State of California
Office of Administrative Law

In re:
Department of Health Care Access and Information

Regulatory Action:

Title 22, California Code of Regulations

Adopt sections: **97341, 97353**
Amend sections: **97300, 97305, 97340, 97342, 97344, 97350, 97351, 97352**

NOTICE OF APPROVAL OF REGULATORY ACTION

Government Code Section 11349.3

OAL Matter Number: 2025-0210-01

OAL Matter Type: Regular (S)

This action adopts and amends regulations for the Health Care Payments Data Program (HPD) to collect non-claims payment (NCP) data.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 3/25/2025.

Date: March 25, 2025

Anna Lisa Thomas

Anna Thomas
Attorney

For: Kenneth J. Pogue
Director

Original: Elizabeth Landsberg, Director
Copy: Sherry Mung

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATION SUBMISSION

REGULAR

STD. 400 (REV. 10/2019)

For use by Secretary of State only

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-2024-0722-02	2025-0210-01S	

For use by Office of Administrative Law (OAL) only

OFFICE OF ADMIN. LAW
2025 FEB 10 PM4:01

NOTICE | REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

MAR 25 2025
3:06 PM

AGENCY WITH RULEMAKING AUTHORITY: Department of Health Care Access and Information (HCAI)

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn	2024, 31-Z	8/2/24

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): HPD Program NCP Data Collection

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT: 97341 & 97353

AMEND: 97300, 97305, 97340, 97342, 97344, 97350, 97351, & 97352

TITLE(S): 22

REPEAL:

3. TYPE OF FILING

- ☒ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify)
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)
November 6, 2024, through November 22, 2024

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify)

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Sherry Mung	916-326-3939		sherry.mung@hcai.ca.gov

8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE: J. Scott Christman

DATE: 2/7/2025

TYPED NAME AND TITLE OF SIGNATORY: J Scott Christman, Chief Deputy Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
MAR 25 2025
Office of Administrative Law

PROPOSED AMENDMENTS TO REGULATIONS – FINAL TEXT

HEALTH CARE PAYMENTS DATA PROGRAM
DATA COLLECTION REGULATIONS

CALIFORNIA CODE OF REGULATIONS TITLE 22
Division 7. Health Planning and Facility Construction

Chapter 11. Health Care Payments Data Program
Article 1. Chapter Definitions

§ 97300. Definitions.

The following definitions shall apply to the regulations contained in this Chapter:

(a) "APCD-CDL™" means ~~one of the following:~~

~~(1) For monthly data files submitted or resubmitted pursuant to this Chapter on or before February 16, 2024, the Common Data Layout for All-Payer Claims Databases, Version 2.1, released July 1, 2021, as developed by the University of New Hampshire and the National Association of Health Data Organizations (NAHDO), and hereby incorporated by reference. This document is available through the APCD Council website; or~~

~~(2) For monthly data files submitted or resubmitted pursuant to this Chapter on or after February 17, 2024,~~ the Common Data Layout for All-Payer Claims Databases, Version 3.0.1, released April 1, 2023, as developed by the University of New Hampshire and the National Association of Health Data Organizations (NAHDO), and hereby incorporated by reference. This document is available through the APCD Council website.

(b) "Data portal" means the secure data submission mechanism through which plans register to submit data and data files are submitted to the system. The data portal is available via the Department's website.

(c) "Data Submission Guide" means ~~one of the following:~~

~~(1) For registrations and monthly data files submitted or resubmitted pursuant to this Chapter on or before February 16, 2024, the Health Care Payments Data Program: Data Submission Guide, Version 1.0, dated November 23, 2021, and hereby incorporated by reference. The Data Submission Guide is available on, and may be downloaded from, the Department's website; or~~

~~(2) For registrations and monthly data files submitted or resubmitted pursuant to this Chapter on or after February 17, 2024,~~ the Health Care Payments Data Program: Data Submission Guide, Version ~~2~~ 3.0, revised on ~~July 17,~~

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~~2023~~October 28, 2024, and hereby incorporated by reference. The Data Submission Guide is available on, and may be downloaded from, the Department's website.

(d) "Delegated submitter" means an entity identified pursuant to Section 97318 as responsible for submitting data to the system on behalf of a plan.

(e) "Dental Data" means dental claims files as described in Section 97342, data for members who are exclusively enrolled for dental services, and data for providers who exclusively provided dental services.

(f) "Dental Plan" means a specialized health care service plan covering dental services only, a dental-only insurance plan, or a public self-insured plan covering dental services only.

(g) "Department" means the Department of Health Care Access and Information.

(h) "Designated submitter representative" means an individual or individuals designated by a registered submitter to submit data on behalf of the registered submitter and receive all communications from the System and the Department regarding data submissions.

(i) "Director" means the Director of the Department of Health Care Access and Information.

(j) "Health insurer" means an insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code, and an insurer offering specialized health insurance offering pharmacy, behavioral health (psychological), or dental services. Insurers providing only other specialized health insurance, or stop-loss insurance, student health insurance, supplemental insurance (including Medicare supplemental insurance), or discount-only insurance, are not considered health insurers.

(k) "Health plan" means a health care service plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a specialized health care service plan offering pharmacy, behavioral health (psychological), or dental services. "Health plan" does not include a health care service plan that holds a restricted or limited license only under the Knox-Keene Health Service Plan Act of 1975. Student health plans and supplemental plans (including Medicare supplemental coverage) are not considered health plans.

(l) "Member" means a person who is enrolled in or covered by a health plan, health insurer, or public self-insured plan.

(m) "NCP Data Layout™" means the Data Layout for Non-Claims Payments, Version 1.0, released April 2024 as developed by the APCD Council, NAHDO, and University of New Hampshire, and hereby incorporated by reference. This document is available through the NAHDO website.

~~(m)~~ (n) "Plan" means a non-exempt health plan, health insurer, or public self-insured plan; and any voluntarily participating entity.

~~(n)~~ (o) "Program" means the Health Care Payments Data Program established pursuant to Health and Safety Code Section 127671.1.

~~(o)~~ (p) "Public self-insured plan" means:

(1) A self-insured plan subject to Health and Safety Code Section 1349.2, or

(2) A state entity, city, county, or other political subdivision of the state, or a public joint labor management trust, that offers self-insured or multiemployer-insured plans that pay for or reimburse any part of the cost of health care services.

~~(p)~~ (q) "Qualified Health Plan" means a Qualified Health Plan offered by the California Health Benefit Exchange.

~~(q)~~ (r) "Registered submitter" means a plan that has registered to submit data to the system. An entity that is a delegated submitter under Section 97318 and has registered to submit data will be considered a registered submitter.

~~(r)~~ (s) "System" means the Health Care Payments Data System.

~~(s)~~ (t) "Voluntarily participating entity" means an entity that chooses to voluntarily submit data to the Program, has been approved by the Department to submit data, and is one of the following business types:

(1) A self-insured employer that is not subject to Health and Safety Code Section 1349.2.

(2) A multiemployer self-insured plan that is responsible for paying for health care services provided to beneficiaries.

(3) The trust administrator for a multiemployer self-insured plan.

(4) A provider, as defined in Health and Safety Code Section 1367.50(b)(2), that is a hospital or clinic.

(5) A supplier, as defined in Health and Safety Code Section 1367.50(b)(3), that has an independent scope of practice and submits claims electronically.

(6) A health plan or health insurer exempt from the requirements of this Chapter.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671, 127671.1, 127673, 127673.1, and 127673.2, Health and Safety Code.

