not apply to the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories.

Next, OHCA adds a second bulleted section to Step 2 specific to the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories. The purpose of this bulleted section is to instruct MCPs to use the 274 files submitted to the DHCS in January of the previous reporting year to crosswalk primary care providers identified in Step 1.

As noted above, the changes to Step 2 collectively ensure submitters categorize claims-based primary care spending using a standardized methodology so OHCA can accurately report on performance of health care entities against the primary care spending benchmark.

OHCA notes that during the informal comment period for this proposed regulation, a stakeholder commented that identifying primary care providers based on the point-in-time snapshot provided by the DMHC Annual Network Review data and the DHCS 274 files may understate primary care spending because it does not capture expenditures for terminated and non-contracted providers who were active during the measurement period. OHCA acknowledges the limitation of defining primary care providers based on a single point in time. However, based on discussions with both the DMHC and the DHCS, OHCA determined that use of the DMHC Annual Network Review data and the DHCS 274 files is necessary to promote consistency between OHCA and the DHCS reporting requirements and to reduce administrative burden for MCPs.

Step 3

OHCA replaces “Centers for Medicare and Medicaid (CMS) Plan or Service” with “place of service” for consistency with the naming convention of the referenced table in the proposed OHCA Primary Care Addendum. This is a non-substantive change, as no obligation is changed.

Step 4

OHCA replaces “final decision” with “fourth step” in the first sentence of Step 4 for consistency with the step-by-step language used throughout Section 4.9. OHCA also strikes “Note:” in the third sentence of Step 4 and relocates the proceeding instruction to a new sub-bullet. These are non-substantive changes, as no obligation is changed.

Next, in the proposed first sub-bullet of Step 4, OHCA adds the facility codes 71 (Clinic, Rural) and 77 (Freestanding Provider-Based FQHC). The purpose of these changes is to instruct submitters to report UB-04 payments with these facility codes that meet the primary care provider taxonomy and HCPCS/CPT service code requirements as primary care spend. The inclusion of these additional facility codes is necessary to ensure consistency with OHCA’s Primary Care Spending Measurement Methodology

for claims payments, in which rural clinic, freestanding facility, and FQHC are listed as primary care places of service.[12]

Finally, in the proposed second sub-bullet of Step 4, OHCA adds instructions for submitters in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories regarding how to report vaccination administration costs associated with the Medi-Cal Only Vaccines for Children (VFC) Program as primary care spend. OHCA adds these instructions in response to feedback received from submitters during the September 2025 data submission. Specifically, submitters expressed concern that OHCA's existing instructions did not capture vaccine administration costs for the VFC Program, which supplies vaccines at no cost to providers serving eligible children in Medi-Cal. Following further consultation with the DHCS regarding this concern, OHCA proposes these additional instructions. These changes are necessary to ensure submitters can accurately identify claims-based primary care spending and to support OHCA in measuring claims-based primary care spend as part of the primary care spending benchmark for MCPs (Health & Saf. Code, § 127505, subds. (a)(1) through (b).)

Step 5

The purpose of this section is to clarify that submitters are required 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). OHCA adds this clarifying language as a new Step 5 for emphasis and in response to questions received from submitters during the September 2025 data submission.

This sentence is necessary to ensure submitters report complete and accurate claims-based primary care spending. This will support OHCA in measuring claims-based primary care spending as part of the primary care spending benchmark

Section 4.9.2, "Primary Care Paid via Non-Claims."

OHCA makes multiple revisions to the language in the first paragraph of this section to make the language more specific and to improve the Guide Version 3.0's ease of use. These are non-substantive changes, as no obligation is changed.

OHCA adds the second paragraph of this section to instruct submitters to complete the Primary Care file prior to completing the proposed Behavioral Health file. This additional instruction is necessary to avoid duplicative reporting of spending in payment subcategories A1, A3, A4, A5, B1, B2, C3, and C4. Spending in these subcategories must be mutually exclusive across the Primary Care and Behavioral Health files to

[12] Memo Re: OHCA's Primary Care Investment Benchmark at p. 11, available at: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/primary-care-investment-benchmark/, last accessed January 22, 2026.

enable OHCA to report on submitter performance towards the primary care spending benchmark and measure behavioral spending (Health & Saf. Code, § 127505, subds. (a)(1) through (b).)

Subcategory A2

OHCA replaces “[a]llocate” with “[i]nclude” in the first sub-bullet of this subcategory section. This is a non-substantive change for consistency with the language used in other subcategory sections.

Subcategory A4 and Subcategory A5

OHCA makes similar changes to the sentence structure and language in both of these subcategory sections for clarity. These changes are non-substantive and are intended to improve the Guide Version 3.0’s ease of use.

Subcategory C1…

OHCA strikes the existing sub-bullet in this subcategory section and replaces it with the following:

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

The purpose of this change is to clarify the existing requirement that payments in subcategories C1 and C2 shall be reported in the Total Allowed Amount field (PRC007) but are not included in the Amount Paid for Primary Care field (PRC008). The existing language is ambiguous regarding whether such payments should be reported at all in any field. This change is necessary to ensure the accuracy and completeness of total medical expense data reported to OHCA.

Subcategory C3…

OHCA adds “a maximum of” to the second sentence of the last sub-bullet in this section for clarity. The existing instruction already requires submitters to limit the portion of shared savings (or recoupments) to a specified ratio. However, based on OHCA’s experience with the September 2025 data submission, describing the limit as a maximum amount is clearer and will ensure submitters accurately allocate payments in this subcategory.

OHCA also renumbers “Figure 3” referenced in this subcategory and throughout Section 4.9.2 to proposed “Figure 4” as necessary due to the addition of a figure earlier in the Guide Version 3.0.

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Figure 4

OHCA renames existing Figure 3 to "Figure 4. Equation for the Maximum Portion for Allocation of Shared Savings and Recoupments (Subcategories C3, C4, C5, and C6) to Primary Care." The proposed title is more descriptive. OHCA also relocates the title from below the figure to above the figure. These changes are intended to improve the Guide Version 3.0's ease of use.

Subcategory D2…

First, OHCA revises the language in the second sentence of the first sub-bullet in this section to clarify that the equation for allocating capitation and full risk payments to primary care is applied to each capitation payment discretely. OHCA proposes this more specific language in response to questions received from submitters during the September 2025 data submission. This language is necessary to ensure submitters accurately report the primary care portions of the specified non-claims payments to OHCA.

Second, OHCA strikes "HCPCS/CPT" in the second sub-bullet of this section because the inclusion of these extraneous acronyms is unnecessary. OHCA also replaces the reference to "Appendix E: Primary Care Code Sets" with "OHCA Primary Care Addendum" in this sub-bullet. This change reflects the consolidation of the existing code sets used for reporting spending in the Primary Care file into the "*OHCA Primary Care Addendum*," dated April 2026, which OHCA proposes to incorporate by reference through this regulatory action. The specific purpose and necessity of the OHCA Primary Care Addendum is described in the *OHCA Primary Care Addendum* section of this Finding of Emergency.

Third, OHCA adds a sentence to the proposed third sub-bullet of this section to clarify that submitters must include as encounters in the denominator sum all encounters included in the relevant capitation payment (*e.g.*, for subcategory D2, all encounters included in professional capitation), when applying the equation in proposed Figure 5 to allocate capitation payments to primary care. OHCA adds this sentence in response to questions received from submitters during the September 2025 data submission. This sentence is necessary to ensure submitters accurately report non-claims-based primary care spending. This will support OHCA in measuring non-claims-based primary care spend as part of the primary care spending benchmark (Health & Saf. Code, § 127505, subds. (a)(1) through (b).)

