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: October 27, 2023

# Table of Contents

1 Introduction ..... 4
1.1 Contact Information ..... 4
1.2 Data Submission Deadlines ..... 5
2 Submitter Registration ..... 6
2.1 Test File Submission ..... 7
3 General File Specifications ..... 8
4 Definitions ..... 10
5 General Information ..... 14
5.1 Data Completeness ..... 14
5.1.1 Claims Payments ..... 14
5.1.2 Non-Claims Payments ..... 14
5.1.3 Pharmacy Rebates ..... 14
5.2 Data Variance Requests ..... 14
5.3 Included Population ..... 15
5.4 Member Attribution ..... 15
5.5 Self-Insured Plans ..... 16
5.6 Specialty or Carved-Out Services ..... 17
5.7 Standard Deviation ..... 17
5.7.1 Statewide TME File ..... 17
5.7.2 Attributed TME File ..... 18
6 File Layouts and Field Specifications ..... 20
6.1 Header Record ..... 20
6.2 Trailer Record ..... 21
6.3 Statewide TME File ..... 21
6.4 Attributed TME File ..... 26
6.5 Regional TME File ..... 32
6.6 Pharmacy Rebates File ..... 35
6.7 Submission Questions File ..... 36
Appendix A: Claims Service Category to Bill Code Mapping ..... 39
Appendix B: Non-Claims Payment Framework ..... 42

DRAFT

Appendix C: Regions........................................................................................ 45

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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, at Chapter 11.5 of Division 7 of Title 22 of the California Code of Regulations, starting with Section 97455.

## 1.1 Contact Information

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

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

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

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



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## 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. Although not required by statute, 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.

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# 2 Submitter Registration

All submitters must register to submit data to the THCE Data Portal. 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 should 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):
    - Commercial (Full Claims)
    - Commercial (Partial Claims)
    - Medi-Cal Managed Care[2]
    - Medicare Advantage
    - Medi-Cal Expenditures for Dual Eligibles[3]
    - Medicare Expenditures for Dual Eligibles
    - 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) 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 expenditures for California members according to the Member Attribution instructions outlined in Section 5.4 of this Guide. The list should also identify the Taxpayer Identification Numbers (TIN) that the submitter associates with each organization for payment purposes. The list should include all organizations

[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 Expenditures for Dual Eligibles market category will be collected beginning with the data submission due September 1, 2025.

contracted for at least 1,000 member lives during the applicable reporting years (e.g., 2022 and 2023 for the 2024 submission).

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).

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# 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 Expenditures (TME) – total medical expenditures for covered health benefits during the reporting period broken out by market category.
2. Attributed TME – total medical expenditures 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 expenditures 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 Questions – 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 should 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 should 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 should be no blank space left between the two pipes.

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

**Date formats**. Dates, unless otherwise specified, should be reported using the 8-digit format of YYYYMMDD. For example, January 18, 2024, should 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).

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# 4 Definitions

This section defines key terms used throughout this data submission guide.

**Allowed Amount**: The allowed amount for a covered benefit, which includes 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.

**Attribution Method**: The following describes the order in which submitters shall attribute a member's total medical expenditures to an organization:

1. **Capitated, Delegated Arrangement** – the member is assigned to a capitated, delegated organization listed on the OHCA Attribution Addendum for which the submitter has delegated functions such as utilization management and claims payment.
2. **Accountable Care Organization (ACO) Arrangement** – the member is attributed to a total cost of care ACO arrangement that includes an organization listed on the OHCA Attribution Addendum.
3. **Attributed to Other Organizations** – the member is attributed using the methods above to an organization **not** listed on the OHCA Attribution Addendum.
4. **Payer-Developed Attribution** – the member is attributed to an organization listed on the OHCA Attribution Addendum or other organization using a submitter-developed, rules-based approach for assigning total medical expenditures.

Members who cannot be attributed to any organization using any of the attribution methods should be reported as follows:

5. **Not Attributed** – member spending that cannot be attributed to any organization.

**Capitation and Full Risk Payments**: 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 period.

**Claims: 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, or outpatient observation services, or inpatient services at non-hospital facilities.

**Claims: 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, observation stays, and

does not include payments made for physician services during the outpatient service that were billed on a professional claim.

**Claims: Long-Term Care**: This category includes payments for long-term care services from claims. Includes skilled nursing facility, 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.

**Claims: Professional**: This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a doctor of medicine or osteopathy, community health center services, freestanding ambulatory surgical center services, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, dieticians, dentists, and chiropractors.