Article 2. Voluntary Participation in the Program

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§ 97305. Voluntary Participation in the Program.

(a) To request to become a voluntarily participating entity, an entity or their authorized agent shall submit to the Department a written request to participate in the Program.

(b) Each request shall provide the voluntarily participating entity's business type (as described in Section 97300~~(s)~~(t)(1)-(6)), the number of covered lives, the types of coverage offered, and contact information.

(c) The Department shall notify requestors if they are approved to participate in the Program.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673 and 127673.2, Health and Safety Code.

Article 5. ~~Monthly~~ Data File Submission

§ 97340. ~~Monthly~~ Data Submission Method.

~~(a)~~ Plans shall submit data files ~~monthly~~ through the data portal.

~~(b) Except as stated in subsection (c), each monthly file shall be submitted by the first business day of the second month after the report month.~~

~~(c) The monthly data file submission for January 2024 shall be submitted no earlier than February 17, 2024, and by March 1, 2024.~~

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673, and 127673.1, Health and Safety Code.

§ 97341. Data Submission Due Dates.

(a) Plans shall submit the monthly data files identified in Section 97342 by the first business day of the second month after the report month.

(b) Plans shall submit the annual data files identified in Section 97342 by the last day of September of the year following the report year. A report year is a calendar year.

Note: Authority cited: Sections 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

§ 97342. Data File Contents.

(a) The following monthly data files, as specified in the Data Submission Guide in conjunction with the APCD-CDL™ and the NCP Data Layout™, shall be submitted.

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§ 97344. Data File Technical Requirements.

Data files shall comply with file format, technical specifications, and other standards specified in the Data Submission Guide, ~~and~~ the APCD-CDL™, and the NCP Data Layout™.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673, and 127673.1, Health and Safety Code.

Article 5.5. Special Rules for Program Opening and Historical Data Submission

§ 97350. Preparation for Historical Data Submission.

(a) Each registered submitter shall use the test function to prepare for historical data file submission.

~~(b) Plans, except dental plans, shall successfully complete the testing process by July 29, 2022.~~

~~(c)~~(b) Dental plans shall successfully complete the testing process by July 31, 2024.

(c) Before plans submit historical data files under Section 97351(b) or (c), plans and delegated submitters shall comply with the registration and testing requirements in Section 4 of the Data Submission Guide.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, and 127673, Health and Safety Code.

§ 97351. Historical Data Files.

~~(a) Plans, except dental plans, shall submit data files, excluding dental data, in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 2021 by October 28, 2022.~~

~~(b)~~ (a) All plans shall submit dental data in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 2021 by October 31, 2024.

(b) All plans shall submit Capitation Files in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through July 31, 2026 by September 1, 2026.

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(c) All plans shall submit Annual Payment Files and Pharmacy Rebate Files in accordance with Sections 97342 and 97344 for the time period from June 29, 2017 through December 31, 2024 by July 31, 2026.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

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(1) Member Eligibility File (ME)--contains demographic information for each individual member residing in California, regardless of whether the member utilized services during the reporting period.

(2) Medical Claims File (MC)--contains service-level medical claims and encounter data processed during the reporting period, that were not fully denied, except as prohibited by federal or state law.

(3) Pharmacy Claims File (PC)--contains detailed pharmacy claims and encounter data processed during the reporting period, that were not fully denied, except as prohibited by federal or state law.

(4) Dental Claims File (DC)--contains service-level dental claims and encounter data processed during the reporting period, that were not fully denied, except as prohibited by federal or state law.

(5) Provider File (PV)--contains demographic-type data on every provider included on the ME, MC, PC, or DC files during the reporting period.

(6) Capitation File (CF)--contains data on payments for member-attributable services under a capitation arrangement.

(b) The following annual data files, as specified in the Data Submission Guide in conjunction with the APCD-CDL™ and the NCP Data Layout™, shall be submitted.

(1) Annual Payment File (AP)--contains data on contractually based non-claims payments.

(2) Pharmacy Rebate File (PR)--contains data on prescription drug rebate payments.

~~(b)~~ (c) Files shall exclude data for any members who are exclusively enrolled in Medi-Cal or one of the following types of coverage:

(1) Supplemental (including Medicare supplemental).

(2) Student health.

(3) Chiropractic-only.

(4) Acupuncture-only.

(5) Vision-only.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1, 127673, and 127673.1, Health and Safety Code.

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§ 97352. Initiation of Monthly Data File Reporting.

~~(a) Plans, except dental plans, shall do the following:~~

~~(1) Begin regular monthly reporting with monthly data files, excluding dental data, for the month of November 2022, or an earlier month at their election.~~

~~(2) By February 1, 2023, submit all remaining data files, excluding dental data, for the months of 2022 prior to their first regular monthly submission.~~

~~(b)~~ (a) All plans shall do the following:

(1) Begin regular monthly reporting of dental data for the month of November 2024.

(2) By February 1, 2025, submit all remaining dental data for period beginning January 2022 through October 2024.

(b) All plans shall begin regular monthly reporting of Capitation Files, as described in Section 97342, for the month of August 2026. This monthly data file shall be submitted by October 1, 2026.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

§ 97353. Initiation of Annual Data File Reporting.

All plans shall begin regular annual reporting of the Annual Payment File and Pharmacy Rebate File, as described in Section 97342, for the calendar year of 2025. These initial annual files shall be submitted by September 30, 2026.

Note: Authority cited: Section 127673, Health and Safety Code. Reference: Sections 127671.1 and 127673, Health and Safety Code.

REPEAL

State of California

Department of Health Care Access and Information

Healthcare Payments Data Program

Data Submission Guide

July 17, 2023

Version 2.0

Table of Contents

1 Introduction

This Data Submission Guide (DSG) describes the requirements with which data submitted to the Healthcare Payments Data (HPD) Program must comply. The Department of Health Care Access and Information (HCAI) maintains and updates these specifications, which are incorporated by reference in California's HPD Program regulations.

The HPD Program uses the Common Data Layout for All-Payer Claims Databases (APCD-CDL™) as the file format for plans to transmit Healthcare enrollment, cost, utilization, and provider data to the HPD System. For more information about the APCD-CDL™, visit the APCD Council's website (https://www.apcdcouncil.org/common-data-layout).

These specifications do not repeat content from the APCD-CDL™; instead the DSG offers additional detail for submissions to the HPD program not covered in the APCD-CDL™.

This version of the DSG is for HPD submissions or resubmissions on or after February 17, 2024, using version 3.0.1 of the APCD-CDL™. Any submission or resubmissions prior to this date must conform with version 1.0 of the DSG dated November 23, 2022, and version 2.1 of the APCD-CDL™.

2 Registration

Two different types of registration are required via the HPD portal: one for plans, and one for plans and delegated submitters.

A dental plan must complete its initial registration (both plan and submitter) with HPD by March 29, 2024.

2.1 Plan Registration

This includes any mandatory submitter, such as a health plan, insurer or public self-insured entity, and any voluntary submitter (directly or through an authorized agent of the voluntary submitter). For licensed entities such as health plans or insurers, the registration is at the license level.

Plan registration will take place during the month of January each year and by the last calendar day of January.

Each of these types of plans will provide the following information during the registration process:

- Legal entity name and address
- Type of entity: mandatory or voluntary, and whether: plan/insurer, public self-insured, private self-insured
- National Association of Insurance Commissioners (NAIC) Code
- Product type(s)
- License Type and License Number
- Lines of Business
- A regulatory contact (first and last name, phone, email and address)
- A business contact for submission issues (name, phone, email and address)
- If the plan will be submitting its own data, list the types of data files that will be submitted
- If the plan is delegating submission, the plan shall provide a list of submitters, and the following information for each submitter:
    - Legal entity name
    - Contact information (name, title, phone, email and address)
    - The type of data files to be submitted

Upon approval of the registration, the registering entity will be notified and provided with a unique Payer Code that will be used in data submission to identify data they are responsible for. Submitted files that contain an invalid Payer Code will not be accepted.

