California Department of Health Care Access and Information (HCAI)

Office of Health Care Affordability (OHCA)

Total Health Care Expenditures
Data Submission Guide

Version 1.0

New: February 2024

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1 Introduction

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

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

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

1.1 Contact Information

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

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

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

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

1.2 Data Submission Deadlines

OHCA's first public reporting of THCE data will be on baseline health care spending for covered health care benefits received by California residents during calendar years 2022 and 2023 (the "Baseline Report"). For purposes of the Baseline Report, payers and fully integrated delivery systems are required to submit THCE data by the statutory deadline of September 1, 2024. OHCA will release the Baseline Report by June 1, 2025. OHCA plans to release a supplementary report on implementation of the Health Care Quality and Affordability Act by June 1, 2026. For this supplementary report, payers and fully integrated delivery systems will be required to submit THCE data for reporting years 2023 and 2024 on or before September 1, 2025.

On or before June 1, 2027, and annually thereafter, OHCA will prepare and publish annual reports concerning health care spending trends and underlying factors, including OHCA's policy recommendations to control costs and improve quality performance and equity of the health care system, while maintaining access to care and high-quality jobs and workforce stability.

For purposes of ongoing annual reporting, payers and fully integrated delivery systems will be required to submit THCE data on or before September 1st of each year. If an annual submission deadline falls on a weekend or state holiday, the due date is the next business day. Submitters will extract and submit data for the previous two calendar years with each annual submission.

1.3 Changes to this Guide

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

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

2 Submitter Registration

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

In the first year of data collection, submitters shall submit a completed registration by April 30, 2024. In subsequent years, submitters shall complete registration annually by the end of May.

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

1. Legal entity name and address
2. Market Category(ies):
     o Commercial (Full Benefits)
     o Commercial (Partial Benefits)
     o Medi-Cal Managed Care[2]
     o Medicare Advantage
     o Medi-Cal Expenses for Dual Eligibles[3]
     o Medicare Expenses for Dual Eligibles
     o Dual Eligible Special Needs Plans (D-SNPs)
3. A regulatory contact (first and last name, phone, email, and mailing address)
4. A business contact for submission issues (first and last name, phone, email, and mailing address)
5. A technical contact for each data file type (first and last name, phone, email, and mailing address)
6. License Type(s) and License Number(s) for all licensed health plans for which the submitter will be reporting THCE data
7. National Association of Insurance Commissioners (NAIC) Code(s),[4] if applicable, for any health insurers for which the submitter will be reporting THCE data
8. A list identifying the organizations on the OHCA Attribution Addendum and any other organizations for which the submitter can attribute total medical expenses for California members according to the Member Attribution instructions outlined in Section 4.5 of this Guide. The list shall also identify the Taxpayer Identification Numbers (TIN) that the submitter associates with each organization for payment

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[2] Data for the Medi-Cal Managed Care market category will be collected beginning with the data submission due September 1, 2025.
[3] Data for the Medi-Cal Expenses for Dual Eligibles market category will be collected beginning with the data submission due September 1, 2025.
[4] Registrants shall use the NAIC code(s) required by the California Department of Insurance when filing pursuant to 10 CCR 2308.1.

purposes. The list shall include all organizations contracted for at least 1,000 member lives during the applicable reporting years (*e.g.*, 2022 and 2023 for the 2024 submission). Newly identified organizations will be added to future iterations of the OHCA Attribution Addendum.

The organization list shall be submitted as a pipe ("|") delimited text file (.txt) with one row per record in the following format:

Col. #	Field Name	Max	Description
1	Organization Code	4	Use this field to report the unique Organization Code provided by OHCA. Refer to the OHCA Attribution Addendum for valid values. **Note**: To report records for other organizations with at least 1,000 attributed members, use code '7777'.
2	Organization Name	80	Use this field to report the full legal name of the organization or individual if applicable.
3	Taxpayer ID Number	9	Nine-digit Taxpayer Identification Number (TIN) associated with the organization for payment purposes. Do not include a hyphen.

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

2.1   Test File Submission

Test files are not required, though submitters may opt to send test files to the THCE Data Portal at their discretion. Test files must be indicated in the header record as described below (refer to the Header Record file layout for more information).

3 General File Specifications

The following specifications shall apply to all files submitted to the THCE Data Portal. A complete submission contains the following five files:

1. Statewide Total Medical Expenses (TME) – total medical expenses for covered health benefits during the reporting period broken out by market category and contracting arrangement.
2. Attributed TME – total medical expenses for covered health benefits during the reporting period attributed to organizations and broken out by market category, age, and sex.
3. Regional TME – total medical expenses for covered health benefits during the reporting period broken out by geographic region and market category.
4. Pharmacy Rebates – statewide medical and retail pharmacy rebate data broken out by market category.
5. Submission Questionnaire – attestations and confirmation that instructions in the Guide were followed when preparing data for submission.

Submission format. Data shall be submitted in a text (.txt) file that is pipe ("|") delimited with one row per record.

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

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

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

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

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

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

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

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

4   General Information

4.1   Data Completeness

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

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

4.1.1   Claims Payments

Submitters shall allow for a claims run-out period of at least 180 days after December 31st of the most recent reporting year (*i.e.*, June 30, 2024 for 2022 and 2023 service dates) to allow for continued claims adjudication. Claims shall be included based on the incurred date or date of service, not the date paid or reconciled. Incurred but not reported (IBNR) or incurred but not paid (IBNP) factors shall not be applied. Refer to Appendix A: Claims Service Category to Bill Code Mapping for more information on claims service categories.