Fourth, in the proposed fifth sub-bullet of this section, OHCA replaces "payer type" to "market category" for consistency with the language used throughout the Guide Version 3.0 when referring to the various payers in the California health care market (*e.g.*, commercial payers report spending in the Commercial (Full Benefits) and Commercial (Partial Benefits) market categories, etc.). OHCA also renumbers "Figure 4" referenced in this sub-bullet and throughout Section 4.9.2 to proposed "Figure 5" as necessary due to the addition of a figure earlier in the Guide Version 3.0.

Fifth, OHCA adds a sentence to the proposed sixth sub-bullet of this section. This sentence clarifies that submitters shall develop a unique ratio for each capitation payment included in a provider contract, and each ratio shall be applied to its corresponding capitation payment. This sentence further emphasizes that submitters shall not apply a single ratio across an entire payment subcategory, when allocating capitation payments to primary care. OHCA adds this sentence in response to questions received from submitters during the September 2025 data submission. This sentence is necessary to ensure submitters to accurately report non-claims-based primary care spending. This will support OHCA in measuring non-claims-based primary care spend as part of the primary care spending benchmark (Health & Saf. Code, § 127505, subds. (a)(1) through (b).)

Finally, OHCA revises the language in the final sub-bullet of this section for grammatical reasons. OHCA also adds a parenthetical example to the instruction in this sub-bullet to improve the Guide Version 3.0's ease of use. These are non-substantive changes, as no obligation is changed.

Figure 5

OHCA renumbers existing Figure 4 to "Figure 5". OHCA also relocates the title from below the figure to above the figure and revises the title to include a parenthetical with specific references to the relevant payment arrangement subcategories. Collectively, these non-substantive changes ensure numbering remains chronological and improve the Guide Version 3.0's ease of use.

Subcategory D3…

OHCA strikes the existing sub-bullet in this subcategory section and replaces it with the following:

> 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).

The purpose of this change is to clarify the existing requirement that payments in subcategories D3 and D4 shall be reported in the Total Allowed Amount field (PRC007) but are not included in the Amount Paid for Primary Care field (PRC008). The existing language is ambiguous regarding whether such payments should be reported at all in any field. This change is necessary to ensure the accuracy and completeness of total medical expense data reported to OHCA.

Category E

OHCA strikes the existing sentence in this category section and replaces it with the following:

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).

The purpose of this change is to clarify the existing requirement that payments in subcategory E1 shall be reported in the Total Allowed Amount field (PRC007) but are not included in the Amount Paid for Primary Care field (PRC008). The existing language is ambiguous regarding whether such payments should be reported at all in any field. This change is necessary to ensure the accuracy and completeness of total medical expense data reported to OHCA.

Section 4.9.3, "Primary Care Member Months."

Based on OHCA's experience during the September 2025 data submission, some submitters incorrectly reported member months in the Primary Care file on a mutually exclusive basis across payment subcategories. This was likely a common source of confusion for submitters because member months are reported on a mutually exclusive basis in all other existing file types.[13]

The purpose of this new section is to emphasize the existing requirement that member months in the Primary Care file are reported on a non-mutually exclusive basis across the payment subcategories. Specifically, when a member has payments in multiple payment subcategories during a given month, a member month shall be assigned to each subcategory in which payments were made during that month. Accordingly, a member with 12 months of coverage may have more than 12 member months reported in the Primary Care file. This section also includes additional clarifying language informed by questions received from submitters during technical assistance meetings with OHCA.

This section is necessary because submitters must accurately report member months on a non-mutually exclusive basis in the Primary Care file for OHCA to understand the member months associated with each distinct payment subcategory listed in Appendix B. OHCA uses this information to assess and validate the reasonableness of the spending amounts assigned to each payment subcategory. For example, OHCA can consider whether a submitter's per member per month capitation amount seems reasonable based on known industry payment trends, payer and provider stakeholder discussions, data available from other states, and comparisons across submitters and files. If an amount does not seem initially reasonable, OHCA can engage with the submitter to confirm accuracy and completeness. OHCA also uses this information to understand trends in payment models used to support primary care and opportunities for increased investment. For example, this information provides OHCA with insight into the distribution of primary care spending across claims and non-claims payment spending categories on a per member per month basis. This information also supports

[13] Member months are not reported in the proposed Behavioral Health file.

OHCA's efforts to monitor trends in the number of Californians covered under primary care capitation. This section is also necessary to ensure instructions regarding member months in the Primary Care file are easy to locate in the Guide Version 3.0.

Section 4.10, "Behavioral Health Payment Allocation Methodology."

The purpose of this section is to introduce submitters to OHCA's behavioral health payment allocation methodology. This section informs submitters that both the behavioral health claims and non-claims portions of total medical expenses will be used to calculate behavioral health spending. This section is necessary because OHCA is required to measure the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).) OHCA will measure behavioral health spending using the data reported by submitters in the Behavioral Health file.

OHCA requires submitters to complete the Primary Care file prior to completing the Behavioral Health file to ensure standardization and consistency across submitters' primary care and behavioral health reporting.

Specifically, for behavioral health paid via non-claims, some payment subcategories must be reported on a mutually exclusive basis. It is possible some submitters could interpret payments in these subcategories as behavioral health or primary care or both. Accordingly, if some submitters complete the Primary Care file first, while others complete the Behavioral Health file first, there could be a lack of standardization in how such claims are reported on a mutually exclusive basis by submitters. In these scenarios, the instruction to complete the Primary Care file first and to not include any of the payments allocated to primary care as behavioral health provides clarity to submitters.

For behavioral health paid via claims, the Primary Care file collects behavioral health in primary care spending in the aggregate with primary care spending, whereas the Behavioral Health file collects behavioral health in primary care spending in the "Outpatient Professional Primary Care" service subcategory. Requiring submitters to complete the Primary Care file before the Behavioral Health file enables OHCA to subtract the behavioral health in primary care spending in the Behavioral Health file from such spending in the Primary Care file to avoid double-counting the spending when reporting primary care and behavioral health care spending together.

Section 4.10.1, "Behavioral Health Paid via Claims."

The purpose of this section is to instruct payers how to identify, designate, categorize, and report the behavioral health claim types included in OHCA's behavioral health spending measurement in the Behavioral Health file.

First, this section specifies the four behavioral health claim types included in OHCA's behavioral health spending measurement:

(1) Medical claims with a primary behavioral health diagnosis.
(2) Medical claims without a primary behavioral health diagnosis with a behavioral health screening or assessment service.
(3) Medi-Cal medical claims for members under 21 years of age without a primary behavioral health diagnosis but with a behavioral health service.
(4) Pharmacy claims for behavioral health treatments.

OHCA determined the four behavioral health claim types included in behavioral health spending measurement after extensive discussion with OHCA's Investment and Payment Workgroup and in consultation with experts on behavioral health spending measurement. OHCA also utilized existing behavioral health spending measurement approaches developed by the Milbank Memorial Fund and Massachusetts as a starting point.[14]

During the informal comment period for this proposed regulation, a stakeholder requested that OHCA include medical claims with a secondary behavioral health diagnosis in behavioral health spending measurement to avoid undercounting certain behavioral health services provided by hospitals. OHCA considered including medical claims with a secondary behavioral health diagnosis during its public decision-making process, including discussion on this topic during the aforementioned Investment and Payment Workgroup meetings. However, OHCA ultimately determined including such claims would result in significant overcounting of non-behavioral health spending and significant additional submitter reporting burden.

OHCA also notes that the January 2026 draft of this regulation initially identified three behavioral health claim types, with the Medi-Cal claim type (proposed claim type three) included as a sub-type of one of the other three claim types. However, based on feedback received during the informal comment period for this proposed regulation, OHCA added the Medi-Cal claim type as a fourth claim type to improve the readability and organization of the instructions in Section 4.10.1 of the Guide Version 3.0.