**Claims: 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). Medicare Advantage payers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their THCE data submission. Pharmacy data should be reported gross of applicable rebates.

**Dual Eligibles**: 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' expenditures to either Medi-Cal or Medicare, the claims should be assigned as follows: Claims for Long-Term Care to Medi-Cal, claims for all other categories to Medicare.

**Market Category**: A segment within the public or private health insurance market for the purposes of reporting total medical expenditures. The market categories are:

1. Commercial (Full Claims) – Fully-insured or self-insured members for which the submitter is able to collect information on all direct medical claims and any claims paid by a delegated entity.
2. Commercial (Partial Claims) – Fully-insured or self-insured members for which the submitter does not have access to claims or encounter data to accurately report all claims-based payments. Refer to Specialty or Carved-Out Services for more information.

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

**Non-Claims: Other**: Any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).

**Non-Claims: Payments with Shared Savings and Recoupments**: 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.

**Non-Claims: Performance Payments**: 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.

**Non-Claims: Population Health and Practice Infrastructure Payments**: 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. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenditures.

**Pharmacy Rebates**: Price concessions, price discounts, or discounts of any sort that reduce payments, including a partial refund of payments or any reductions to the ultimate amount paid; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data

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

to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all other compensation to carriers, their pharmacy benefit managers (PBMs), rebate aggregators, or subsidiaries.

**Reporting Year**: Service year for which data are being reported.

**Run-Out Period**: The amount of time provided following a reporting year to allow for claims to be fully adjudicated (i.e., considered to be "final" claims). Submitters should allow for a run-out period of 180 days following December 31 of the most recent reporting year (i.e., June 30, 2024 for 2022 and 2023 service dates).

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# 5 General Information

## 5.1 Data Completeness

Submitters should 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 should 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.

### 5.1.1 Claims Payments

Submitters should allow for a claims run-out period of at least 180 days after December 31st of the reporting year and not extract data before June 30 of the following year. Claims should 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 should not be applied. Refer to Appendix A: Claims Service Category to Bill Code Mapping for more information on claims service categories.

### 5.1.2 Non-Claims Payments

Submitters should allow for a non-claims reconciliation period of at least 180 days after December 31st of the reporting year to reconcile non-claims payments including incentives, capitation, risk settlements, and other non-claims-based payments. Submitters should 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 should 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.

### 5.1.3 Pharmacy Rebates

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

## 5.2 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.

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.

## 5.3 Included Population

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

Data should only be reported by the primary payer on the claim, as secondary coverage expenditures would generally double count a portion of the Allowed Amount by the primary payer.

When calculating total medical expenditures and member months, submitters should 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 expenditures and member months for members with whom the submitter is not directly contracted (i.e., members “from other plans”) should not be included.

## 5.4 Member Attribution

Submitters should attribute member-level expenditures according to the defined method to organizations listed on the OHCA Attribution Addendum. Attribution should be calculated on a monthly basis and reported in terms of member months.

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

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

Member attribution should 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 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 should 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'.
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 expenditures. 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 should be reported using the **Not Attributed** attribution method and the Organization Code '9999'.

## 5.5 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 should 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 should be entered on the Submission Questions file in the Self-Insured Business field (SQS021).

## 5.6 Specialty or Carved-Out Services

Some payers and fully integrated delivery systems carve-out covered services (e.g., pharmacy and behavioral health) and may not have access to claims or encounter data to accurately report claims-based payments. Available claims data plus an estimate of carved-out services for this population should be reported in the Commercial (Partial Claims) market category.

To estimate the carved-out services amount for the partial claim population, submitters should use their full-claim population spend to create an estimate for carved-out services. For example, for those members for whom pharmacy benefits are carved out, the submitter might include its commercial market book-of-business average pharmacy spending per member per month (PMPM) for the same year, calculated for members who had primary coverage, and apply to all partial claim member months for which the carved-out services applied. This estimate will enable measurement between populations with and without carved-out spending.

## 5.7 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 should be based on PMPM spending and calculated after any adjustments for specialty or carved-out services. Non-claims expenditures should be excluded from the calculation of standard deviation.

### 5.7.1 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 should calculate the average claims-based allowed amount after partial claims adjustments. Non-claims expenditures should 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 expenditures 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 member months, not individual members)

  Validating results: Using the 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 should use the formula for population standard deviation (divided by N). Submitters should 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 should correspond to a specific market category.

### 5.7.2 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 should calculate the average claims-based allowed amount after partial claims adjustments. Non-claims expenditures should 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 expenditures 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 member months, not individual members)

  Validating results: Using the 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 should use the formula for population standard deviation (divided by N). Submitters should 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 should correspond to an organization and market category.