4.1.2   Non-Claims Payments

Submitters shall allow for a non-claims reconciliation period of at least 180 days after December 31st of the most recent reporting year (*i.e.*, June 30, 2024 for 2022 and 2023 service dates) to reconcile non-claims payments including incentives, capitation, risk settlements, and other non-claims-based payments. Submitters shall apply reasonable and appropriate estimations of non-claims liability for each provider (including payments expected to be made to providers not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period. Non-claims shall be reported based on the incurred date or date of service, not the date paid or reconciled. Refer to Appendix B: Non-Claims Payment Framework for more information on non-claims payment categories.

4.1.3   Pharmacy Rebates

Pharmacy rebate data shall be reported based on actual amounts as of the time of submission without estimates.

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

4.2　Data Variance Requests

Submitters that are unable to submit data files meeting the file intake specifications in this Guide may request a temporary variance to specific data submission requirements from OHCA pursuant to 22 CCR 97449(I).

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

4.3　Included Population

Data must include all health care spending for covered benefits on behalf of, or by, California residents who are covered by Medicare, Medi-Cal, or commercial insurance, and receive care from any provider in or outside of California. Claims paid for residents of states other than California who receive care from California providers shall not be included. When reporting spending by geographic region, members shall be assigned to a region based on their residence address.

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

When calculating total medical expenses and member months, submitters shall include all members for whom the submitter is directly contracted with a group purchaser, individual subscriber, or public agency to arrange for the provision of health care services. Total medical expenses and member months for members with whom the submitter is not directly contracted (*i.e.*, members "from other plans") shall not be included.

4.4　Market Categories

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

1. Commercial (Full Benefits) – The Commercial (Full Benefits) market category shall be used when a submitter is able to report information on all claims and/or capitation paid on behalf of a member and the submitter is responsible for all covered benefits including pharmacy. In this scenario, the submitter has a

complete picture of the member's total medical expenses, even in the case where a capitated, delegated organization pays downstream claims.

2. Commercial (Partial Benefits) – If the submitter does not have all of the information on claims and/or capitation paid on behalf of the member (*e.g.*, self-funded pharmacy), the submitter shall use their Commercial (Full Benefits) population spend to create an estimate of expenses for those members on a PMPM basis. The estimate will be added to the spending for members for whom certain benefits are carved out (*e.g.*, pharmacy). The total medical expenses for these members shall be reported in the Commercial (Partial Benefits) market category to indicate a portion of spending has been estimated.

> **Note for the Commercial (Full Benefits) and Commercial (Partial Benefits) categories**: Within the Statewide TME File, spending shall be further disaggregated by product type and payment arrangement (capitated/delegated or non-capitated/direct). Product types include:
> - Health maintenance organization (HMO) or point of service (POS) products, which require a primary care provider to manage the member's care.
> - Preferred provider organization (PPO) or exclusive provider organization (EPO) products, which allow members to schedule visits without a referral.
> - Other products, which do not fit the descriptions above.

3. Medi-Cal Managed Care[5]
4. Medicare Advantage
5. Medi-Cal Expenses for Dual Eligibles[6] – The portion of dual eligibles' expenses that are assigned to Medi-Cal.
6. Medicare Expenses for Dual Eligibles – The portion of dual eligibles' expenses that are assigned to Medicare.

> **Note for Medi-Cal Expenses for Dual Eligibles and Medicare Expenses for Dual Eligibles categories**: Dual Eligibles are members who are enrolled in both Medicare and Medi-Cal, for whom Medicare is the primary payer for acute and post-acute care services while Medi-Cal provides assistance with Medicare premiums and cost sharing and covers some services that Medicare does not. If a submitter cannot directly assign dual eligibles' expenses to either Medi-Cal or Medicare, the claims shall be assigned as follows: Claims for Long-Term Care to Medi-Cal, claims for all other categories to Medicare.

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[5] Data for the Medi-Cal Managed Care market category will be collected beginning with the data submission due September 1, 2025.
[6] Data for the Medi-Cal Expenses for Dual Eligibles market category will be collected beginning with the data submission due September 1, 2025.

7. Dual Eligible Special Needs Plans (D-SNPs) – Medicare Advantage health plans which provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medi-Cal).

4.5   Member Attribution

Submitters shall attribute member-level expenses to organizations listed on the OHCA Attribution Addendum (incorporated at 22 CCR 97445) according to the methods described below. Attribution shall be calculated on a monthly basis and reported in terms of member months.

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

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

Member attribution shall be performed in the following order:

1. First, identify members for whom utilization management and claims payment functions have been delegated to an organization listed on the OHCA Attribution Addendum through a capitated payment arrangement. Report data for these members using the **Capitated, Delegated Arrangement** attribution method.
2. Next, attribute remaining members to a total cost of care Accountable Care Organization (ACO) arrangement that includes an organization listed on the OHCA Attribution Addendum. Report data for these members using the **ACO Arrangement** attribution method.
3. The list of organizations in the OHCA Attribution Addendum is not comprehensive. Data for members who can be attributed using the above steps to an organization **not** listed on the OHCA Attribution Addendum shall be reported using the **Attributed to Other Organizations** attribution method.
    a. Report data in separate records for any organization with at least 1,000 attributed members. Include the full legal name in the Organization Name field and use the Organization Code '7777'.
    b. Report data for all organizations with 1-999 attributed members in a single record leaving the Organization Name field blank and using the Organization Code '8888'.