2.2 Submitter Registration

Each entity who will submit data to HPD must register via the data portal. Plans who will submit data themselves (without any delegation) must also register as a submitter.

Submitter registration will take place each year after plan registration has been completed and by the last calendar day of February.

Each registering submitter must provide the following information to register:

- Legal entity name and address
- At least two designated submitter representatives (first and last name, title, phone, email and address)
- A list of all plans who they will submit data on behalf of. For each plan entity, the following information is required:
    - Payer Code and Name
    - A complete list of all data file types (Eligibility, Medical Claims, Pharmacy Claims, Dental Claims, and Provider) they will submit for each Payer Code

Upon approval of the registration, the registering submitter will be notified and provided with a unique Submitter Code that will be used in data submission to identify data they are responsible for. Submitted files that contain an invalid Submitter Code or invalid Payer Code/Submitter Code combination will not be accepted.

3 Test File Submission

Submitters shall submit test files through the HPD data portal. Test files are identified by CDLHD008 = "T".

4 Key Updates in this Version

There were a few key updates and additions with version 3.0.1 that data submitters should take careful note of.

- Member Gender was updated to Member Sex – this was applied to the Eligibility, Medical Claims, Pharmacy Claims, and Dental Claims files.
- All race and ethnicity fields will now use the six-character concept code (see APCD-CDL™ definitions for more information).
- Submitters shall send secondary race and ethnicity data as available.
- New additions to the eligibility file include: Member Gender Identity (CDLME081) and Member Sexual Orientation (CDLME082). Submitters shall send this data as available.

5 File Intake Specifications

Plans will be assigned a Payer Code by HCAI during the registration process. Submitters will be assigned a Data Submitter Code. Both codes are required data elements within the submitted data files.

Each file submitted to the HPD System must contain a valid File Header and a valid File Trailer.

Submitters must comply with the data definitions in the APCD-CDL™ Version 3.0.1. The data elements in the following tables include those fields designated as "Required" and "Situational". All other data elements in the APCD-CDL™ shall be populated with available data.

Files submitted to the HPD Systems will be either accepted or rejected. Reasons for rejection include the following:

- Invalid file format, including layout, field lengths, or data types
- Eligibility records, medical claims, pharmacy claims, and dental claims for which paid dates or eligibility dates do not match the reporting period as indicated by the Period Beginning Date and Period Ending Date in the File Header

- Invalid values for required or situationally required data elements – unless a Data Variance has been approved by HCAI
- Other technical deficiencies related to file submission, storage, or processing

Data elements designated in the following sections as "Required" must be populated at all times. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a required field will result in the rejection of the submitted file.

Data elements designated in the following sections as "Situational" must be populated under specific circumstances. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a situational field will result in the rejection of the submitted file if the situational circumstance is present. For example, the claims file data element "Admission Date" is designated as "Situational" and is required when the claim/encounter is "Inpatient".

Only Required and Situational data elements are included in the following tables, however, ALL fields in the APCD-CDL™ are required to be submitted if data is available.

Data elements designated in the following sections as "Required" must be populated at all times, unless a variance has been registered and accepted for a specific field.

5.1 File Header

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLHD001	Record Type	Required	
CDLHD002	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLHD004	Data Submitter	Required	
CDLHD005	File Type	Required	
CDLHD006	Period Beginning Date	Required	
CDLHD007	Period Ending Date	Required	
CDLHD008	Test File Flag	Required	"P" = Production File "T" = Test File
CDLHD010	APCD-CDL™ Version Number	Required	"3.0.1"

5.2 File Trailer

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLTR001	Record Type	Required	
CDLTR002	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLTR004	Data Submitter Name	Required	
CDLTR005	File Type	Required	
CDLTR006	Extraction Date	Required	
CDLTR007	Control Total of Paid Amount	Situational	Required for claims files.
CDLTR008	Record Count	Required	

5.3 Member Eligibility File

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLME001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLME002	Payer Code	Required	Assigned by HCAI during registration.
CDLME004	Member Insurance / Product Category Code	Required	
CDLME005	Eligibility Year	Required	Must be within the reporting period.
CDLME006	Eligibility Month	Required	Must be within the reporting period.
CDLME007	Insured Group or Policy Number	Required	
CDLME008	Coverage Level Code	Required	
CDLME011	Plan Specific Contract Number	Required	
CDLME012	Subscriber Last Name	Required	
CDLME013	Subscriber First Name	Required	
CDLME017	Individual Relationship Code	Required	
CDLME018	Member Sex	Required	
CDLME019	Member Date of Birth	Required	
CDLME020	Member Last Name	Required	
CDLME021	Member First Name	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLME023	Member Street Address	Required	
CDLME024	Member City Name	Required	
CDLME025	Member State or Province	Required	
CDLME026	Member ZIP Code	Required	
CDLME036	Medical Coverage Under This Plan	Required	
CDLME037	Pharmacy Coverage Under This Plan	Required	
CDLME038	Dental Coverage Under This Plan	Required	
CDLME039	Behavioral Health Coverage Under this Plan	Required	
CDLME040	Primary Insurance Indicator	Required	
CDLME041	Coverage Type	Required	
CDLME042	Plan State	Required	
CDLME043	Market Category Code	Required	
CDLME046	Member PCP ID	Situational	Required when a PCP is assigned: CDLME048 = "1" or "2".
CDLME047	NPI of Member's PCP	Situational	Required when a PCP is assigned: CDLME048 = "1" or "2".
CDLME048	PCP Assignment	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLME052	HIOS Plan Indicator	Required	
CDLME053	HIOS Plan ID	Situational	Required when CDLME052 = "1".
CDLME054	Metal Tier	Situational	Required when CDLME052 = "1".
CDLME057	Enrolled Through a Public Health Insurance Exchange	Situational	Required when CDLME052 = "1".
CDLME061	Carrier Specific Unique Member ID	Required	
CDLME062	Carrier Specific Unique Subscriber ID	Required	
CDLME075	Member Medicare Beneficiary Identifier	Situational	Required for Medicare beneficiaries.
CDLME076	ACO Identifier	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: EP = Exclusive Provider Organization HM = Health Maintenance Organization (HMO) (commercial only) PR = Preferred Provider Organization (PPO) (commercial only) PS = Point of Service (POS) (commercial only)

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLME077	ACO Name	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: EP = Exclusive Provider Organization HM = Health Maintenance Organization (HMO) (commercial only) PR = Preferred Provider Organization (PPO) (commercial only) PS = Point of Service (POS) (commercial only)
CDLME078	Physician Organization Identifier	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: HM = Health Maintenance Organization (HMO) (commercial only) HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C PS = Point of Service (POS) (commercial only)
CDLME079	Vision Coverage Indicator	Required	
CDLME080	Financial Risk Type	Required	
CDLME899	Record Type	Required	