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[14] *See, e.g.*, Milbank Memorial Fund Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending ("Milbank Specifications"), available at: https://www.milbank.org/wp-content/uploads/2024/08/BH-Measurement-Technical-Specifications.pdf, last accessed February 10, 2026; and Massachusetts Center for Health Information and Analysis' Data Specification Manual for Payer Reporting of Primary Care and Behavioral Health Expenses ("CHIA Manual"), available at: https://www.chiamass.gov/assets/docs/p/pbhc/2025-PCBH/PCBH-2025-Data-Specification-Manual.pdf, last accessed February 10, 2026; *see also* OHCA Proposed Behavioral Health Spending Definition and Measurement Methodology ("OHCA BH Proposal") at pp. 7-8, available at: https://hcai.ca.gov/wp-content/uploads/2025/08/OHCA-Proposed-Behavioral-Health-Definition_2025.08.04-1.pdf, last accessed February 10, 2026 (includes information on OHCA's Behavioral Health Spending Measurement Methodology for claims and non-claims behavioral health spending).

Next, for each of the four claim types listed above, this section outlines how to determine reportable behavioral health spending based on a corresponding step-by-step process and illustrative graphic flow chart. For the first three behavioral health claim types, the process explains how to identify the behavioral health claim type, how to designate the claim or claim lines as either mental health or substance use disorder, how to categorize the claim or claim lines into service subcategories, and how to report the claim or claim lines as behavioral health spending in the Behavioral Health file. For the fourth behavioral health claim type, the process explains how to identify the behavioral health pharmacy claim type, how to designate the claim as either mental health or substance use disorder, how to categorize the claim into service subcategories based on the mental health or substance use disorder designation, and how to report the claim as behavioral health pharmacy claims spending in the Behavioral Health file. The corresponding step-by-step process for each of the four claim types refers submitters to specified code set tables within the OHCA Behavioral Health Addendum. The specific purpose and necessity of each code set table is discussed in the *OHCA Behavioral Health Addendum* section of this Finding of Emergency.

OHCA developed the instructions for identifying, designating, categorizing, and reporting behavioral health spending in consultation with experts in behavioral health spending measurement, using existing measurement approaches developed by the Milbank Memorial Fund and Massachusetts as a starting point.[15] OHCA's proposed measurement approach was also informed by months of discussion with the Investment and Payment Workgroup and additional stakeholder feedback, including from OHCA's sibling state departments.[16]

With regards to behavioral health service subcategories, OHCA's Investment and Payment Workgroup, the Board, and the Advisory Committee, provided input on service subcategories of interest for purposes of monitoring behavioral health spending and future development of OHCA's behavioral health investment benchmarks. OHCA also conducted analysis of spending in each potential service subcategory using data from HCAI's Health Care Payments Data (HPD) Program to refine service subcategory selection. OHCA's code selection was further informed by the Milbank Memorial Fund's Advisory Group recommendations for a standardized definition of clinical behavioral

[15] *See, e.g.*, Milbank Specifications, available at: https://www.milbank.org/wp-content/uploads/2024/08/BH-Measurement-Technical-Specifications.pdf, last accessed February 10, 2026 *and* CHIA Manual, available at: https://www.chiamass.gov/assets/docs/p/pbhc/2025-PCBH/PCBH-2025-Data-Specification-Manual.pdf, last accessed February 10, 2026.
[16] *See* OHCA BH Proposal at pp. 4-5, available at: https://hcai.ca.gov/wp-content/uploads/2025/08/OHCA-Proposed-Behavioral-Health-Definition_2025.08.04-1.pdf, last accessed February 10, 2026.

health spending.[17] Specifically, OHCA applied the Milbank recommendations to HPD Program data, which indicated a higher level of specificity (i.e., service subcategory ordering and mutually exclusive subcategorization) was needed to reduce the mis-categorization or double-counting of claims.

This section is necessary because submitters must report medical claims spend for all four behavioral health claim types to ensure OHCA receives comprehensive information regarding the behavioral health spending that occurs in multiple common clinical scenarios. The standardized stratifications detailed in this section are necessary for OHCA to accurately measure and report on the percentage of total health care expenditures allocated to behavioral health (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Section 4.10.2, "Behavioral Health Paid via Non-Claims."

The purpose of this section is to instruct payers how to identify behavioral health portions of non-claims payments and report them in the Behavioral Health file.

Specifically, this section lists payment categories and subcategories included in Appendix B: Payment Arrangements and Classification, and provides a methodology endorsed by OHCA's Investment and Payment Workgroup for apportioning these non-claims payments to behavioral health. Non-claims payments in the listed subcategories may include payments for both non-behavioral health and behavioral health spending. To avoid overcounting non-behavioral health spending, some subcategories of non-claims payments are fully allocated to behavioral health spending, others are partially allocated to behavioral health spending, and a few are excluded from behavioral health spending. For example, for payments in subcategories C3 (Condition-related, episode-based payments with shared savings) and C4 (Condition-related, episode-based payments with risk of recoupments), submitters are required to include spending for service bundles for behavioral health-related episodes of care shared savings or recoupment arrangements identified in submitter contracts with providers only. Spending in these subcategories for non-behavioral health-related episodes of care shared savings or recoupment arrangements are not reported as behavioral health spending. OHCA requires submitters to perform the allocations, as opposed to OHCA, because OHCA does not have access to submitter contracts with providers.

OHCA developed these allocations and instructions in consultation with experts on behavioral health spending measurement, using existing measurement approaches

[17] *See* Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending (Milbank Recommendations) at Appendix A, available at: https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/, last accessed January 29, 2026.

developed by the Milbank Memorial Fund and Massachusetts as a starting point.[18] OHCA's proposed measurement approach was also informed by months of discussion with the Investment and Payment Workgroup and additional stakeholder feedback, including from OHCA's sibling state departments.[19]

This section also includes graphic flow charts to improve the Guide Version 3.0's ease of use. Figure 10 visually instructs submitters how to allocate non-claims payment subcategory A4 or A5 payments to behavioral health. Figure 11 visually instructs submitters how to allocate non-claims capitation and full risk payments (subcategories D2, D4, D5, and D6) to behavioral health. Figure 12 visually instructs submitters how to allocate non-claims payment subcategory E1 payments to behavioral health.

This section is necessary because submitters must identify and report non-claims behavioral health spending using a standardized methodology for OHCA to accurately measure and report on the percentage of total health care expenditures allocated to behavioral health (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Section 5, "File Layouts and Field Specifications."

In each subsection, updates include re-numbering as needed due to additions or deletions, and corresponding text edits as described in Sections 1-5, above. OHCA also adds a clarifying example to the "Submission Year" field. This addition is necessary to ensure submitters report the accurate submission year if a file is submitted (or resubmitted) after December 31 of the annual data file submission deadline year pursuant to 22 CCR 97449(h).

Sections 5.1 and 5.2

Sections 5.1 and 5.2 are the tables of data elements that must be submitted with each data file's header and trailer records. OHCA amends these tables for consistency with the proposed Behavioral Health file type identified in Section 3.1 of the Guide Version 3.0. OHCA incorporates the reasons it provides for this new file type in Section 3.1, "Required Files" here. OHCA also revises the field for "Guide Version Number" for clarity and consistency. Specifically, the change to decimal type with a max value of two digits with 1 digit after the decimal is necessary to ensure submitters use a standardized

[18] *See, e.g.*, Milbank Specifications, available at: https://www.milbank.org/wp-content/uploads/2024/08/BH-Measurement-Technical-Specifications.pdf, last accessed February 10, 2026 *and* CHIA Manual, available at: https://www.chiamass.gov/assets/docs/p/pbhc/2025-PCBH/PCBH-2025-Data-Specification-Manual.pdf, last accessed February 10, 2026.
[19] *See* OHCA BH Proposal at pp. 4-5, available at: https://hcai.ca.gov/wp-content/uploads/2025/08/OHCA-Proposed-Behavioral-Health-Definition_2025.08.04-1.pdf, last accessed February 10, 2026.

value for identifying the version number of the Guide used to complete the data submission

Sections 5.3 through 5.9

These are the tables of data elements that must be submitted with the 7 existing required data files identified in Section 3.1 of the Guide Version 3.0. OHCA updates these tables for consistency with the proposed amendments to existing data submission requirements. OHCA incorporates the reasons it provides for these amendments in Sections 3.1 through 4.10 here.