After attributing members using the methods above, attribute total medical expenses for remaining members using the following:

4. Any members who **cannot** be attributed using one of the above methods may be attributed to an organization listed on the OHCA Attribution Addendum or other organization using a submitter-developed, rules-based approach for assigning total medical expenses. Report data for these members using the attribution method **Payer-Developed Attribution**.
    a. Report data in separate records for any organization not listed on the OHCA Attribution Addendum with at least 1,000 attributed members. Include the full legal name in the Organization Name field and use the Organization Code '7777'.
    b. Report data for all organizations not listed on the OHCA Attribution Addendum with 1-999 attributed members in a single record leaving the Organization Name field blank and using the Organization Code '8888'.
5. Not all members will be attributed. Data for members who cannot be attributed to any organization using any of the attribution methods shall be reported using the **Not Attributed** attribution method and the Organization Code '9999'.

4.6   Self-Insured Plans

For self-insured lines of business, the administrative cost and profit portion of THCE is calculated using additional data submitted by self-insured payers on the income from fees from any self-insured accounts.

OHCA requests submitters with self-insured lines of business report aggregate information on the fees earned from their self-insured accounts (*e.g.*, "fees from uninsured plans") as part of the THCE data submission. Submitters shall follow the instructions for Part 1, Line 12 on the NAIC Supplemental Health Care Exhibit (SHCE) for their California-situs self-insured accounts. The amount shall be entered on the Submission Questionnaire file in the Self-Insured Business field (SQS021).

4.7   Standard Deviation

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

4.7.1 Statewide TME File

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

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

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

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

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

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

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

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

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

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

4.7.2 Attributed TME File

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

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

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

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

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

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

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

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

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

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

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

5 File Layouts and Field Specifications

5.1 Header Record

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

5.2   Trailer Record

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

5.3   Statewide TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	SWT001	Data Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	SWT002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	SWT003	Market Category	Integer	1	Use this field to report the market category code. Refer to Market Categories for more information. Valid values include: • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care • 4 = Medicare Advantage • 5 = Medi-Cal Expenses for Dual Eligibles

Col. #	Field ID	Field Name	Type	Max	Description
					• 6 = Medicare Expenses for Dual Eligibles • 7 = Dual Eligible Special Needs Plans (D-SNPs)
4	SWT004	Product Type	Integer	1	Use this field to designate the product type. Refer to Market Categories for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include: • 1 = HMO/POS • 2 = PPO/EPO • 3 = Other For other Market Categories, valid value includes: • 0 = Not applicable
5	SWT005	Payment Arrangement	Integer	1	Use this field to designate the payment arrangement. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include: • 1 = Capitated / Delegated • 2 = Non-capitated / Direct For other Market Categories, valid value includes: • 0 = Not applicable
6	SWT006	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. **Note**: This field reported as an integer.
7	SWT007	Claims: Hospital Inpatient	Integer	12	Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities.

Col. #	Field ID	Field Name	Type	Max	Description
					Note: This is a money field reported in whole dollars. This field may contain a negative value.
8	SWT008	Claims: Hospital Outpatient	Integer	12	Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible).
					This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.
					Note: This is a money field reported in whole dollars. This field may contain a negative value.
9	SWT009	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible).
					This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor.
					Note: This is a money field reported in whole dollars. This field may contain a negative value.
10	SWT010	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible).
					This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs

Col. #	Field ID	Field Name	Type	Max	Description
					designed to assist individuals with long-term care needs who receive care in their home and community. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
11	SWT011	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This amount excludes pharmacy rebates. This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
12	SWT012	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
13	SWT013	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (SWT007 through SWT012). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
14	SWT014	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers and organizations to provide a defined set of services to a designated population of patients for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
15	SWT015	Member Responsibility	Integer	12	Report the total member responsibility amount (*i.e.*, copay, coinsurance, and deductible) for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims across all categories (SWT007 through SWT012) as well as capitation payments (SWT014). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
16	SWT016	Non-Claims: Population Health and Practice Infrastructure Payments	Integer	12	Report the total amount of prospective, non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. Do not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
17	SWT017	Non-Claims: Performance Payments	Integer	12	Report the total amount of non-claims bonus payments paid to health care providers and organizations for reporting data or achieving specific predefined goals for quality, cost reduction, equity, or another performance achievement domain. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
18	SWT018	Non-Claims: Payments with Shared Savings and Recoupments	Integer	12	Report the net total amount of non-claims payments made to health care providers and organizations (or recouped from health care providers and organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
19	SWT019	Non-Claims: Other	Integer	12	Report the total other non-claims-based payments paid for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
20	SWT020	Standard Deviation	Decimal	7,5	Report the standard deviation of the total claims spending for the members included in this record for the reporting year. Report up to 5 decimal places (*e.g.*, 12.12345). Refer to the Standard Deviation instructions for more information.
21	SWT899	Record Type	Text	3	Use this field to report the value of 'SWT' to indicate TME reporting at the statewide level.

5.4   Attributed TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	ATT001	Data Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	ATT002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	ATT003	Organization Code	Text	4	Use this field to report the unique Organization Code provided by OHCA. Refer to the OHCA Attribution Addendum for valid values. **Note**: To report records for other organizations with at least 1,000 attributed members, use code '7777'. To report records for organizations with 1-999 attributed members, use code '8888'. To report records for members that cannot be attributed, use code '9999'.
4	ATT004	Organization Name	Text	80	Use this field to report the full legal name of the organization or individual if applicable. Leave blank if Organization Code (ATT003) is '8888' or '9999'.
5	ATT005	Attribution Method	Integer	1	Use this field to report the method as to how these members were attributed. Valid values include: • 1 = Capitated, Delegated Arrangement • 2 = ACO Arrangement • 3 = Attributed to Other Organizations • 4 = Payer-Developed Attribution • 5 = Not Attributed **Note**: When Organization Code (ATT003) is reported as '7777' or '8888' this field shall be reported as '3' (Attributed to Other Organizations) or '4' (Payer-Developed Attribution). When Organization Code (ATT003) is reported as '9999' this field shall be reported as '5' (Not Attributed). Refer to the Member Attribution instructions for more information.
6	ATT006	Market Category	Integer	1	Use this field to report the market category code. Refer to Market Categories for more information. Valid values include: • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care