5.4 Medical Claims File

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLMC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLMC002	Payer Code	Required	Assigned by HCAI during registration.
CDLMC004	Member Insurance / Product Category Code	Required	
CDLMC005	Payer Claim Control Number	Required	
CDLMC006	Line Counter	Required	
CDLMC007	Version Number	Required	
CDLMC009	Insured Group or Policy Number	Required	
CDLMC012	Plan Specific Contract Number	Required	
CDLMC013	Subscriber Last Name	Required	
CDLMC014	Subscriber First Name	Required	
CDLMC017	Individual Relationship Code	Required	
CDLMC018	Member Sex	Required	
CDLMC019	Member Date of Birth	Required	
CDLMC020	Member Last Name	Required	
CDLMC021	Member First Name	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLMC022	Member ZIP Code	Required	
CDLMC024	Paid Date	Required	For capitated encounters use processed date.
CDLMC025	Admission Date	Situational	Required for inpatient claims and encounters.
CDLMC026	Admission Hour	Situational	Required for inpatient claims and encounters.
CDLMC027	Admission Type	Situational	Required for inpatient claims and encounters.
CDLMC028	Point of Origin	Situational	Required for institutional claims.
CDLMC029	Discharge Date	Situational	Required for inpatient claims and encounters when Discharge Status (CDLMC031) NOT equal to "30" (Still a patient).
CDLMC030	Discharge Hour	Situational	Required for inpatient claims and encounters when Discharge Status (CDLMC031) NOT equal to "30" (Still a patient).
CDLMC031	Discharge Status	Situational	Required for inpatient claims and encounters.
CDLMC032	Type of Bill – Institutional	Situational	Required for institutional claims.
CDLMC033	Place of Service – Professional	Situational	Required for professional claims.
CDLMC034	Admitting Diagnosis	Situational	Required for inpatient claims.
CDLMC036	ICD Version Indicator	Required	
CDLMC037	Principal Diagnosis	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLMC087	Revenue Code	Situational	Required for institutional claims.
CDLMC088	Procedure Code	Situational	Required for professional and outpatient claims.
CDLMC119	Date of Service – From	Required	
CDLMC120	Date of Service – Thru	Required	
CDLMC121	Service Units/Quantity	Required	Can be zero or negative. A decimal point must be included. Count of services performed: Do NOT hard code this field to a 1 or 0, use the actual data value.
CDLMC122	Unit of Measure	Situational	Required if CDLMC121 is NOT zero.
CDLMC123	Charge Amount	Required	Can be zero or a negative value.
CDLMC125	Plan Paid Amount	Required	Can be zero or a negative value. Capitated claims will be zero.
CDLMC126	Co-Pay Amount	Required	Can be zero or a negative value.
CDLMC127	Coinsurance Amount	Required	Can be zero or a negative value.
CDLMC128	Deductible Amount	Required	Can be zero or a negative value.
CDLMC129	Other Insurance Paid Amount	Required	Can be zero or a negative value.
CDLMC131	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including

APCD-CDL Data Element #	Name	HPD Requirements	Notes
			member responsibility amounts, should be included in this field.
CDLMC132	Payment Arrangement Type Indicator	Required	
CDLMC134	Rendering Provider ID	Required	
CDLMC135	Rendering Provider NPI	Situational	Required for non-atypical providers.
CDLMC136	Rendering Provider Entity Type Qualifier	Required	
CDLMC137	In Plan Network Indicator	Required	
CDLMC138	Rendering Provider First Name	Situational	Required when CDLMC136 = "1".
CDLMC140	Rendering Provider Last Name or Organization Name	Required	
CDLMC142	Rendering Provider Specialty	Required	
CDLMC143	Rendering Provider City Name	Required	
CDLMC144	Rendering Provider State or Province	Required	
CDLMC145	Rendering Provider ZIP Code	Required	
CDLMC147	Billing Provider ID	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLMC148	Billing Provider NPI	Required	
CDLMC149	Billing Provider Last Name or Organization Name	Required	
CDLMC156	Type of Claim	Required	
CDLMC157	Claim Status	Required	
CDLMC160	Claim Line Type	Required	
CDLMC161	Carrier Specific Unique Member ID	Required	
CDLMC162	Carrier Specific Unique Subscriber ID	Required	
CDLMC164	Medical Record Number	Situational	Required for Institutional claims and encounters
CDLMC899	Record Type	Required	

5.5 Pharmacy Claims File

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLPC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLPC002	Payer Code	Required	Assigned by HCAI during registration.
CDLPC004	Member Insurance/ Product Category code	Required	
CDLPC005	Payer Claim Control Number	Required	
CDLPC006	Line Counter	Required	
CDLPC007	Version Number	Required	
CDLPC009	Insured Group or Policy Number	Required	
CDLPC012	Plan Specific Contract Number	Required	
CDLPC013	Subscriber Last Name	Required	
CDLPC014	Subscriber First Name	Required	
CDLPC017	Individual Relationship Code	Required	
CDLPC018	Member Sex	Required	
CDLPC019	Member Date of Birth	Required	
CDLPC020	Member Last Name	Required	
CDLPC021	Member First Name	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLPC022	Member ZIP Code	Required	
CDLPC023	Date Prescription Filled	Required	
CDLPC024	Paid Date	Required	For capitated encounters use processed date.
CDLPC025	Drug Code	Required	Report NDCs only. If CDLPC029 = "Y", report the NDC of the first listed ingredient.
CDLPC026	New Prescription or Refill	Required	
CDLPC027	Generic Drug Indicator	Required	
CDLPC028	Dispensed as Written Code	Required	
CDLPC029	Compound Drug Indicator	Required	
CDLPC030	Compound Drug Name or Compound Drug Ingredient List	Situational	Required if CDLPC029 = "Y". Use either the compound drug name or a list of NDC codes separated by a semi-colon.
CDLPC032	Quantity Dispensed	Required	
CDLPC033	Days' Supply	Required	
CDLPC034	Drug Unit of Measure	Required	
CDLPC035	Prescription Number	Required	
CDLPC036	Charge Amount	Required	
CDLPC037	Plan Paid Amount	Required	Can be zero or a negative value.

APCD-CDL Data Element #	Name	HPD Requirements	Notes
			Capitated encounters will be zero.
CDLPC038	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts, should be included in this field.
CDLPC039	Sales Tax Amount	Required	Can be zero or a negative value.
CDLPC040	Ingredient Cost/List Price	Required	Can be zero or a negative value.
CDLPC041	Postage Amount Claimed	Required	Can be zero or a negative value.
CDLPC042	Dispensing Fee	Required	Can be zero or a negative value.
CDLPC043	Co-Pay Amount	Required	Can be zero or a negative value.
CDLPC044	Coinsurance Amount	Required	Can be zero or a negative value.
CDLPC045	Deductible Amount	Required	Can be zero or a negative value.
CDLPC047	Other Insurance Paid Amount	Required	Can be zero or a negative value.
CDLPC048	Member Self-Pay Amount	Required	Can be zero or a negative value.
CDLPC049	Payment Arrangement Type Flag	Required	
CDLPC050	Prescribing Physician ID	Required	
CDLPC051	Prescribing Physician NPI	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLPC052	Prescribing Physician First Name	Required	
CDLPC053	Prescribing Physician Last Name	Required	
CDLPC055	Pharmacy ID	Required	
CDLPC057	Pharmacy NPI	Required	
CDLPC059	Pharmacy Location State	Required	
CDLPC060	Pharmacy ZIP Code	Required	
CDLPC061	Pharmacy Country Code	Required	
CDLPC062	Mail-Order Pharmacy Indicator	Required	
CDLPC064	In Plan Network Indicator	Required	
CDLPC065	Record Status Code	Required	
CDLPC066	Claim Line Type	Required	
CDLPC068	Carrier Specific Unique Member ID	Required	
CDLPC069	Carrier Specific Unique Subscriber ID	Required	
CDLPC071	Pharmacy City	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLPC899	Record Type	Required	