OHCA also makes changes to data elements in Sections 5.3-5.9 that are not addressed elsewhere in this document. In all files, OHCA renumbers the “Submission Year” field and corresponding column numbers where necessary, to ensure that the field remains the second-to-last field if new fields are added in future versions of the Guide.

In Section 5.3, OHCA replaces the reference to Section 4.4, “Market Categories” with a reference to proposed Section 4.4.1, “Product Types.” OHCA also adds “all” and “regardless of product type” to the language in the “Product Type” field describing the entry for “0 = Not applicable.” OHCA makes these revisions for clarity and consistency with the proposed changes described in Section 4.4, “Market Categories” and the proposed addition of Section 4.4.1, “Product Types.” These revisions are necessary to emphasize that disaggregation by product type is only required in the Commercial (Full Benefits) and Commercial (Partial Benefits) market categories.

In Section 5.4, OHCA adds the word “physician” to multiple field descriptions. These non-substantive changes clarify that in the Attributed TME file total medical expense for covered health benefits is attributed to physician organizations, as defined in 22 CCR 97445(l), as opposed to organizations generally.

Also in Section 5.4, OHCA adds language to the data field description for “Organization National Provider Identifier” specifying submitters are required to use the Type 2 National Provider Identifier (NPI) to populate the field. OHCA adds this instruction based on a question received during the September 2025 data submission about the correct NPI number to use in this field when multiple NPIs are available. This revision is necessary for clarity and to ensure consistent identification of physician organizations in the Attributed TME file. OHCA also adds the parenthetical “(SQS017)” in the “Age Band” data field, and inserts “only” into the descriptions in the “Age Band” and “Sex” data fields to address common data validation errors encountered during the September 2025 data submission. These are non-substantive changes, as no obligation is changed.

In Section 5.6, OHCA strikes “[r]eport” and adds the following language in Field IDs RXR004 through RXR006: “For the Commercial (Partial Benefits) market category, if pharmacy rebates are carved out, create a reasonable estimate of pharmacy rebates. For all other market categories, report….” This non-substantive change is necessary for

consistency with the existing requirement in Section 4.1.3, “Pharmacy Rebates,” that submitters create a reasonable estimate of pharmacy rebates when pharmacy benefits are carved-out.
In Section 5.7, OHCA adds “in the Attributed TME file” to the “Unknown Age Band” field description. The existing language already includes a parenthetical “(ATT009)” identifying the relevant field in the Attributed TME file, but spelling out the name of the file is clearer. This is a non-substantive change, as no obligation is changed.

Also in Section 5.7, OHCA adds the following sentence to the “Procedure and Condition-Specific Episode-based Payment Arrangements” field: “This field is required when amounts are reported in the Primary Care File for Payment Subcategory (PRC006) C1, C2, C3, or C4.” OHCA adds this sentence for consistency with proposed revised language in Appendix D, “Condition and Procedure Types.”’ OHCA incorporates the reasons it provides for the change in the Appendix D section of this Finding of Emergency here.

Again in Section 5.7, OHCA adds an “Other Product Type” field. The purpose of this field is to capture information regarding the types of health plan or health insurance products offered by submitters that cannot be classified in OHCA’s existing product type descriptions. OHCA adds this field to inform potential future changes to the existing product type descriptions. OHCA also adds this field as a way to validate whether submitters accurately classified product types in the data submission. This field is necessary to ensure the disaggregation of spending by submitters by product type is consistent and accurate.

Lastly in Section 5.7, OHCA adds an “Attestation” field. The purpose of this field is to obtain an attestation under penalty of perjury from a representative of the submitter certifying the information provided in the data submission is true and correct to the best of the representative’s knowledge. Certification under penalty of perjury is necessary to ensure that the data submission contains truthful, factual representations made in good faith, which helps ensure the reliability of the submission to OHCA. (See e.g., *In re Marriage of Reese & Guy* (1999) 73 Cal.App.4th 1214, 1223 [judicial explanation for the use of certifications under penalty of perjury: “The whole point of permitting a declaration under penalty of perjury, in lieu of a sworn statement, is to help ensure that declarations contain a truthful factual representation and are made in good faith.”], disapp. on another point in *Laborde v. Aronson* (2001) 92 Cal. App.4th 459, 465.)

During the informal comment period for this regulatory proposal, a stakeholder questioned whether an attestation under penalty of perjury was appropriate and recommended OHCA remove “under penalty of perjury under the laws of the State of California” from this field description. The stakeholder also stated the DMHC does not require attestations under penalty of perjury for data submissions. However, OHCA retains this language because it is necessary (for the reasons stated above) and consistent with data submission regulations for OHCA’s Cost and Impact Market Impact Review (CMIR) program and HCAI’s Hospital Annual Financial Data Reporting (HAFDR) system. (Cal. Code Regs., tit. 22, § 97438, subd. (a) [CMIR] and § 77043,

subd. (a) [HAFDR].) Additionally, OHCA notes that all documents submitted by health plans to the DMHC's eFiling system, including all required health plan filings, exhibits, and attachments, are certified under penalty of perjury by a health plan representative. (Cal. Code Regs., tit. 28 § 1300.41.8, subd. (c)(2).)[20]

In Section 5.8, OHCA revises the description of the "Quality Indicator" field (APM007) for consistency with the proposed changes in Section 4.8, "APM File Payment Allocation." OHCA incorporates the reasons it provides for these changes in Section 4.8 of this Finding of Emergency here. OHCA also revises the last paragraph in the "Total Amount Allowed" field (APM008) to read as follows: "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." The purpose of this change is to emphasize this key difference between the APM file and all other files. This change is necessary to enable accurate reporting on submitter progress towards APM adoption goals. (Health & Saf. Code, § 127505, subd. (a)(1) and (b).).

In Sections 5.8 and 5.9, OHCA replaces the reference to Section 4.4, "Market Categories" with a reference to proposed Section 4.4.1, "Product Types." OHCA also adds "only," "all," and "regardless of product type" to the language in the "Product Type" field describing the entry for "0 = Not applicable." OHCA makes these revisions for clarity and consistency with the proposed changes described in Section 4.4, "Market Categories" and the proposed addition of Section 4.4.1, "Product Types." These revisions are necessary to emphasize that disaggregation by product type is only required in the Commercial (Full Benefits) and Commercial (Partial Benefits) market categories.

In Section 5.9, OHCA adds the following sentence to the "Payment Subcategory" field: "Note: When the 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." OHCA adds this sentence for consistency with proposed revised language in Appendix D, "Condition and Procedure Types." OHCA incorporates the reasons it provides for the change in the Appendix D section of this Finding of Emergency here.

Also in Section 5.9, OHCA revises the description of the "Member Months" field (PRC009) for consistency with the proposed changes in Section 4.9.3, "Primary Care Member Months." OHCA incorporates the reasons it provides for these changes in Section 4.9.3 of this Finding of Emergency here.

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[20] *See e.g.*, DMHC Electronic Filing Signature Verification Form (DMHC 10-066), available at: https://www.dmhc.ca.gov/Portals/0/Docs/OPL/ElectronicFilingSignatureVerification.pdf?ver=90Sv-i-feYWw_uyHxsArxw%3d%3d, last accessed February 12, 2026.

Section 5.10

This is the table of data elements that must be submitted with the proposed Behavioral Health file type identified in Section 3.1 of the Guide Version 3.0. OHCA incorporates the necessity statements for the Behavioral Health file type from Section 3.1, “Required Files” here.

Appendix A, "Claims Service Category to Bill Code Mapping"

OHCA revises the language in the introductory paragraph of this Appendix. OHCA also adds "Example" to the title of the third column of this Appendix. Collectively, the purpose of these revisions is to emphasize that the codes listed in this Appendix are examples and are not comprehensive. OHCA makes these revisions in response to questions received during the September 2025 data submission.