Col. #	Field ID	Field Name	Type	Max	Description
					• 4 = Medicare Advantage • 5 = Medi-Cal Expenses for Dual Eligibles • 6 = Medicare Expenses for Dual Eligibles • 7 = Dual Eligible Special Needs Plans (D-SNPs)
7	ATT007	Age Band (in Years)	Integer	1	Use this field to report the appropriate age band (in years) of the members. Age band is assigned based on the age of the member on the last day of the reporting year (December 31st). Valid values include: • 1 = 0-1 • 2 = 2-18 • 3 = 19-39 • 4 = 40-54 • 5 = 55-64 • 6 = 65-74 • 7 = 75-84 • 8 = 85+ For reporting non-claims payments (ATT019 through ATT022), valid value includes: • 0 = Not applicable
8	ATT008	Sex	Text	1	Use this field to report the member's sex as reported by the member. Valid values include: • F = Female • M = Male • U = Unknown For reporting non-claims payments (ATT019 through ATT022), valid value includes: • X = Not applicable
9	ATT009	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. **Note**: This field reported as an integer.

Col. #	Field ID	Field Name	Type	Max	Description
10	ATT010	Claims: Hospital Inpatient	Integer	12	Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
11	ATT011	Claims: Hospital Outpatient	Integer	12	Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
12	ATT012	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician

Col. #	Field ID	Field Name	Type	Max	Description
					assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
13	ATT013	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
14	ATT014	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This amount excludes pharmacy rebates. This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
15	ATT015	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
16	ATT016	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (ATT010 through ATT015). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
17	ATT017	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers and organizations to provide a defined set of services to a designated population of patients for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
18	ATT018	Member Responsibility	Integer	12	Report the total member responsibility amount (*i.e.*, copay, coinsurance, and deductible) for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims across all categories (ATT010 through ATT015) as well as capitation payments (ATT017). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
19	ATT019	Non-Claims: Population Health and Practice Infrastructure Payments	Integer	12	Report the total amount of prospective, non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. Do not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses.

Col. #	Field ID	Field Name	Type	Max	Description
					Note: This is a money field reported in whole dollars. This field may contain a negative value.
20	ATT020	Non-Claims: Performance Payments	Integer	12	Report the total amount of non-claims bonus payments paid to health care providers and organizations for reporting data or achieving specific predefined goals for quality, cost reduction, equity, or another performance achievement domain. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
21	ATT021	Non-Claims: Payments with Shared Savings and Recoupments	Integer	12	Report the net total amount of non-claims payments made to health care providers and organizations (or recouped from health care providers and organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
22	ATT022	Non-Claims: Other	Integer	12	Report the total other non-claims-based payments paid for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
23	ATT023	Standard Deviation	Decimal	7,5	Report the standard deviation of the total claims spending for the members included in this record for the reporting year. Report up to 5 decimal places (*e.g.*, 12.12345). Refer to the Standard Deviation instructions for more information.
24	ATT899	Record Type	Text	3	Use this field to report the value of 'ATT' to indicate TME reporting at the attributed organization level.

5.5   Regional TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	RET001	Data Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	RET002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	RET003	Region	Text	4	Use this field to report either the Rating Region or the Service Planning Area (for Los Angeles County) of the member's residence address. Refer to Appendix C: Regions for a list of valid values.
4	RET004	Market Category	Integer	1	Use this field to report the market category code. Refer to Market Categories for more information. Valid values include: • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care • 4 = Medicare Advantage • 5 = Medi-Cal Expenses for Dual Eligibles • 6 = Medicare Expenses for Dual Eligibles • 7 = Dual Eligible Special Needs Plans (D-SNPs)
5	RET005	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. **Note**: This field reported as an integer.
6	RET006	Claims: Hospital Inpatient	Integer	12	Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (*e.g.*, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
7	RET007	Claims: Hospital Outpatient	Integer	12	Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
8	RET008	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
9	RET009	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services (*e.g.*, personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community.

Col. #	Field ID	Field Name	Type	Max	Description
					Note: This is a money field reported in whole dollars. This field may contain a negative value.
10	RET010	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This amount excludes pharmacy rebates. This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (*e.g.*, administered in a hospital setting). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
11	RET011	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories (*e.g.*, durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
12	RET012	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (*i.e.*, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (RET006 through RET011). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
13	RET013	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers and organizations to provide a defined set of services to a designated population of patients for the reporting year. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
14	RET014	Member Responsibility	Integer	12	Report the total member responsibility amount (*i.e.*, copay, coinsurance, and deductible) for all members for the reporting year. Include all amounts not paid by the primary payer. Include

Col. #	Field ID	Field Name	Type	Max	Description
					member responsibility amounts from claims across all categories (RET006 through RET011) as well as capitation payments (RET013). **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
15	RET899	Record Type	Text	3	Use this field to report the value of 'RET' to indicate TME reporting at the regional level.