5.6 Dental Claims File

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLDC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLDC002	Payer Code	Required	Assigned by HCAI during registration.
CDLDC004	Member Insurance / Product Category Code	Required	
CDLDC005	Payer Claim Control Number	Required	
CDLDC006	Line Counter	Required	
CDLDC007	Version Number	Required	
CDLDC009	Insured Group or Policy Number	Required	
CDLDC012	Plan Specific Contract Number	Required	
CDLDC013	Subscriber Last Name	Required	
CDLDC014	Subscriber First Name	Required	
CDLDC017	Individual Relationship Code	Required	
CDLDC018	Member Sex	Required	
CDLDC019	Member Date of Birth	Required	
CDLDC020	Member Last Name	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLDC021	Member First Name	Required	
CDLDC022	Member ZIP Code	Required	
CDLDC023	Paid Date	Required	For capitated encounters use processed date.
CDLDC024	Place of Service - Professional	Required	
CDLDC026	ICD-9/ICD-10 Flag	Situational	Required when CDLDC025 is populated.
CDLDC027	Procedure Code	Required	Valid values can also include CPT and HCPCS.
CDLDC057	Date of Service – From	Required	
CDLDC058	Date of Service – Thru	Required	
CDLDC059	Charge Amount	Required	Can be zero or a negative value.
CDLDC060	Plan Paid Amount	Required	Can be zero or a negative value. Capitated claims will be zero.
CDLDC061	Co-Pay Amount	Required	Can be zero or a negative value.
CDLDC062	Coinsurance Amount	Required	Can be zero or a negative value.
CDLDC063	Deductible Amount	Required	Can be zero or a negative value.
CDLDC064	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts, should be included in this field.

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLDC065	Payment Arrangement Type Indicator	Required	
CDLDC066	Rendering Provider ID	Required	
CDLDC067	Rendering Provider NPI	Situational	Required for non-atypical providers.
CDLDC068	Rendering Provider Entity Type Qualifier	Required	
CDLDC069	Rendering Provider First Name	Situational	Required when CDLDC068 = "1".
CDLDC071	Rendering Provider Last Name or Organization Name	Required	
CDLDC073	Rendering Provider Specialty	Required	
CDLDC074	Rendering Provider City Name	Required	
CDLDC075	Rendering Provider State or Province	Required	
CDLDC076	Rendering Provider ZIP Code	Required	
CDLDC078	Billing Provider ID	Required	
CDLDC079	Billing Provider NPI	Required	
CDLDC080	Billing Provider Last Name or	Required	

APCD-CDL Data Element #	Name	HPD Requirements	Notes
	Organization Name		
CDLDC156	Type of Claim	Required	
CDLDC083	Claim Status	Required	
CDLDC084	Claim Line Type	Required	
CDLDC085	Carrier Specific Unique Member ID	Required	
CDLDC086	Carrier Specific Unique Subscriber ID	Required	
CDLDC899	Record Type	Required	

5.7 Provider File

APCD-CDL Data Element #	Name	HPD Requirements	Notes
CDLPV001	Data Submitter Code	Required	Will be assigned by HCAI during registration.
CDLPV002	Payer Code	Required	Will be assigned by HCAI during registration.
CDLPV004	Payer Assigned Provider ID	Required	
CDLPV006	Entity Type Qualifier	Required	
CDLPV007	Provider NPI	Required	
CDLPV010	Provider First Name	Situational	Required when CDLPV006 = "1".
CDLPV012	Provider Last Name or Organization Name	Required	
CDLPV014	Provider Office Street Address	Required	
CDLPV015	Provider Office City	Required	
CDLPV016	Provider Office State	Required	
CDLPV017	Provider Office ZIP Code	Required	
CDLPV019	Provider Country Code	Required	
CDLPV021	Provider Specialty	Required	
CDLPV899	Record Type	Required	

ADOPT

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

RULEMAKING FILE
(Health Care Payments Data Program Data Collection)

Item 20:
INCORPORATED BY REFERENCE – *HEALTH CARE PAYMENTS DATA PROGRAM: DATA SUBMISSION GUIDE, VERSION 3.0 FINAL*

State of California

Department of Health Care Access and Information

Health Care Payments Data Program

Data Submission Guide

October 28, 2024

Version 3.0

Table of Contents

Document Change Log

Version	Date	Changes
3.0	October 28, 2024	Added new section 4 which describes requirements for registration and testing for historical NCP Data Files. Applied minor grammar corrections to file names. NCP Data Layout™ Version 1.0 File Specifications. • Introduction – Added link to NCP Data Layout™, removed date-dependent usage of v2.1 vs 3.0.1 • Submitter Registration – Added NCP data files • File Intake Specifications – Specified which files will use APCD-CDL™ v3.0.1 and which files will use NCP Data Layout™ v1.0 • File Header – Updated possible values for CDLHD005 • File trailer – Updated possible values for CDLTR005 and CDLTR007 • Removed typo entry for Dental Claims (CDLDC156) • Added file tables for Annual Payment file, Pharmacy Rebate file and Capitation file
2.0	July 17, 2023	Updated to use APCD-CDL™ version 3.0.1: • Member Gender was updated to Member Sex • Race fields updated to use the six-character concept code New additions to the eligibility file include: Member Gender Identity (CDLME081) and Member Sexual Orientation (CDLME082)
1.0	September 1, 2021	Initial publication.

1 Introduction

This Data Submission Guide (DSG) describes the requirements with which data submitted to the Health Care Payments Data (HPD) Program must comply. The Department of Health Care Access and Information (HCAI) maintains and updates these specifications, which are incorporated by reference in California's HPD Program regulations.

The HPD Program uses the following standards:

- Common Data Layout for All-Payer Claims Databases (APCD-CDL™) for Eligibility, Medical Claims, Pharmacy Claims, Dental Claims and Provider files. The version used is 3.0.1 and was published on April 1, 2023.
- NCP Data Layout™, A Data Layout for Non-Claims Payments for Annual Payments, Pharmacy Rebates, and Capitation files. The version used is 1.0 and was published April 2024.

For more information about the APCD-CDL™, visit the APCD Council's website (https://www.apcdcouncil.org/common-data-layout).

For more information about the NCP Data Layout™, visit the National Association of Health Data Organizations (NAHDO) website (https://nahdo.org/datalayouts).

The File Intake Specifications do not repeat content from either of the standards, instead, the DSG offers additional detail for submissions to the HPD Program not covered in these standard documents (such as required and situational field designations).

2 Registration

Two different types of registration are required via the HPD portal: one for plans, and one for plans and delegated submitters.

A dental plan must complete its initial registration (both plan and submitter) with HPD by March 29, 2024.

2.1 Plan Registration

This includes any mandatory submitter, such as a health plan, insurer or public self-insured entity, and any voluntary submitter (directly or through an authorized agent of the voluntary submitter). For licensed entities such as health plans or insurers, the registration is at the license level.

Plan registration will take place during the month of January each year and by the last calendar day of January.

Each of these types of plans will provide the following information during the registration process:

- Legal entity name and address
- Type of entity: mandatory or voluntary, and whether: plan/insurer, public self-insured, private self-insured
- National Association of Insurance Commissioners (NAIC) Code
- Product type(s)
- License Type and License Number
- Lines of Business
- A regulatory contact (first and last name, phone, email and address)
- A business contact for submission issues (name, phone, email and address)
- If the plan will be submitting its own data, list the types of data files that will be submitted.
- If the plan is delegating submission, the plan shall provide a list of submitters, and the following information for each submitter:
    - Legal entity name
    - Contact information (name, title, phone, email and address)
    - The type of data files to be submitted

Upon approval of the registration, the registering entity will be notified and provided with a unique Payer Code that will be used in data submission to identify data they are responsible for. Submitted files that contain an invalid Payer Code will not be accepted.