Additionally, OHCA adds a bullet for "Critical Access Hospital: 085X" to the list of hospital outpatient bill code types. OHCA makes this addition in response to a submitter question during the September 2025 data submission and to clarify that Critical Access Hospitals are an example meeting the existing category description of "all hospital types and hospital-licensed satellite clinics…."

Finally, OHCA replaces "CSM" with "CMS" in the "Example Code Sets" column of the "Professional" claims service category. This change is necessary to correct a typographical error.

Appendix B, "Payment Arrangements and Classification"

OHCA amends the title of the appendix to "Appendix B: Payment Arrangements and Classification." The title change is necessary to ensure submitters understand that the proposed iteration of the appendix is no longer identical to HCAI's Expanded Non-Claims Payments Framework (hereinafter, the "framework").[21] Instead, the proposed iteration of the appendix remains consistent with the framework but only includes payment arrangements and classifications that will be used by submitters when completing data submissions. The proposed title change also reflects revisions made to the appendix intended to improve its clarity and ease of use.

Specifically, OHCA revises payment arrangement category "E" to subcategory "E1" for accuracy and strikes category "F" in its entirety because it is not applicable to reporting in the APM and Primary Care files or the proposed Behavioral Health file. OHCA also deletes language in the descriptions of categories C and D explaining when payments in the categories may be considered "linked to quality" because this language is only relevant to the APM file. OHCA relocates this specification to Section 4.8 of the Guide Version 3.0. OHCA incorporates the reasons it provides for this change in Section 4.8 of this Finding of Emergency here.

OHCA adds "…claims (fee-for-service) and…" to Appendix B's introductory sentence. OHCA also adds subcategory "X9," "Fee-for-service only claims" to the table and strikes "Non-Claims" from the "Payment Category and Subcategory" column title. OHCA makes these three revisions in response to submitter confusion during the September 2025

[21] *See* HCAI's Expanded Non-Claims Payments Framework, available at: https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/, last accessed January 26, 2026.

data submission regarding whether and how to report fee-for-service spending in the APM and Primary Care files. These revisions ensure the appendix is inclusive of all payment arrangements and classifications that will be used by submitters when reporting data to OHCA, including fee-for-service claims. These revisions are necessary because submitters must accurately categorize claims and non-claims payment arrangements using a standardized methodology for OHCA to measure and report on progress towards APM adoption goals, the Primary Care Investment Benchmark, and the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Appendix D, "Condition and Procedure Types"

OHCA makes multiple amendments to Appendix D to clarify when and how submitters shall categorize payment arrangements when completing Field ID SQS024, "Procedure and Condition-Specific Episode-based Payment Arrangements," in the Submission Questionnaire File.

OHCA revises the language in the introductory paragraph to replace "episode-based payments" with "payment arrangements" and strike the phrase "…into their respective payment subcategories and procedure or condition type." The purpose of the former change is to make the introduction clearer by relocating the reference to "episode-based payments" to proposed new phrasing at the end of the sentence that includes specific references to the payment arrangement subcategories that are episode-based (*i.e.*, C1, C2, C3, or C4.). The purpose of the latter change is to remove unnecessary language. These are non-substantive changes, as no obligation is changed.

OHCA replaces "APM006" with "PRC006" in the Procedure-related, Episode-based Payments" and "Condition-related, Episode-based Payments" subsections. The purpose of this change is to correct an error in the existing instructions. Because the APM file requires submitters to allocate all of a member's spending in the subcategory furthest along the continuum of provider clinical and financial risk, APM006 reflects allocated subcategory spending (*e.g.*, a member in a C2 payment arrangement may be reported in D1 because the latter subcategory is further along the continuum). The Primary Care file does not utilize this allocation methodology. Accordingly, PRC006 is the correct cross-reference for identifying the submitter's actual payment arrangement subcategories.

Also in the "Procedure-related, Episode-based Payments" and "Condition-related, Episode-based Payments" subsections, OHCA replaces "…use the procedure types in…" with more specific instructions regarding how and where to report the condition and procedure types listed in the corresponding table.

Each of the above changes is necessary to ensure submitters accurately report information related to episode-based payment arrangements, which are included as part of OHCA's APM Adoption Goals. The data reported using Appendix D supports OHCA's

work to promote the shift from payments based on fee-for-service to alternative payment models. (*See* Health & Saf. Code, § 127504, subd. (a).).

Appendix E, "Cross-File Data Quality Checks"

OHCA strikes the existing "Appendix E: Primary Care Code Sets" and replaces it with "Appendix E: Cross-File Data Quality Checks." As explained in the *OHCA Primary Care Addendum* section of this Finding of Emergency, OHCA proposes to consolidate all primary care code sets included in the existing version of the Guide into a new *OHCA Primary Care Addendum*, incorporated by reference through this regulatory action.

OHCA adds the proposed appendix in response to submitter feedback received during the September 2025 data submission. Specifically, submitters requested a list of the most common cross-file data quality checks OHCA performs after all required files have been received from a submitter. Submitters indicated they would use such a list to perform their own cross-file data quality checks prior to submitting files to OHCA.

Although the proposed appendix does not contain any additional requirements for submitters beyond what is already specified elsewhere in the Guide Version 3.0, including it as an appendix ensures it is easily accessible to submitters as they extract and aggregate THCE data and finalize file submissions. OHCA also includes the proposed appendix in the Guide Version 3.0 to ensure it is regularly updated consistent with any changes to data specifications in future versions of the Guide.

The proposed appendix is necessary to promote consistency and accuracy across each submitter's required files. The proposed appendix is also necessary to reduce the amount of time spent by submitters and OHCA remediating easily preventable data quality errors identified after OHCA receives all required files from a submitter.

OHCA notes that during the informal comment period for this regulation, a stakeholder requested OHCA automate all cross-file data quality checks and related communications. OHCA appreciates this comment and will continue to refine its cross-file validation process as operations allow. However, the Data Portal currently receives file submissions individually as they are ready and applies automated validations to individual files before each file is initially accepted. After all of a submitter's required files are initially accepted, cross-file validations are performed manually to confirm file accuracy and completeness.

OHCA Attribution Addendum

Amended section 97445(t) incorporates by reference the *Office of Health Care Affordability: Attribution Addendum*, dated April 2026 (Attribution Addendum) because it is necessary to provide submitters with an up-to-date, standardized list of physician organizations for purposes of attributing total medical expenses in the Attributed TME file. The proposed version of the Attribution Addendum is the document's fourth iteration

and reflects OHCA's continued efforts to refine its attribution approach for total medical expenses.

OHCA developed the proposed version of the Attribution Addendum utilizing actual data from the Attributed TME files received from submitters during the September 2024 and September 2025 data submissions. The proposed version of the Attribution Addendum reflects updated physician organization identifying information, which OHCA will continue to update through the regulatory process as listed entities reorganize, enter, and exit the health care market. The proposed version of the Attribution Addendum also removes five non-physician organization entities OHCA identified following the September 2025 data submission. The removal of these entities is necessary to ensure submitters do not erroneously attribute total medical expense to non-physician organization entities when reporting spending data in the Attributed TME file.

This document is incorporated by reference due to its length and necessary formatting features, as it would be cumbersome to place in the California Code of Regulations directly. The final version of the Attribution Addendum will be available on, and may be downloaded from, the HCAI website, located at: https://hcai.ca.gov/.

OHCA Behavioral Health Addendum

Amended section 97445(u) incorporates by reference the *Office of Health Care Affordability: Behavioral Health Addendum*, dated April 2026 (Behavioral Health Addendum) because it is necessary to provide submitters with an up-to-date, standardized list of medical codes submitters will use to identify and report behavioral health spending in the Behavioral Health file. As with the Guide Version 3.0 and the Attribution Addendum, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

The Behavioral Health Addendum is comprised of seven parts: Behavioral Health Diagnosis Codes, Behavioral Health Screening and Assessment Service Codes, Medi-Cal Only Behavioral Health Services for Members Under 21, Behavioral Health Service Subcategories, Behavioral Health National Drug Codes, Behavioral Health Service Codes, and Care Setting Codes. All seven parts of the Behavioral Health Addendum are discussed individually below.