5.6 Pharmacy Rebates File

Col. #	Field ID	Field Name	Type	Max	Description
1	RXR001	Data Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	RXR002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	RXR003	Market Category	Integer	1	Use this field to report the market category code. Valid values include: • 1 = Commercial (Full Benefits) • 2 = Commercial (Partial Benefits) • 3 = Medi-Cal Managed Care • 4 = Medicare Advantage • 5 = Medi-Cal Expenses for Dual Eligibles • 6 = Medicare Expenses for Dual Eligibles • 7 = Dual Eligible Special Needs Plans (D-SNPs)
4	RXR004	Medical Pharmacy Rebate Amount	Integer	12	Report the total amount of rebates for drugs covered under the members' medical benefit for the reporting year. Report only actual amounts; do not include estimates. **Note**: This is a money field reported in whole dollars.
5	RXR005	Retail Pharmacy Rebate Amount	Integer	12	Report the total amount of rebates for drugs covered under the members' retail pharmacy benefit for the reporting year. Report only actual amounts; do not include estimates. **Note**: This is a money field reported in whole dollars.
6	RXR006	Total Pharmacy Rebate Amount	Integer	12	Report the total amount of pharmacy rebates for the reporting year. Report only actual amounts; do not include estimates. This amount shall equal the sum of all reported rebate amounts (RXR004 through RXR005).

Col. #	Field ID	Field Name	Type	Max	Description
					Note: This is a money field reported in whole dollars.
7	RXR899	Record Type	Text	3	Use this field to report the value of 'RXR' to indicate reporting pharmacy rebates.

5.7 Submission Questionnaire File

Col. #	Field ID	Field Name	Type	Max	Description
1	SQS001	Data Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	SQS002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	SQS003	Valid Values	Text	1	Is spending reported in a manner consistent with the instructions in Version 1.0 of the THCE Data Submission Guide? Valid values include: • Y = Yes • N = No
4	SQS004	CA Residents Only	Text	1	Does the spending data include California residents only? Valid values include: • Y = Yes • N = No
5	SQS005	Members	Text	1	Does the spending data represent members in a full-service health care service plan, specialized mental health care service plan, health insurance plan, or specialized behavioral health-only policy? Valid values include: • Y = Yes • N = No
6	SQS006	Primary Payer	Text	1	Does the spending data only include members for whom the payer or fully integrated delivery system is primary payer on the claim? Valid values include: • Y = Yes • N = No
7	SQS007	Allowed Amounts	Text	1	Does the spending data include allowed amounts? Valid values include: • Y = Yes • N = No

Col. #	Field ID	Field Name	Type	Max	Description
8	SQS008	Attribution	Text	1	Does the spending data include all data for all attributed members for each month a member was attributed? Valid values include: • Y = Yes • N = No
9	SQS009	Attribution Methodology	Text	500	Briefly describe the approach used to attribute members in the Payer-Developed Attribution method.
10	SQS010	Date Incurred or Served	Text	1	Are spending data submitted based on the incurred date or date of service? Valid values include: • Y = Yes • N = No
11	SQS011	Claims Runout	Date	8	For claims runout, what is the maximum payment date for claims payments? Format = YYYYMMDD
12	SQS012	Non-Claims Runout	Date	8	For non-claims runout, what is the maximum payment date for non-claims payments? Format = YYYYMMDD
13	SQS013	IBNR IBNP	Text	1	Are spending data reported without IBNR/IBNP factors applied? Valid values include: • Y = Yes • N = No
14	SQS014	Pharmacy Rebates	Text	1	Are pharmacy rebate data actuals, without estimates? Valid values include: • Y = Yes • N = No
15	SQS015	Standard Deviation	Text	1	Is the standard deviation calculated using the formula for population standard deviation? Valid values include: • Y = Yes • N = No
16	SQS016	Standard Deviation Members	Text	1	In calculating standard deviation, is spending included for every month the member was attributed, regardless of whether the member has paid claims? Valid values include: • Y = Yes • N = No
17	SQS017	Standard Deviation Non-Claims Excluded	Text	1	Does the standard deviation data exclude non-claims spending? Valid values include: • Y = Yes

Col. #	Field ID	Field Name	Type	Max	Description
					• N = No
18	SQS018	Standard Deviation Age/Sex	Text	1	Is standard deviation calculated by Age/Sex band? Valid values include: • Y = Yes • N = No
19	SQS019	Estimate Methodology	Text	500	Briefly describe the methodology used to estimate spend in the Commercial (Partial Benefits) market category.
20	SQS020	Self-Insured Plans	Text	1	Does the submission include spending data from self-insured accounts? Valid values include: • Y = Yes • N = No
21	SQS021	Administrative Costs and Profits for Self-Insured Plans	Integer	12	Report aggregate information on the fees earned from self-insured accounts (*e.g.*, "fees from uninsured plans"). Submitters shall follow the instructions for Part 1, Line 12 on the NAIC SHCE for their California-situs self-insured accounts. This field is required when the value in Self-Insured Plans (SQS020) is 'Y'. **Note**: This is a money field reported in whole dollars. This field may contain a negative value.
22	SQS899	Record Type	Text	3	Use this field to report the value of 'SQS' to indicate submission questionnaire responses.

Appendix A: Claims Service Category to Bill Code Mapping

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

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

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

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

Appendix B: Non-Claims Payment Framework

The table below provides guidance to submitters on mapping payment types to non-claims payment categories used for data submission.

Non-Claims Payment Category	Payment Types	Corresponding HCP-LAN Category[7]
Population Health and Practice Infrastructure Payments	Care management/care coordination/population health/medication reconciliation	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	Primary care and behavioral health integration	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	Social care integration	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	Practice transformation payments	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	EHR/HIT infrastructure and other data analytics payments	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
Performance Payments	Retrospective/prospective incentive payments: pay-for-reporting	2B: Pay for Reporting: Bonuses for reporting data or penalties for not reporting data

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[7] For submitters familiar with the Health Care Payment Learning and Action Network (HCP-LAN)'s Alternative Payment Models (APM) Framework, payment types are also mapped to the corresponding HCP-LAN APM Framework category. See HCP-LAN APM Framework website, located at: https://hcp-lan.org/apm-framework/.