2.2 Submitter Registration

Each entity who will submit data to HPD must register via the data portal. Plans who will submit data themselves (without any delegation) must also register as a submitter.

Submitter registration will take place each year after plan registration has been completed and by the last calendar day of February.

Each registering submitter must provide the following information to register:

- Legal entity name and address
- At least two designated submitter representatives (first and last name, title, phone, email and address)
- A list of all plans who they will submit data on behalf of. For each plan entity, the following information is required:
    - Payer Code and Name
    - A complete list of all data file types (Eligibility, Medical Claims, Pharmacy Claims, Dental Claims, Provider, Annual Payments, Pharmacy Rebates, and Capitation) they will submit for each Payer Code

Upon approval of the registration, the registering submitter will be notified and provided with a unique Submitter Code that will be used in data submission to identify data they are responsible for. Submitted files that contain an invalid Submitter Code or invalid Payer Code/Submitter Code combination will not be accepted.

3 Test File Submission

Registered submitters shall submit test files through the HPD data portal. Test files are identified by CDLHD008 = "T".

4 Special Registration and Testing Requirements for Historical NCP Data Files

In this DSG, "NCP Data Files" means Capitation Files, Annual Payment Files, and Pharmacy Rebate Files.

Plans and delegated submitters must register and test as required in Sections 4.1 and 4.2 below before submitting historical NCP Data Files[1].

[1] Historical NCP Data File submission is required by California Code of Regulations, title 22, section 97351(b) and (c).

4.1 Registration Update

Before testing required by Section 4.2 of this DSG, plans and delegated submitters must do the following:

- Plans must update their 2025 Plan Registrations by identifying the entities that will submit their historical NCP data files. Plans must provide the information required by Section 2.1 of this DSG for these entities.
- Registered submitters which will submit historical NCP Data Files must update their 2025 Submitter Registrations. Registered submitters must provide the information required by Section 2.2 of this DSG regarding their historical NCP Data File submission(s).
- Delegated submitters which did not register as registered submitters in 2025 and which will submit historical NCP Data Files must register as a submitter under Section 2.2 of this DSG.

4.2 Testing

After registering under Section 4.1 of this DSG, registered submitters must:

- By September 1, 2025, submit at least one test file through the data portal for each historical NCP Data File type they will submit.
    - For example, if a registered submitter will submit historical Annual Payment Files and historical Capitation Files, it must submit at least one test Annual Payments File and one test Capitation File by September 1, 2025.
- By June 30, 2026, successfully complete testing for each historical NCP Data File type they will submit.
    - "Successfully complete testing" means that the registered submitter, for each NCP Data File type it will submit, submitted a test file that was not rejected by HCAI. Reasons for rejection are stated in Section 5 of this DSG.
    - Registered submitters may need to submit multiple test files before successfully completing testing.

5 File Intake Specifications

Plans will be assigned a Payer Code by HCAI during the registration process. Submitters will be assigned a Data Submitter Code. Both codes are required data elements within the submitted data files.

Each file submitted to the HPD System must contain a valid File Header and a valid File Trailer.

Submitters must comply with the data definitions in the APCD-CDL™ Version 3.0.1 and the NCP Data Layout™ Version 1.0. The data elements in the following tables include those fields designated as "Required" and "Situational". All other data elements shall be populated with available data.

The below files use APCD-CDL™ Version 3.0.1 as the standard.

- File Header
- File Trailer
- Member Eligibility File
- Medical Claims File
- Pharmacy Claims File
- Dental Claims File
- Provider File

The below files use the NCP Data Layout™ Version 1.0 as the standard.

- Annual Payment File
- Pharmacy Rebate File
- Capitation File

Files submitted to the HPD System will be either accepted or rejected. Reasons for rejection include the following:

- Invalid file format, including layout, field lengths, or data types.
- Eligibility records, medical claims, pharmacy claims, and dental claims for which paid dates or eligibility dates do not match the reporting period as indicated by the Period Beginning Date and Period Ending Date in the File Header.
- Invalid values for required or situationally required data elements – unless a Data Variance has been approved by HCAI.
- Other technical deficiencies related to file submission, storage, or processing.

Data elements designated in the following sections as "Required" must be populated at all times. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a required field will result in the rejection of the submitted file.

Data elements designated in the following sections as "Situational" must be populated under specific circumstances. Unless a variance has been registered and accepted for a specific field, failure to provide a valid value in a situational field will result in the rejection of the submitted file if the situational circumstance is present. For example, the claims file data element "Admission Date" is designated as "Situational" and is required when the claim/encounter is "Inpatient".

Only Required and Situational data elements are included in the following tables, however, all fields are required to be submitted if data is available.

Data elements designated in the following sections as "Required" must be populated at all times, unless a variance has been registered and accepted for a specific field.

5.1 File Header

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLHD001	Record Type	Required	
CDLHD002	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLHD004	Data Submitter Name	Required	
CDLHD005	File Type	Required	ME = Member Eligibility MC = Medical Claims PC = Pharmacy Claims DC = Dental Claims PV = Provider File AP = Annual Payments PR = Pharmacy Rebates CF = Capitation File
CDLHD006	Period Beginning Date	Required	YYYYMMDD
CDLHD007	Period Ending Date	Required	YYYYMMDD
CDLHD008	Test File Flag	Required	"P" = Production File "T" = Test File
CDLHD010	APCD-CDL™ Version Number	Required	"3.0.1"

5.2 File Trailer

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLTR001	Record Type	Required	
CDLTR002	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLTR004	Data Submitter Name	Required	
CDLTR005	File Type	Required	ME = Member Eligibility MC = Medical Claims PC = Pharmacy Claims DC = Dental Claims PV = Provider File AP = Annual Payments PR = Pharmacy Rebates CF = Capitation File
CDLTR006	Extraction Date	Required	YYYYMMDD
CDLTR007	Control Total of Paid Amount	Situational	Required for claims (MC, PC, and DC) and non-claims (AP, PR, and CF) files. Control total for each file (CDLMC125, CDLPC037, CDLDC060, CDLAP015, CDLPR010, CDLMA012). Do not code decimal point or provide any punctuation.
CDLTR008	Record Count	Required	Total number of records submitted in the file, excluding header and trailer records.

5.3 Member Eligibility File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLME001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLME002	Payer Code	Required	Assigned by HCAI during registration.
CDLME004	Member Insurance / Product Category Code	Required	
CDLME005	Eligibility Year	Required	Must be within the reporting period.
CDLME006	Eligibility Month	Required	Must be within the reporting period.
CDLME007	Insured Group or Policy Number	Required	
CDLME008	Coverage Level Code	Required	
CDLME011	Plan Specific Contract Number	Required	
CDLME012	Subscriber Last Name	Required	
CDLME013	Subscriber First Name	Required	
CDLME017	Individual Relationship Code	Required	
CDLME018	Member Sex	Required	
CDLME019	Member Date of Birth	Required	
CDLME020	Member Last Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLME021	Member First Name	Required	
CDLME023	Member Street Address	Required	
CDLME024	Member City Name	Required	
CDLME025	Member State or Province	Required	
CDLME026	Member ZIP Code	Required	
CDLME036	Medical Coverage Under This Plan	Required	
CDLME037	Pharmacy Coverage Under This Plan	Required	
CDLME038	Dental Coverage Under This Plan	Required	
CDLME039	Behavioral Health Coverage Under this Plan	Required	
CDLME040	Primary Insurance Indicator	Required	
CDLME041	Coverage Type	Required	
CDLME042	Plan State	Required	
CDLME043	Market Category Code	Required	
CDLME046	Member PCP ID	Situational	Required when a PCP is assigned: CDLME048 = "1" or "2".