Behavioral Health Diagnosis Codes

Submitters will identify behavioral health claims using specified International Classification of Diseases, Tenth Revisions (ICD-10) diagnosis codes published by the World Health Organization and maintained by the U.S. Centers for Disease Control and Prevention (CDC).[22] OHCA also provides diagnosis code condition descriptions,

[22] *See* ICD-10 Topics Page, available at: https://www.cdc.gov/nchs/icd/icd-10/index.html, last accessed January 29, 2026.

categories based on ICD-10 classification, and each code's designation by OHCA as either mental health (MH) or substance use disorder (SUD). The listed codes must be present on a medical claim as the primary diagnosis for a submitter to report the claim as behavioral health spending. OHCA selected the listed codes in consultation with experts in behavioral health spending measurement and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed by the Milbank Memorial Fund's Advisory Group recommendations for a standardized definition of clinical behavioral health spending.[23]

This part of the Behavioral Health Addendum is necessary to ensure submitters use a consistent and standardized code set to identify and report behavioral health spending to OHCA. This will enable OHCA to measure and report on the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Behavioral Health Screening and Assessment Service Codes

Submitters will identify behavioral health claims using specified Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) screening and assessment codes maintained by CMS and the American Medical Association (AMA).[24] OHCA also provides screening and assessment code service descriptions and each code's designation by OHCA as either MH or SUD. The listed codes must be present on medical claim lines without a primary behavioral health diagnosis for a submitter to report the claim line as behavioral health spending. OHCA selected the listed codes in consultation with experts in behavioral health spending measurement and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed by the Milbank Memorial Fund's Advisory Group recommendations for a standardized definition of clinical behavioral health spending.[25]

This part of the Behavioral Health Addendum is necessary to ensure submitters use a consistent and standardized code set to identify and report behavioral health spending to OHCA. This will enable OHCA to measure and report on the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

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[23] *See* Milbank Recommendations at Appendix A, available at: https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/, last accessed January 29, 2026.
[24] *See* CMS HCPCS Main Page, available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system, last accessed January 29, 2026.
[25] *See* Milbank Recommendations at Appendix A, available at: https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/, last accessed January 29, 2026.

Medi-Cal Only Behavioral Health Services for Members Under 21

In the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories only, submitters will identify claim lines for members under 21 years of age as behavioral health spending using specified HCPCS and CPT service codes maintained by CMS and the AMA.[26] OHCA also includes service code descriptions and each code's designation by OHCA as either MH or SUD. For members under 21 years of age, the listed codes must be present on a medical claim without a primary behavioral health diagnosis for a submitter to report the claim line with the listed code as behavioral health spending. OHCA selected the listed codes in consultation with experts in behavioral health spending measurement. OHCA's code set was also developed in collaboration with the DHCS to ensure consistency with any existing DHCS guidance to Medi-Cal providers.

During the informal comment period for this proposed regulation, a stakeholder requested OHCA add eight additional codes that are billable for behavioral health treatment. OHCA ultimately added four of the requested codes because the codes are consistent with other codes already included by OHCA. OHCA declined to add the other four requested codes because the codes are not specific to behavioral health treatment without a behavioral health diagnosis. Accordingly, including the codes would result in overcounting non-behavioral health spending.

This part of the Behavioral Health Addendum is necessary to ensure submitters use a consistent and standardized code set to identify and report behavioral health spending to OHCA. This will enable OHCA to measure and report on the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Behavioral Health Service Subcategories

Submitters will categorize behavioral health claims into service subcategories using specified combinations of the following code types: place of service codes, HCPCS and CPT service codes, primary care provider taxonomy codes, and revenue codes. The service subcategories and corresponding code combinations are provided in this part of the Behavioral Health Addendum. Additional information describing each listed code is provided in the Behavioral Health Service Codes and Care Setting Codes parts of the Behavioral Health Addendum.

OHCA developed the service subcategories and corresponding code combinations in consultation with experts in behavioral health spending measurement and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed

[26] *See* CMS HCPCS Main Page, available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system, last accessed January 29, 2026.

by the Milbank Memorial Fund's Advisory Group recommendations for a standardized definition of clinical behavioral health spending.[27]

This part of the Behavioral Health Addendum is necessary to ensure submitters use a consistent and standardized methodology to report behavioral health spending to OHCA. This will enable OHCA to measure and report on the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Behavioral Health National Drug Codes

Submitters will identify behavioral health pharmacy spend using specified National Drug Codes (NDCs) maintained by the U.S. Food and Drug Administration (FDA).[28] OHCA also provides drug label names, generic drug names, brand names, and each code's designation by OHCA as either mental health (MH) or substance use disorder (SUD). The listed codes must be present on a pharmacy claim for a submitter to report the claim as behavioral health spending. OHCA selected the listed codes in consultation with experts in behavioral health spending measurement and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed by behavioral health code lists developed by Massachusetts and the Milbank Memorial Fund's Advisory Group recommendations for a standardized definition of clinical behavioral health spending.[29]

This part of the Behavioral Health Addendum is necessary to ensure submitters use a consistent and standardized code set to identify and report behavioral health pharmacy spending to OHCA. This will enable OHCA to measure and report on the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

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[27] *See* Milbank Recommendations at Appendix A, available at: https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/, last accessed January 29, 2026.
[28] *See* National Drug Code Directory, available at: https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory, last accessed January 29, 2026.
[29] *See* Massachusetts Center for Health Information and Analysis' Primary Care and Behavioral Health Supplemental Data Code List and Crosswalk, available at: https://www.chiamass.gov/assets/docs/p/pbhc/2025-PCBH/PCBH-2025-Supplemental-Code-List-and-Crosswalk.xlsx, last accessed January 29, 2026, *and* Milbank Recommendations at Appendix A, available at: https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/, last accessed January 29, 2026.

Behavioral Health Service Codes

As noted in the Behavioral Health Service Subcategories part, submitters will use specified code combinations, including HCPCS and CPT service codes maintained by CMS and the AMA, to categorize behavioral health claims into service subcategories.[30] This part of the Behavioral Health Addendum provides additional information regarding each service code to assist submitters when identifying service codes.

This part of the Behavioral Health Addendum is necessary to ensure submitters accurately categorize claims into services subcategories for behavioral health spend reporting. This will support OHCA in measuring the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) through (b).)

Care Setting Codes

As noted in the Behavioral Health Service Subcategories part, submitters will use specified code combinations, including place of service (POS) and revenue codes maintained by the Centers for Medicare and Medicaid Services (CMS) and the National Uniform Billing Committee (NUBC), respectively, to categorize behavioral health claims into service subcategories.[31] This part of the Behavioral Health Addendum provides additional information regarding each care setting code to assist submitters when identifying service subcategories. Submitters must understand the meaning of each care setting code to ensure each care setting code is used accurately when assigning claims to a service subcategory.

This part of the Behavioral Health Addendum is necessary to ensure submitters accurately categorize claims into services subcategories for behavioral health spend reporting. This will support OHCA in measuring the percentage of total health care expenditures allocated to behavioral health. (Health & Saf. Code, § 127505, subds. (a)(1) through (b).)

The final version of the Behavioral Health Addendum will be available on, and may be downloaded from, the HCAI website, located at: https://hcai.ca.gov/.

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[30] *See* CMS HCPCS Main Page, available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system, last accessed January 29, 2026.
[31] *See* Centers for Medicare and Medicaid Services (CMS) Place of Service Code Set, available at: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets, last accessed January 29, 2026. and NUBC Main Page, available at: https://www.nubc.org/, last accessed January 29, 2026.