Non-Claims Payment Category	Payment Types	Corresponding HCP-LAN Category[7]
	Retrospective/prospective incentive payments: pay-for-performance	2C: Pay for Performance: Bonuses for quality performance
Payments with Shared Savings and Recoupments	Procedure-related, episode-based payments with shared savings	3A: Shared Savings: Shared savings with upside risk only
	Procedure-related, episode-based payments with risk of recoupments	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
	Condition-related, episode-based payments with shared savings	3A: Shared Savings: Shared savings with upside risk only
	Condition-related, episode-based payments with risk of recoupments	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
	Risk for total cost of care (*e.g.*, ACO) with shared savings	3A: Shared Savings: Shared savings with upside risk only
	Risk for total cost of care (*e.g.*, ACO) with risk of recoupments	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
Capitation and Full Risk Payments	Primary Care capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
	Professional capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for

Non-Claims Payment Category	Payment Types	Corresponding HCP-LAN Category[7]
		specialty services, such as oncology or mental health
	Facility capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
	Behavioral Health capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
	Global capitation	4B: Comprehensive Population-based Payment: Global budgets or full/percent of premium payments
	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C: Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems

Appendix C: Regions

Total medical expenses shall be reported by region based on the member's residence address. Use the table below to determine which Rating Region or Service Planning Area (Los Angeles County only) to use in the Region field (RET003) on the Regional TME file.

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

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
RR09	Monterey	
RR09	San Benito	
RR09	Santa Cruz	
RR10	Mariposa	
RR10	Merced	
RR10	San Joaquin	
RR10	Stanislaus	
RR10	Tulare	
RR11	Fresno	
RR11	Kings	
RR11	Madera	
RR12	San Luis Obispo	
RR12	Santa Barbara	
RR12	Ventura	
RR13	Imperial	
RR13	Inyo	
RR13	Mono	
RR14	Kern	
RR17	Riverside	
RR17	San Bernadino	
RR18	Orange	
RR19	San Diego	
SPA1	Los Angeles - Gorman	93243
SPA1	Los Angeles - Acton	93510
SPA1	Los Angeles - Edwards AFB	93523
SPA1	Los Angeles - Lake Hughes	93532
SPA1	Los Angeles - Lancaster	93534
SPA1	Los Angeles - Lancaster	93535
SPA1	Los Angeles - Lancaster	93536
SPA1	Los Angeles - Littlerock	93543
SPA1	Los Angeles - Palmdale	93550
SPA1	Los Angeles - Palmdale	93551
SPA1	Los Angeles - Palmdale	93552
SPA1	Los Angeles - Pearblossom	93553
SPA1	Los Angeles - Valyermo	93563
SPA1	Los Angeles - Lake Los Angeles	93591
SPA2	Los Angeles - Calabasas	90290
SPA2	Los Angeles - La Canada	91011
SPA2	Los Angeles - La Crescenta	91020
SPA2	Los Angeles - Sunland LA	91040
SPA2	Los Angeles - Tujunga LA	91042
SPA2	Los Angeles - Glendale	91046

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA2	Los Angeles - Glendale	91201
SPA2	Los Angeles - Glendale	91202
SPA2	Los Angeles - Glendale	91203
SPA2	Los Angeles - Glendale	91204
SPA2	Los Angeles - Glendale	91205
SPA2	Los Angeles - Glendale	91206
SPA2	Los Angeles - Glendale	91207
SPA2	Los Angeles - Glendale	91208
SPA2	Los Angeles - La Crescenta	91214
SPA2	Los Angeles - Calabasas	91301
SPA2	Los Angeles - Calabasas	91302
SPA2	Los Angeles - Mid-SFV LA	91303
SPA2	Los Angeles - Canoga Park LA	91304
SPA2	Los Angeles - Mid-SFV LA	91306
SPA2	Los Angeles - Canoga Park LA	91307
SPA2	Los Angeles - Northwest SFV LA	91311
SPA2	Los Angeles - Encino LA	91316
SPA2	Los Angeles - Santa Clarita	91321
SPA2	Los Angeles - Northridge LA	91324
SPA2	Los Angeles - Northridge LA	91325
SPA2	Los Angeles - Northwest SFV LA	91326
SPA2	Los Angeles - Pacoima LA	91331
SPA2	Los Angeles - Mid-SFV LA	91335
SPA2	Los Angeles - San Fernando	91340
SPA2	Los Angeles - Sylmar LA	91342
SPA2	Los Angeles - North Hills LA	91343
SPA2	Los Angeles - Northwest SFV LA	91344
SPA2	Los Angeles - North Hills LA	91345
SPA2	Los Angeles - Santa Clarita	91350
SPA2	Los Angeles - Santa Clarita	91351
SPA2	Los Angeles - Sunland LA	91352
SPA2	Los Angeles - Santa Clarita	91354
SPA2	Los Angeles - Santa Clarita	91355
SPA2	Los Angeles - Encino LA	91356
SPA2	Los Angeles - Westlake Village	91361
SPA2	Los Angeles - Thousand Oaks	91362
SPA2	Los Angeles - Woodland Hills LA	91364
SPA2	Los Angeles - Woodland Hills LA	91367
SPA2	Los Angeles - Santa Clarita	91381
SPA2	Los Angeles - Santa Clarita	91384
SPA2	Los Angeles - Van Nuys LA	91401
SPA2	Los Angeles - Van Nuys LA	91402