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLME047	NPI of Member's PCP	Situational	Required when a PCP is assigned: CDLME048 = "1" or "2".
CDLME048	PCP Assignment	Required	
CDLME052	HIOS Plan Indicator	Required	
CDLME053	HIOS Plan ID	Situational	Required when CDLME052 = "1".
CDLME054	Metal Tier	Situational	Required when CDLME052 = "1".
CDLME057	Enrolled Through a Public Health Insurance Exchange	Situational	Required when CDLME052 = "1".
CDLME061	Carrier Specific Unique Member ID	Required	
CDLME062	Carrier Specific Unique Subscriber ID	Required	
CDLME075	Member Medicare Beneficiary Identifier	Situational	Required for Medicare beneficiaries.
CDLME076	ACO Identifier	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: EP = Exclusive Provider Organization

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			HM = Health Maintenance Organization (HMO) (commercial only) PR = Preferred Provider Organization (PPO) (commercial only) PS = Point of Service (POS) (commercial only)
CDLME077	ACO Name	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: EP = Exclusive Provider Organization HM = Health Maintenance Organization (HMO) (commercial only) PR = Preferred Provider Organization (PPO) (commercial only) PS = Point of Service (POS) (commercial only)
CDLME078	Physician Organization Identifier	Situational	Required when Member Insurance / Product Category Code (CDLME004) is one of the following values: HM = Health Maintenance Organization (HMO) (commercial only)

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			HN = Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C PS = Point of Service (POS) (commercial only)
CDLME079	Vision Coverage Indicator	Required	
CDLME080	Financial Risk Type	Required	
CDLME899	Record Type	Required	

5.4 Medical Claims File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLMC002	Payer Code	Required	Assigned by HCAI during registration.
CDLMC004	Member Insurance / Product Category Code	Required	
CDLMC005	Payer Claim Control Number	Required	
CDLMC006	Line Counter	Required	
CDLMC007	Version Number	Required	
CDLMC009	Insured Group or Policy Number	Required	
CDLMC012	Plan Specific Contract Number	Required	
CDLMC013	Subscriber Last Name	Required	
CDLMC014	Subscriber First Name	Required	
CDLMC017	Individual Relationship Code	Required	
CDLMC018	Member Sex	Required	
CDLMC019	Member Date of Birth	Required	
CDLMC020	Member Last Name	Required	
CDLMC021	Member First Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC022	Member ZIP Code	Required	
CDLMC024	Paid Date	Required	For capitated encounters use processed date.
CDLMC025	Admission Date	Situational	Required for inpatient claims and encounters.
CDLMC026	Admission Hour	Situational	Required for inpatient claims and encounters.
CDLMC027	Admission Type	Situational	Required for inpatient claims and encounters.
CDLMC028	Point of Origin	Situational	Required for institutional claims.
CDLMC029	Discharge Date	Situational	Required for inpatient claims and encounters when Discharge Status (CDLMC031) NOT equal to "30" (Still a patient).
CDLMC030	Discharge Hour	Situational	Required for inpatient claims and encounters when Discharge Status (CDLMC031) NOT equal to "30" (Still a patient).
CDLMC031	Discharge Status	Situational	Required for inpatient claims and encounters.
CDLMC032	Type of Bill – Institutional	Situational	Required for institutional claims.
CDLMC033	Place of Service – Professional	Situational	Required for professional claims.
CDLMC034	Admitting Diagnosis	Situational	Required for inpatient claims.
CDLMC036	ICD Version Indicator	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC037	Principal Diagnosis	Required	
CDLMC087	Revenue Code	Situational	Required for institutional claims.
CDLMC088	Procedure Code	Situational	Required for professional and outpatient claims.
CDLMC119	Date of Service – From	Required	
CDLMC120	Date of Service – Thru	Required	
CDLMC121	Service Units/Quantity	Required	Can be zero or negative. A decimal point must be included. Count of services performed: Do NOT hard code this field to a 1 or 0, use the actual data value.
CDLMC122	Unit of Measure	Situational	Required if CDLMC121 is NOT zero.
CDLMC123	Charge Amount	Required	Can be zero or a negative value.
CDLMC125	Plan Paid Amount	Required	Can be zero or a negative value. Capitated claims will be zero.
CDLMC126	Co-Pay Amount	Required	Can be zero or a negative value.
CDLMC127	Coinsurance Amount	Required	Can be zero or a negative value.
CDLMC128	Deductible Amount	Required	Can be zero or a negative value.

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC129	Other Insurance Paid Amount	Required	Can be zero or a negative value.
CDLMC131	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts, should be included in this field.
CDLMC132	Payment Arrangement Type Indicator	Required	
CDLMC134	Rendering Provider ID	Required	
CDLMC135	Rendering Provider NPI	Situational	Required for non-atypical providers.
CDLMC136	Rendering Provider Entity Type Qualifier	Required	
CDLMC137	In Plan Network Indicator	Required	
CDLMC138	Rendering Provider First Name	Situational	Required when CDLMC136 = "1".
CDLMC140	Rendering Provider Last Name or Organization Name	Required	
CDLMC142	Rendering Provider Specialty	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLMC143	Rendering Provider City Name	Required	
CDLMC144	Rendering Provider State or Province	Required	
CDLMC145	Rendering Provider ZIP Code	Required	
CDLMC147	Billing Provider ID	Required	
CDLMC148	Billing Provider NPI	Required	
CDLMC149	Billing Provider Last Name or Organization Name	Required	
CDLMC156	Type of Claim	Required	
CDLMC157	Claim Status	Required	
CDLMC160	Claim Line Type	Required	
CDLMC161	Carrier Specific Unique Member ID	Required	
CDLMC162	Carrier Specific Unique Subscriber ID	Required	
CDLMC164	Medical Record Number	Situational	Required for Institutional claims and encounters.
CDLMC899	Record Type	Required	