OHCA Medi-Cal Payments Addendum

Proposed section 97445(v) incorporates by reference the *Office of Health Care Affordability: Medi-Cal Payments Addendum*, dated April 2026 (Medi-Cal Payments Addendum) because it is necessary to provide submitters in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories (hereinafter, "MCPs") with standardized instructions for excluding and including certain Medi-Cal specific payments in the APM file, Primary Care file, and Behavioral Health file. As with the Guide Version 3.0 and the Attribution Addendum, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

The Medi-Cal Payments Addendum instructs MCPs to include or exclude listed Medi-Cal payments when reporting Total Amount Allowed (APM008) in the APM file, Total Amount Allowed (PRC007) and Amount Paid for Primary Care (PRC008) in the Primary Care File, and Amount Paid for Behavioral Health (BHV009) in the Behavioral Health file. The Medi-Cal Payments addendum includes "Arrangement Type" and "Program Name" columns MCPs will use to identify each Medi-Cal specific payment arrangement. The Medi-Cal Payments Addendum also includes two columns indicating whether to include or exclude each Medi-Cal specific payment arrangement: one column applies to the Statewide, Attributed, and Regional TME files; the other column applies to the APM, Primary Care, and proposed Behavioral Health files. OHCA acknowledges that all Medi-Cal specific payment arrangements are included in the Statewide, Attributed, and Regional TME files. OHCA includes a column for these files for completeness and to avoid any potential confusion regarding application of the specified inclusions and exclusions. The identifying information in the Medi-Cal Payments Addendum will be familiar to affected submitters because it relies on the same program names and acronyms used by the DHCS in its interactions with MCPs.

OHCA instructs MCPs to include or exclude certain Medi-Cal specific payments to enable more apples-to-apples comparisons between the Medi-Cal, Medicare Advantage, and commercial market categories when measuring APM adoption and primary care and behavioral health spending as a percentage of TME. (Health & Saf. Code, §§ 127504 and 127505, subds. (a)(1) through (b).) Significantly, OHCA instructs submitters to include all Medi-Cal specific payments in the Statewide, Regional, and Attributed TME files. This proposal will allow OHCA to better understand the overall impact of Medi-Cal specific payments on TME. OHCA will continue to refine the Medi-Cal Payments Addendum through the regulatory process based on data received during the September 2026 submission year.

OHCA developed the Medi-Cal Payments Addendum in collaboration with the DHCS. In the proposed iteration of the document, the Medi-Cal specific payment arrangements MCPs are required to include in all files generally reflect MCPs' usual managed care plan obligations to pay for health care and other services for their members, even if those payments are limited by the payment arrangement (*e.g.*, specified minimum and/or maximum fee schedules, California Children's Services and Whole Child Model,

Ground Emergency Medical Transport Quality Assurance Fee, and vaccine administration fees). Payment arrangements that do not generally reflect MCPs' usual obligations (*e.g.*, specified pass-through payments, uniform dollar increase payments, and value-based payments) are excluded from the APM, Primary Care, and proposed Behavioral Health files. OHCA also solicited stakeholder feedback on the contents of the Medi-Cal Payments Addendum during the informal comment period for this regulatory proposal and made responsive revisions to clarify the document's application across specified required files.

The final version of the Medi-Cal Payments Addendum will be available on, and may be downloaded from, the HCAI website, located at: https://hcai.ca.gov/.

OHCA Primary Care Addendum

Proposed section 97445(w) incorporates by reference the *Office of Health Care Affordability: Primary Care Addendum*, dated April 2026 (Primary Care Addendum) because it is necessary to provide submitters with an up-to-date, standardized list of medical codes submitters will use to identify and report primary care spending in the Primary Care file. As with the Guide Version 3.0 and the Attribution Addendum, this document contains layouts and formatting that would be cumbersome to print in the California Code of Regulations, therefore, incorporation by reference is appropriate.

The Primary Care Addendum is comprised of four parts: Primary Care Providers Taxonomy List codes, CMS Place of Service codes, Primary Care Services codes, and Medi-Cal Vaccines for Children (VFC) Program Services codes. The first three parts are included in the existing Guide as Appendix E. OHCA relocates and consolidates these three code sets into the proposed Primary Care Addendum to improve the Guide Version 3.0's ease of use and to facilitate future regulatory updates to the code sets. Specifically, OHCA anticipates it will need to update the contents of the code sets periodically as coding standards and industry code sets change over time. All four parts of the Primary Care Addendum are discussed individually below.

Primary Care Providers Taxonomy List (Relocated from existing Appendix E)

Submitters will identify primary care providers using specified Health Care Provider Taxonomy codes maintained by the National Uniform Claim Committee (NUCC).[32] OHCA selected the listed codes in consultation with experts and after extensive stakeholder engagement. OHCA's code selection was also informed by the primary care provider taxonomy code sets used in Colorado and North Carolina.[33] OHCA

[32] *See* National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy website, available at: https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40, last accessed January 29, 2026.
[33] *See* Primary Care Spending and Alternative Payment Use in Colorado 2020-2022 (Colorado Report) at pp. 24-26, available at: https://civhc.org/wp-

revised the code set for the Guide Version 3.0 based on feedback received following the September 2025 data submission, including feedback received from the DHCS. The NUCC Name is also provided for convenience of the submitter in ensuring the correct taxonomy code is used.

This part of the Primary Care Addendum is necessary to ensure submitters use a consistent and standardized method to identify claims-based primary care spending that counts towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Primary Care CMS Places of Service (Relocated from existing Appendix E)

Submitters will identify primary care places of service using specified Place of Service codes for Professional Claims maintained by the Centers for Medicare and Medicaid Services (CMS).[34] OHCA selected the listed codes in consultation with experts and after extensive stakeholder engagement. The CMS primary care Place of Service codes selected by OHCA were also informed by the code set utilized in North Carolina.[35] OHCA revised the code set for the Guide Version 3.0 based on feedback received following the September 2025 data submission, including feedback received from the DHCS. The Place of Service name is also provided for convenience of the submitter in ensuring the correct Place of Service code is used.

During the informal comment period for this regulatory proposal, a stakeholder requested OHCA include urgent care facilities in its list of primary care places of service. This issue was discussed during the extensive stakeholder engagement process noted above, but OHCA ultimately decided not to include urgent care places of service because these care settings do not promote coordinated, comprehensive, integrated primary care.

This part of the Primary Care Addendum is necessary to ensure submitters use a consistent and standardized method to identify claims-based primary care spending that

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content/uploads/2024/03/CIVHC-Report-of-Primary-Care-Spending-January-2024-corrected-prospective-payment-graphs-01232024.pdf, last accessed January 29, 2026 (listing Colorado's specified primary care provider taxonomy codes) *and* North Carolina Primary Care Payment Reform Task Force Report to Joint Legislative Oversight Committee on Health and Human Services, dated April 17, 2024 (North Carolina Report) at pp. 24-25, available at: https://webservices.ncleg.gov/ViewDocSiteFile/87160, last accessed January 29, 2026 (listing North Carolina's specified primary care provider taxonomy codes).

[34] *See* Centers for Medicare and Medicaid Services (CMS) Place of Service Code Set, available at: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets, last accessed January 29, 2026.

[35] *See* North Carolina Report at p. 25, available at: https://webservices.ncleg.gov/ViewDocSiteFile/87160, last accessed January 29, 2026.

counts towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

HCPCS/CPT Primary Care Services (Relocated from existing Appendix E)
Submitters will identify primary care services using specified HCPCS and CPT codes maintained by CMS and the AMA.[36] OHCA selected the listed codes in consultation with experts, the DHCS, and after extensive stakeholder engagement. Additionally, OHCA's code selection was informed by the primary care service code set used in Colorado and the primary care service code set included in the New England States' All-Payer Report on Primary Care Payments.[37] OHCA revised the code set for the Guide Version 3.0 based on feedback received following the September 2025 data submission, including feedback received from the DHCS. The Description is also provided for convenience of the submitter in ensuring the correct HCPCS and CPT codes are used.