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA2	Los Angeles - Sherman Oaks LA	91403
SPA2	Los Angeles - Van Nuys LA	91405
SPA2	Los Angeles - Mid-SFV LA	91406
SPA2	Los Angeles - Van Nuys LA	91411
SPA2	Los Angeles - Sherman Oaks LA	91423
SPA2	Los Angeles - Encino LA	91436
SPA2	Los Angeles - Burbank	91501
SPA2	Los Angeles - Burbank	91502
SPA2	Los Angeles - Burbank	91504
SPA2	Los Angeles - Burbank	91505
SPA2	Los Angeles - Burbank	91506
SPA2	Los Angeles - North Hollywood LA	91601
SPA2	Los Angeles - Studio City LA	91602
SPA2	Los Angeles - Studio City LA	91604
SPA2	Los Angeles - North Hollywood LA	91605
SPA2	Los Angeles - North Hollywood LA	91606
SPA2	Los Angeles - North Hollywood LA	91607
SPA2	Los Angeles - Studio City	91608
SPA3	Los Angeles - Altadena	91001
SPA3	Los Angeles - Arcadia	91006
SPA3	Los Angeles - Arcadia	91007
SPA3	Los Angeles - Duarte	91010
SPA3	Los Angeles - Mt. Wilson	91023
SPA3	Los Angeles - Sierra Madre	91024
SPA3	Los Angeles - South Pasadena	91030
SPA3	Los Angeles - Pasadena	91101
SPA3	Los Angeles - Pasadena	91103
SPA3	Los Angeles - Pasadena	91104
SPA3	Los Angeles - Pasadena	91105
SPA3	Los Angeles - Pasadena	91106
SPA3	Los Angeles - Pasadena	91107
SPA3	Los Angeles - San Marino	91108
SPA3	Los Angeles - Azusa	91702
SPA3	Los Angeles - Baldwin Park	91706
SPA3	Los Angeles - Claremont	91711
SPA3	Los Angeles - Covina	91722
SPA3	Los Angeles - Covina	91723
SPA3	Los Angeles - Covina	91724

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA3	Los Angeles - El Monte	91731
SPA3	Los Angeles - El Monte	91732
SPA3	Los Angeles - El Monte	91733
SPA3	Los Angeles - Glendora	91740
SPA3	Los Angeles - Glendora	91741
SPA3	Los Angeles - La Puente	91744
SPA3	Los Angeles - Hacienda-Rowland Heights	91745
SPA3	Los Angeles - La Puente	91746
SPA3	Los Angeles - Hacienda-Rowland Heights	91748
SPA3	Los Angeles - La Verne	91750
SPA3	Los Angeles - Monterey Park	91754
SPA3	Los Angeles - Monterey Park	91755
SPA3	Los Angeles - Diamond Bar	91765
SPA3	Los Angeles - Pomona	91766
SPA3	Los Angeles - Pomona	91767
SPA3	Los Angeles - Pomona	91768
SPA3	Los Angeles - Rosemead	91770
SPA3	Los Angeles - San Dimas	91773
SPA3	Los Angeles - San Gabriel	91775
SPA3	Los Angeles - San Gabriel	91776
SPA3	Los Angeles - Temple City	91780
SPA3	Los Angeles - Walnut	91789
SPA3	Los Angeles - West Covina	91790
SPA3	Los Angeles - West Covina	91792
SPA3	Los Angeles - Alhambra	91801
SPA3	Los Angeles - Alhambra	91803
SPA4	Los Angeles - Wilshire LA	90004
SPA4	Los Angeles - Wilshire LA	90005
SPA4	Los Angeles - Wilshire LA	90006
SPA4	Los Angeles - Wilshire LA	90010
SPA4	Los Angeles - Central LA	90012
SPA4	Los Angeles - Central LA	90013
SPA4	Los Angeles - Central LA	90014
SPA4	Los Angeles - Central LA	90015
SPA4	Los Angeles - Central LA	90017
SPA4	Los Angeles - Wilshire LA	90019
SPA4	Los Angeles - Wilshire LA	90020
SPA4	Los Angeles - Central LA	90021
SPA4	Los Angeles - East LA	90023
SPA4	Los Angeles - Central LA	90026

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA4	Los Angeles - Hollywood LA	90027
SPA4	Los Angeles - Hollywood LA	90028
SPA4	Los Angeles - Hollywood LA	90029
SPA4	Los Angeles - Northeast LA	90031
SPA4	Los Angeles - Northeast LA	90032
SPA4	Los Angeles - East LA	90033
SPA4	Los Angeles - West Wilshire LA	90036
SPA4	Los Angeles - Hollywood LA	90038
SPA4	Los Angeles - Northeast LA	90039
SPA4	Los Angeles - Northeast LA	90041
SPA4	Los Angeles - Northeast LA	90042
SPA4	Los Angeles - West Hollywood	90046
SPA4	Los Angeles - West Wilshire LA	90048
SPA4	Los Angeles - Wilshire LA	90057
SPA4	Los Angeles - Northeast LA	90065
SPA4	Los Angeles - Hollywood LA	90068
SPA4	Los Angeles - West Hollywood	90069
SPA4	Los Angeles - Central LA	90071
SPA5	Los Angeles - West LA	90025
SPA5	Los Angeles - West LA	90034
SPA5	Los Angeles - West LA	90035
SPA5	Los Angeles - Westchester LA	90045
SPA5	Los Angeles - Brentwood LA	90049
SPA5	Los Angeles - Culver City/Ladera	90056
SPA5	Los Angeles - West LA	90064
SPA5	Los Angeles - Venice/Mar Vista LA	90066
SPA5	Los Angeles - Westwood LA	90067
SPA5	Los Angeles - Veterans Administration LA	90073
SPA5	Los Angeles - Bel Air LA	90077
SPA5	Los Angeles - Playa del Ray LA	90094
SPA5	Los Angeles - Beverly Hills	90210
SPA5	Los Angeles - Beverly Hills	90211
SPA5	Los Angeles - Beverly Hills	90212
SPA5	Los Angeles - Culver City/Ladera	90230
SPA5	Los Angeles - Culver City/Ladera	90232
SPA5	Los Angeles - Malibu	90265
SPA5	Los Angeles - Pacific Palisades LA	90272
SPA5	Los Angeles - Venice/Mar Vista LA	90291