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# 6 File Layouts and Field Specifications

## 6.1 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:<br>• SWT = Statewide TME<br>• ATT = Attributed TME<br>• RET = Regional TME<br>• RXR = Pharmacy Rebates<br>• SQS = Submission Questions |
| 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:<br>• T = Test<br>• 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. |

## 6.2 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:<br>• SWT = Statewide TME<br>• ATT = Attributed TME<br>• RET = Regional TME<br>• RXR = Pharmacy Rebates<br>• SQS = Submission Questions |
| 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 should not include the header and trailer records. |

## 6.3 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. Valid values include:<br>• 1 = Commercial (Full Claims)<br>• 2 = Commercial (Partial Claims)<br>• 3 = Medi-Cal Managed Care<br>• 4 = Medicare Advantage |

| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| | | | | | • 5 = Medi-Cal Expenditures for Dual Eligibles<br>• 6 = Medicare Expenditures for Dual Eligibles<br>• 7 = Dual Eligible Special Needs Plans (D-SNPs) |
| 4 | SWT004 | Contracting Arrangement | Integer | 1 | Use this field to designate the type of contracting arrangement. For Commercial (Full Claims) and Commercial (Partial Claims) (Market Category = 1 or 2), valid values include:<br>• 1 = Capitated / Delegated<br>• 2 = Non-capitated / Direct<br><br>For other Market Categories, valid value includes:<br>• 0 = Not applicable |
| 5 | SWT005 | Member Months | Integer | 12 | Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted.<br><br>**Note**: This field reported as an integer. |
| 6 | SWT006 | Claims: Hospital Inpatient | Integer | 12 | Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible).<br><br>**Definition**: 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, or outpatient observation services, or inpatient services at non-hospital facilities.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 7 | SWT007 | Claims: Hospital Outpatient | Integer | 12 | Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible). |

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| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| | | | | | **Definition**: 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, observation stays, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 8 | SWT008 | Claims: Professional | Integer | 12 | Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible).<br><br>**Definition**: This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a doctor of medicine or osteopathy, community health center services, freestanding ambulatory surgical center services, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, dieticians, dentists, and chiropractors<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 9 | SWT009 | Claims: Long-Term Care | Integer | 12 | Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible).<br><br>**Definition**: This category includes payments for long-term care services from claims. Includes skilled nursing facility, 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.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |

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| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| 10 | SWT010 | Claims: Retail Pharmacy | Integer | 12 | Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible). This amount excludes pharmacy rebates.<br><br>**Definition**: 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).<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 11 | SWT011 | Claims: Other | Integer | 12 | Report the total allowed amount for all claims not included in other claims categories (e.g., durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible).<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 12 | SWT012 | Claims: Total | Integer | 12 | Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible). This total should equal the sum of the individual claims categories (SWT006 through SWT011).<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 13 | SWT013 | 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.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 14 | SWT014 | 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 (SWT006 through SWT011) as well as capitation payments (SWT013).<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 15 | SWT015 | 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 expenditures.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 16 | SWT016 | 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.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 17 | SWT017 | 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.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 18 | SWT018 | Non-Claims: Other | Integer | 12 | Report the total other non-claims-based payments paid for the reporting year.<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 19 | SWT019 | 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. |
| 20 | SWT899 | Record Type | Text | 3 | Use this field to report the value of 'SWT' to indicate TME reporting at the statewide level. |

## 6.4 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.<br><br>**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.<br><br>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:<br>• 1 = Capitated, Delegated Arrangement<br>• 2 = ACO Arrangement<br>• 3 = Attributed to Other Organizations<br>• 4 = Payer-Developed Attribution<br>• 5 = Not Attributed<br><br>**Note**: When Organization Code (ATT003) is reported as '7777' or '8888' this field should be reported as '3' (Attributed to Other Organizations) or '4' (Payer-Developed Attribution). When Organization Code (ATT003) is reported as '9999' this field should 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. Valid values include:<br>• 1 = Commercial (Full Claims)<br>• 2 = Commercial (Partial Claims)<br>• 3 = Medi-Cal Managed Care |

| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| | | | | | • 4 = Medicare Advantage<br>• 5 = Medi-Cal Expenditures for Dual Eligibles<br>• 6 = Medicare Expenditures for Dual Eligibles<br>• 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:<br>• 1 = 0-1<br>• 2 = 2-18<br>• 3 = 19-39<br>• 4 = 40-54<br>• 5 = 55-64<br>• 6 = 65-74<br>• 7 = 75-84<br>• 8 = 85+<br><br>For reporting non-claims payments (ATT019 through ATT022), valid value includes:<br>• 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:<br>• F = Female<br>• M = Male<br>• U = Unknown<br><br>For reporting non-claims payments (ATT019 through ATT022), valid value includes:<br>• 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.<br><br>**Note**: This field reported as an integer. |