This part of the Primary Care Addendum is necessary to ensure submitters use a consistent and standardized method to identify primary care claims that count towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

Medi-Cal Only Vaccines for Children (VFC) Program Services

Submitters in the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories will identify vaccine administration costs in the Medi-Cal Only Vaccines for Children (VFC) Program as primary care spending using specified HCPCS and CPT codes maintained by CMS and the AMA.[38] OHCA selected the listed codes in consultation with the DHCS to ensure consistency with existing DHCS guidance regarding the VFC Program.[39] The vaccine description for each CPT code is also provided for convenience of the submitter in ensuring the correct CPT codes are used.

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[36] *See* CMS HCPCS Main Page, available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system, last accessed January 29, 2026.
[37] *See* Colorado Report at pp. 28-42, available at: https://civhc.org/wp-content/uploads/2024/03/CIVHC-Report-of-Primary-Care-Spending-January-2024-corrected-prospective-payment-graphs-01232024.pdf, last accessed January 29, 2026; The New England States' All-Payer Report on Primary Care Payments at p. 60, available at: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf, last accessed January 29, 2026.
[38] *See* CMS HCPCS Main Page, available at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system, last accessed January 29, 2026.
[39] *See* DHCS Guidance to Medi-Cal Providers (Vaccine 1), available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/C08C7E98-AA63-4BC8-BA3C-BE8E06ED9A31/vaccine.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO, last accessed January 29, 2026.

This part of the Primary Care Addendum is necessary to ensure submitters use a consistent and standardized method to identify primary care spending that count towards OHCA's Primary Care Investment Benchmark. (Health & Saf. Code, § 127505, subds. (a)(1) and (b).)

The final version of the Primary Care Addendum will be available on, and may be downloaded from, the HCAI website, located at: https://hcai.ca.gov/.

ANTICIPATED BENEFITS OF THE PROPOSAL

These proposed emergency regulations effectuate the Legislature's intent to have a comprehensive view of health care spending, cost trends, and variation that will inform actions to reduce the overall rate of growth in health care costs. (*See* Health & Saf. Code, § 127500.5, subd. (b).) By measuring progress towards reducing the rate of growth in per capita total health care spending, OHCA intends to develop a comprehensive strategy for cost containment in California and to ultimately lower consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care. (*See* Health & Saf. Code, § 127500.5, subd. (o)(1).) These clarifying amendments will ensure OHCA receives complete and accurate total health care expenditure data in a standardized format.

TECHNICAL, THEORETICAL, AND/OR EMPIRICAL STUDY, REPORTS, OR DOCUMENT(S) RELIED UPON:

Reports / Articles / Other Resources:

- California Department of Health Care Services (DHCS) Guidance to Medi-Cal Providers (Vaccine 1), available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/C08C7E98-AA63-4BC8-BA3C-BE8E06ED9A31/vaccine.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO, last accessed January 29, 2026.
- California Department of Managed Health Care Electronic Filing Signature Verification Form (DMHC 10-066), available at: https://www.dmhc.ca.gov/Portals/0/Docs/OPL/ElectronicFilingSignatureVerification.pdf?ver=90Sv-i-feYWw_uyHxsArxw%3d%3d, last accessed February 12, 2026.
- DHCS All-Plan Letter 23-001, available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2,023/APL23-001.pdf, last accessed February 19, 2026.
- HCAI Expanded Non-Claims Payments Framework, available at: https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/, last accessed January 26, 2026.
- Massachusetts Center for Health Information and Analysis' Data Specification Manual for Payer Reporting of Primary Care and Behavioral Health Expenses, available at: https://www.chiamass.gov/assets/docs/p/pbhc/2025-PCBH/PCBH-2025-Data-Specification-Manual.pdf, last accessed February 10, 2026.
- Milbank Memorial Fund Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending at Appendix A, available at: https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/, last accessed January 29, 2026.
- Milbank Memorial Fund Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending, available at:

https://www.milbank.org/wp-content/uploads/2024/08/BH-Measurement-Technical-Specifications.pdf, last accessed February 10, 2026;

- North Carolina Primary Care Payment Reform Task Force Report to Joint Legislative Oversight Committee on Health and Human Services, dated April 17, 2024 at pp. 8-9 and 24-25, available at: https://webservices.ncleg.gov/ViewDocSiteFile/87160, last accessed February 20, 2026.
- OHCA Alternative Payment Model (APM) Standards and Adoption Goals Approved by the California Health Care Affordability Board, June 2024, available at: https://hcai.ca.gov/wp-content/uploads/2024/07/Board-Adopted-APM-Standards-and-Adoption-Goals-Memo-Final.pdf, last accessed January 20, 2026.
- OHCA Primary Care Investment Benchmark, Updated December 2024, available at: https://hcai.ca.gov/wp-content/uploads/2024/12/Board-Approved-Primary-Care-Investment-Benchmark-Memo.pdf, last accessed January 22, 2026.
- OHCA Proposed Behavioral Health Spending Definition and Measurement Methodology, available at: https://hcai.ca.gov/wp-content/uploads/2025/08/OHCA-Proposed-Behavioral-Health-Definition_2025.08.04-1.pdf, last accessed February 10, 2026.
- Primary Care Spending and Alternative Payment Use in Colorado 2020-2022 at pp. 24-26, available at: https://civhc.org/wp-content/uploads/2024/03/CIVHC-Report-of-Primary-Care-Spending-January-2024-corrected-prospective-payment-graphs-01232024.pdf, last accessed January 29, 2026
- The New England States' All-Payer Report on Primary Care Payments, available at: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf, last accessed February 20, 2026.

Public Meetings:

- September 18, 2024, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- December 18, 2024, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- January 15, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- February 19, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- March 19, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- April 16, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- May 21, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- June 9, 2025, Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.

- June 16, 2025, Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- June 18, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- July 16, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- July 22, 2025, Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- August 20, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- September 17, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- September 22, 2025, Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- October 22, 2025, THCE Data Submitter Workgroup – Relevant Presentation Slides.
- November 19, 2025, Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- December 17, 2025, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- January 14, 2026, Health Care Affordability Advisory Committee Meeting – Relevant Presentation Slides, Minutes.
- January 21, 2026, THCE Data Submitter Workgroup – Relevant Presentation Slides.
- January 28, 2026, Health Care Affordability Board Meeting – Relevant Presentation Slides, Minutes.
- March 18, 2026, Investment and Payment Workgroup Meeting – Relevant Presentation Slides.
- March 18, 2026, THCE Data Submitter Workgroup – Relevant Presentation Slides.
- March 25, 2026, Health Care Affordability Board Meeting – Relevant Presentation Slides, Draft Minutes.

Written comments received and considered concerning January 2026 draft proposal:

- January 29, 2026 email from the California Hospital Association
- January 30, 2026 letter from the California Association of Health Plans
- January 30, 2026 email from Health Plan of San Mateo

CONSISTENCY AND COMPATIBILITY WITH EXISTING STATE REGULATIONS

During the process of developing this regulation, HCAI conducted a search for any similar regulations on this topic and concluded that these regulations are neither inconsistent nor incompatible with existing state regulations.

LOCAL MANDATE

No local mandate is imposed on a local agency or school district that requires reimbursement pursuant to Government Code section 17500 *et seq*.

DISCLOSURES REGARDING THE PROPOSED ACTION:

FISCAL IMPACT ESTIMATES

Cost or savings to any local agency or school district requiring reimbursement pursuant to Government Code section 17500 et seq.: None.

Cost or savings to any state agency:

OHCA does not anticipate any additional cost or savings from this proposal beyond those it initially reported.

Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None.

Other nondiscretionary cost or savings imposed on local agencies: None.

Cost or savings in federal funding to the state: None.