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA5	Los Angeles - Venice/Mar Vista LA	90292
SPA5	Los Angeles - Playa del Rey LA	90293
SPA5	Los Angeles - Santa Monica	90401
SPA5	Los Angeles - Santa Monica	90402
SPA5	Los Angeles - Santa Monica	90403
SPA5	Los Angeles - Santa Monica	90404
SPA6	Los Angeles - South Central LA	90001
SPA6	Los Angeles - South Central LA	90002
SPA6	Los Angeles - South Central LA	90003
SPA6	Los Angeles - University LA	90007
SPA6	Los Angeles - Crenshaw LA	90008
SPA6	Los Angeles - University LA	90011
SPA6	Los Angeles - Crenshaw LA	90016
SPA6	Los Angeles - University LA	90018
SPA6	Los Angeles - University LA	90037
SPA6	Los Angeles - Crenshaw LA	90043
SPA6	Los Angeles - South Central LA	90044
SPA6	Los Angeles - South Central LA	90047
SPA6	Los Angeles - South Central LA	90059
SPA6	Los Angeles - West Compton LA	90061
SPA6	Los Angeles - University LA	90062
SPA6	Los Angeles - Compton	90220
SPA6	Los Angeles - Compton	90221
SPA6	Los Angeles - Compton	90222
SPA6	Los Angeles - Paramount	90723
SPA7	Los Angeles - East LA	90022
SPA7	Los Angeles - Commerce	90040
SPA7	Los Angeles - Huntington Park/Vernon	90058
SPA7	Los Angeles - East LA	90063
SPA7	Los Angeles - Bell	90201
SPA7	Los Angeles - Downey	90240
SPA7	Los Angeles - Downey	90241
SPA7	Los Angeles - Downey	90242
SPA7	Los Angeles - Huntington Park	90255
SPA7	Los Angeles - Maywood	90270
SPA7	Los Angeles - South Gate	90280
SPA7	Los Angeles - Whittier	90601
SPA7	Los Angeles - Whittier	90602
SPA7	Los Angeles - Whittier	90603
SPA7	Los Angeles - Whittier	90604

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA7	Los Angeles - Whittier	90605
SPA7	Los Angeles - Whittier	90606
SPA7	Los Angeles - La Habra	90631
SPA7	Los Angeles - La Mirada	90638
SPA7	Los Angeles - Montebello	90640
SPA7	Los Angeles - Norwalk	90650
SPA7	Los Angeles - Pico Rivera	90660
SPA7	Los Angeles - Santa Fe Springs	90670
SPA7	Los Angeles - Artesia	90701
SPA7	Los Angeles - Cerritos	90703
SPA7	Los Angeles - Bellflower	90706
SPA7	Los Angeles - Lakewood	90712
SPA7	Los Angeles - Lakewood	90713
SPA7	Los Angeles - Lakewood	90715
SPA7	Los Angeles - Hawaiian Gardens	90716
SPA8	Los Angeles - El Segundo	90245
SPA8	Los Angeles - Gardena	90247
SPA8	Los Angeles - Gardena	90248
SPA8	Los Angeles - Gardena	90249
SPA8	Los Angeles - Hawthorne	90250
SPA8	Los Angeles - Beach Cities	90254
SPA8	Los Angeles - Lawndale	90260
SPA8	Los Angeles - Beach Cities	90266
SPA8	Los Angeles - Palos Verdes	90274
SPA8	Los Angeles - Palos Verdes	90275
SPA8	Los Angeles - Beach Cities	90277
SPA8	Los Angeles - Beach Cities	90278
SPA8	Los Angeles - Inglewood	90301
SPA8	Los Angeles - Inglewood	90302
SPA8	Los Angeles - Inglewood	90303
SPA8	Los Angeles - Inglewood	90304
SPA8	Los Angeles - Inglewood	90305
SPA8	Los Angeles - Torrance	90501
SPA8	Los Angeles - Torrance	90502
SPA8	Los Angeles - Torrance	90503
SPA8	Los Angeles - Torrance	90504
SPA8	Los Angeles - Torrance	90505
SPA8	Los Angeles - Harbor City LA	90710
SPA8	Los Angeles - Lomita	90717
SPA8	Los Angeles - San Pedro LA	90731
SPA8	Los Angeles - San Pedro LA	90732
SPA8	Los Angeles - Wilmington LA	90744

Rating Region / Service Planning Area	County Name	ZIP Code (Los Angeles County only)
SPA8	Los Angeles - Carson	90745
SPA8	Los Angeles - Carson	90746
SPA8	Los Angeles - Carson	90747
SPA8	Los Angeles - Long Beach	90802
SPA8	Los Angeles - Long Beach	90803
SPA8	Los Angeles - Long Beach	90804
SPA8	Los Angeles - Long Beach	90805
SPA8	Los Angeles - Long Beach	90806
SPA8	Los Angeles - Long Beach	90807
SPA8	Los Angeles - Long Beach	90808
SPA8	Los Angeles - Long Beach	90810
SPA8	Los Angeles - Long Beach	90813
SPA8	Los Angeles - Long Beach	90814
SPA8	Los Angeles - Long Beach	90815
SPA8	Los Angeles - Long Beach	90822
SPA8	Los Angeles - Long Beach	90840