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| 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).<br><br>**Definition**: 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, or outpatient observation services, or inpatient services at non-hospital facilities.<br><br>**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).<br><br>**Definition**: 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, observation stays, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.<br><br>**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).<br><br>**Definition**: This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a doctor of medicine or osteopathy, |

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| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| | | | | | community health center services, freestanding ambulatory surgical center services, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, dieticians, dentists, and chiropractors<br><br>**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).<br><br>**Definition**: This category includes payments for long-term care services from claims. Includes skilled nursing facility, 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.<br><br>**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.<br><br>**Definition**: This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (e.g., administered in a hospital setting). |

| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| | | | | | **Note**: This is a money field reported in whole dollars. This field may contain a negative value. |
| 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).<br><br>**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 should equal the sum of the individual claims categories (ATT010 through ATT015).<br><br>**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.<br><br>**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).<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |

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| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| 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 expenditures.<br><br>**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.<br><br>**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.<br><br>**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.<br><br>**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. |

## 6.5 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 home 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. Valid values include:<br>• 1 = Commercial (Full Claims)<br>• 2 = Commercial (Partial Claims)<br>• 3 = Medi-Cal Managed Care<br>• 4 = Medicare Advantage<br>• 5 = Medi-Cal Expenditures for Dual Eligibles<br>• 6 = Medicare Expenditures for Dual Eligibles<br>• 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.<br><br>**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).<br><br>**Definition**: 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, or outpatient observation services, or 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. |
| 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).<br><br>**Definition**: 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, observation stays, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.<br><br>**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).<br><br>**Definition**: This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a doctor of medicine or osteopathy, community health center services, freestanding ambulatory surgical center services, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, dieticians, dentists, and chiropractors<br><br>**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).<br><br>**Definition**: This category includes payments for long-term care services from claims. Includes skilled nursing facility, nursing homes, intermediate care facilities, assisted living |

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| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| | | | | | 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.<br><br>**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.<br><br>**Definition**: 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).<br><br>**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).<br><br>**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 should equal the sum of the individual claims categories (RET006 through RET011).<br><br>**Note**: This is a money field reported in whole dollars. This field may contain a negative value. |

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| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| 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.<br><br>**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 member responsibility amounts from claims across all categories (RET006 through RET011) as well as capitation payments (RET013).<br><br>**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. |

## 6.6 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:<br>• 1 = Commercial (Full Claims)<br>• 2 = Commercial (Partial Claims)<br>• 3 = Medi-Cal Managed Care<br>• 4 = Medicare Advantage<br>• 5 = Medi-Cal Expenditures for Dual Eligibles<br>• 6 = Medicare Expenditures for Dual Eligibles<br>• 7 = Dual Eligible Special Needs Plans (D-SNPs) |

| Col. # | Field ID | Field Name | Type | Max | Description |
|---|---|---|---|---|---|
| 4 | RXR004 | Medical Pharmacy Rebate Amount | Integer | 12 | Report the total amount of pharmacy rebates applicable to pharmacies paid under the members' medical coverage for the reporting year. Report only actual amounts; do not include estimates.<br><br>**Note**: This is a money field reported in whole dollars. |
| 5 | RXR005 | Retail Pharmacy Rebate Amount | Integer | 12 | Report the total amount of pharmacy rebates applicable to pharmacies paid under the members' pharmacy coverage for the reporting year. Report only actual amounts; do not include estimates.<br><br>**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 should equal the sum of all reported rebate amounts (RXR004 through RXR005).<br><br>**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. |

## 6.7 Submission Questions 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 definitions and instructions in Version 1.0 of the THCE Data Submission Guide? Valid values include:<br>• Y = Yes<br>• N = No |
| 4 | SQS004 | CA Residents Only | Text | 1 | Does the spending data include California residents only? Valid values include:<br>• Y = Yes<br>• 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:<br>• Y = Yes<br>• 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:<br>• Y = Yes<br>• N = No |
| 7 | SQS007 | Allowed Amounts | Text | 1 | Does the spending data include allowed amounts? Valid values include:<br>• Y = Yes<br>• N = No |
| 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:<br>• Y = Yes<br>• 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:<br>• Y = Yes<br>• N = No |
| 11 | SQS011 | Claims Runout | Date | 8 | For claims runout, what is the maximum payment date for claims payments?<br>Format = YYYYMMDD |
| 12 | SQS012 | Non-Claims Runout | Date | 8 | For non-claims runout, what is the maximum payment date for non-claims payments?<br>Format = YYYYMMDD |
| 13 | SQS013 | IBNR IBNP | Text | 1 | Are spending data reported without IBNR/IBNP factors applied? Valid values include:<br>• Y = Yes<br>• N = No |
| 14 | SQS014 | Pharmacy Rebates | Text | 1 | Are pharmacy rebate data actuals, without estimates? Valid values include:<br>• Y = Yes |

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| | | | | | • N = No |
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| 15 | SQS015 | Standard Deviation | Text | 1 | Is the standard deviation calculated using the formula for population standard deviation? Valid values include:<br>• Y = Yes<br>• 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:<br>• Y = Yes<br>• N = No |
| 17 | SQS017 | Standard Deviation Non-Claims Excluded | Text | 1 | Does the standard deviation data exclude non-claims spending? Valid values include:<br>• Y = Yes<br>• N = No |
| 18 | SQS018 | Standard Deviation Age/Sex | Text | 1 | Is standard deviation calculated by Age/Sex band? Valid values include:<br>• Y = Yes<br>• N = No |
| 19 | SQS019 | Carve-out methodology | Text | 500 | Briefly describe the methodology used to estimate carved-out services. |
| 20 | SQS020 | Self-Insured Plans | Text | 1 | Does the submission include spending data from self-insured accounts? Valid values include:<br>• Y = Yes<br>• 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 should 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’.<br><br>**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 question responses. |

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# 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 expenditures. The codes listed are provided as examples but not meant to be an exhaustive list.

| Claims Service Category | Definition | 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, or outpatient observation services, or inpatient services at non-hospital facilities. | Type of bill codes:<br>• Hospital: 011X<br>• Hospital Swing Bed: 018X<br>• 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, observation stays, and does not include payments made for physician services during the outpatient service that were billed on a professional claim. | Type of bill codes:<br>• Hospital Inpatient, Part B only: 012X<br>• Hospital Outpatient: 013X<br>• Hospital Other Part B: 014X<br>• Religious Nonmedical Hospital: 043X<br>• Critical Access Hospital: 085X |
| Professional | This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a doctor of medicine or osteopathy, community health center services, freestanding ambulatory surgical center services, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, dieticians, dentists, and chiropractors. | All professional claims (CSM-1500) *excluding*:<br>• Ambulance/transportation services (Place of service codes: 41, 42)<br>• Durable Medical Equipment<br>• Independent Labs (Place of service code: 81)<br>• Optical services |

| Claims Service Category | Definition | 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 facility, 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:<br>• SNF: 021X<br>• SNF Part B: 022X<br>• SNF Outpatient: 023X<br>• SNF Swing Bed: 028X<br>• ICF: 065X, 066X<br>• Home Health: 032X, 033X<br>• Home Health Part B: 034X<br>• 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:<br>• Ambulance services (Place of service codes: 41, 42)<br>• Durable Medical Equipment<br>• Independent Labs (Place of service code: 81)<br>• Optical services<br>• Medical services provided at a pharmacy (Place of service code: 01)<br>Institutional Claims Type of Bill Codes: |

| Claims Service Category | Definition | Code Sets |
| --- | --- | --- |
| | | • Clinic: Rural Health: 071X<br>• Clinic: ESRD: 072X<br>• Clinic: Free Standing: 073X<br>• Clinic: Outpatient Rehabilitation Facility (ORF): 074X<br>• Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF): 075X<br>• Clinic: Community Mental Health Center: 076X<br>• Federally Qualified Health Center (FQHC): 077X<br>• Licensed Freestanding Emergency Medical Facility: 078X<br>• Clinic: Other 079X<br>• Hospice: 081X, 082X<br>• Ambulatory Surgical Clinic Non-professional services: 083X<br>• Freestanding birth center: 084X<br>• Freestanding Non-residential Opioid Treatment Program: 087X<br>• Special Facility – Other: 089X |

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# 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[6] |
|---|---|---|
| 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 |

[6] 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[6] |
|---|---|---|
| | 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[6] |
|---|---|---|
| | | 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 |

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# Appendix C: Regions

Total medical expenditures should be reported by region based on the member's home 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 |

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| 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 |

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| 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 |

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| 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 |

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