5.5 Pharmacy Claims File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLPC002	Payer Code	Required	Assigned by HCAI during registration.
CDLPC004	Member Insurance/ Product Category code	Required	
CDLPC005	Payer Claim Control Number	Required	
CDLPC006	Line Counter	Required	
CDLPC007	Version Number	Required	
CDLPC009	Insured Group or Policy Number	Required	
CDLPC012	Plan Specific Contract Number	Required	
CDLPC013	Subscriber Last Name	Required	
CDLPC014	Subscriber First Name	Required	
CDLPC017	Individual Relationship Code	Required	
CDLPC018	Member Sex	Required	
CDLPC019	Member Date of Birth	Required	
CDLPC020	Member Last Name	Required	
CDLPC021	Member First Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC022	Member ZIP Code	Required	
CDLPC023	Date Prescription Filled	Required	
CDLPC024	Paid Date	Required	For capitated encounters use processed date.
CDLPC025	Drug Code	Required	Report NDCs only. If CDLPC029 = "Y", report the NDC of the first listed ingredient.
CDLPC026	New Prescription or Refill	Required	
CDLPC027	Generic Drug Indicator	Required	
CDLPC028	Dispensed as Written Code	Required	
CDLPC029	Compound Drug Indicator	Required	
CDLPC030	Compound Drug Name or Compound Drug Ingredient List	Situational	Required if CDLPC029 = "Y". Use either the compound drug name or a list of NDC codes separated by a semi-colon.
CDLPC032	Quantity Dispensed	Required	
CDLPC033	Days' Supply	Required	
CDLPC034	Drug Unit of Measure	Required	
CDLPC035	Prescription Number	Required	
CDLPC036	Charge Amount	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC037	Plan Paid Amount	Required	Can be zero or a negative value. Capitated encounters will be zero.
CDLPC038	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts, should be included in this field.
CDLPC039	Sales Tax Amount	Required	Can be zero or a negative value.
CDLPC040	Ingredient Cost/List Price	Required	Can be zero or a negative value.
CDLPC041	Postage Amount Claimed	Required	Can be zero or a negative value.
CDLPC042	Dispensing Fee	Required	Can be zero or a negative value.
CDLPC043	Co-Pay Amount	Required	Can be zero or a negative value.
CDLPC044	Coinsurance Amount	Required	Can be zero or a negative value.
CDLPC045	Deductible Amount	Required	Can be zero or a negative value.
CDLPC047	Other Insurance Paid Amount	Required	Can be zero or a negative value.
CDLPC048	Member Self- Pay Amount	Required	Can be zero or a negative value.

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC049	Payment Arrangement Type Flag	Required	
CDLPC050	Prescribing Physician ID	Required	
CDLPC051	Prescribing Physician NPI	Required	
CDLPC052	Prescribing Physician First Name	Required	
CDLPC053	Prescribing Physician Last Name	Required	
CDLPC055	Pharmacy ID	Required	
CDLPC057	Pharmacy NPI	Required	
CDLPC059	Pharmacy Location State	Required	
CDLPC060	Pharmacy ZIP Code	Required	
CDLPC061	Pharmacy Country Code	Required	
CDLPC062	Mail-Order Pharmacy Indicator	Required	
CDLPC064	In Plan Network Indicator	Required	
CDLPC065	Record Status Code	Required	
CDLPC066	Claim Line Type	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPC068	Carrier Specific Unique Member ID	Required	
CDLPC069	Carrier Specific Unique Subscriber ID	Required	
CDLPC071	Pharmacy City	Required	
CDLPC899	Record Type	Required	

5.6 Dental Claims File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLDC001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLDC002	Payer Code	Required	Assigned by HCAI during registration.
CDLDC004	Member Insurance / Product Category Code	Required	
CDLDC005	Payer Claim Control Number	Required	
CDLDC006	Line Counter	Required	
CDLDC007	Version Number	Required	
CDLDC009	Insured Group or Policy Number	Required	
CDLDC012	Plan Specific Contract Number	Required	
CDLDC013	Subscriber Last Name	Required	
CDLDC014	Subscriber First Name	Required	
CDLDC017	Individual Relationship Code	Required	
CDLDC018	Member Sex	Required	
CDLDC019	Member Date of Birth	Required	
CDLDC020	Member Last Name	Required	
CDLDC021	Member First Name	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLDC022	Member ZIP Code	Required	
CDLDC023	Paid Date	Required	For capitated encounters use processed date.
CDLDC024	Place of Service - Professional	Required	
CDLDC026	ICD-9/ICD-10 Flag	Situational	Required when CDLDC025 is populated.
CDLDC027	Procedure Code	Required	Valid values can also include CPT and HCPCS.
CDLDC057	Date of Service – From	Required	
CDLDC058	Date of Service – Thru	Required	
CDLDC059	Charge Amount	Required	Can be zero or a negative value.
CDLDC060	Plan Paid Amount	Required	Can be zero or a negative value. Capitated claims will be zero.
CDLDC061	Co-Pay Amount	Required	Can be zero or a negative value.
CDLDC062	Coinsurance Amount	Required	Can be zero or a negative value.
CDLDC063	Deductible Amount	Required	Can be zero or a negative value.
CDLDC064	Allowed Amount	Required	Can be zero or a negative value. For capitated encounters, a Fee-For-Service equivalent amount, including member responsibility amounts,

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
			should be included in this field.
CDLDC065	Payment Arrangement Type Indicator	Required	
CDLDC066	Rendering Provider ID	Required	
CDLDC067	Rendering Provider NPI	Situational	Required for non-atypical providers.
CDLDC068	Rendering Provider Entity Type Qualifier	Required	
CDLDC069	Rendering Provider First Name	Situational	Required when CDLDC068 = "1".
CDLDC071	Rendering Provider Last Name or Organization Name	Required	
CDLDC073	Rendering Provider Specialty	Required	
CDLDC074	Rendering Provider City Name	Required	
CDLDC075	Rendering Provider State or Province	Required	
CDLDC076	Rendering Provider ZIP Code	Required	
CDLDC078	Billing Provider ID	Required	

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLDC079	Billing Provider NPI	Required	
CDLDC080	Billing Provider Last Name or Organization Name	Required	
CDLDC083	Claim Status	Required	
CDLDC084	Claim Line Type	Required	
CDLDC085	Carrier Specific Unique Member ID	Required	
CDLDC086	Carrier Specific Unique Subscriber ID	Required	
CDLDC899	Record Type	Required	

5.7 Provider File

APCD-CDL™ Data Element #	Name	HPD Requirements	Notes
CDLPV001	Data Submitter Code	Required	Will be assigned by HCAI during registration.
CDLPV002	Payer Code	Required	Will be assigned by HCAI during registration.
CDLPV004	Payer Assigned Provider ID	Required	
CDLPV006	Entity Type Qualifier	Required	
CDLPV007	Provider NPI	Required	
CDLPV010	Provider First Name	Situational	Required when CDLPV006 = "1".
CDLPV012	Provider Last Name or Organization Name	Required	
CDLPV014	Provider Office Street Address	Required	
CDLPV015	Provider Office City	Required	
CDLPV016	Provider Office State	Required	
CDLPV017	Provider Office ZIP Code	Required	
CDLPV019	Provider Country Code	Required	
CDLPV021	Provider Specialty	Required	
CDLPV899	Record Type	Required	

5.8 Annual Payment File

NCP Data Layout™ Data Element #	Name	HPD Requirements	Notes
CDLAP001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLAP002	Payer Code	Required	Assigned by HCAI during registration.
CDLAP003	Reporting Period Start Date	Required	YYYYMM
CDLAP004	Reporting Period End Date	Required	YYYYMM
CDLAP005	Contract Number	Required	
CDLAP006	Contract Type	Required	See NCP Data Layout™ for specific valid values.
CDLAP007	Billing Provider ID	Required	
CDLAP008	Billing Provider NPI	Required	Must be a valid NPI.
CDLAP009	Billing Provider Tax ID	Required	Do not include punctuation.
CDLAP010	Billing Provider Last Name or Organization Name	Required	
CDLAP011	Billing Provider First Name	Situational	Required for individual providers.
CDLAP012	Payment Category	Required	See NCP Data Layout™ for specific valid values.
CDLAP013	Payment Subcategory	Required	See NCP Data Layout™ for specific valid values.
CDLAP014	Member Count	Situational	Required when Payment Category (CDLAP012) = 'B', 'D' or 'Z'.

NCP Data Layout™ Data Element #	Name	HPD Requirements	Notes
CDLAP015	Member Months	Situational	Required when Payment Category (CDLAP012) = 'B', 'D' or 'Z'.
CDLAP016	Total Amount Paid/Allowed	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP017	Total Member Responsibility Amount	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP018	Total Amount Paid for Primary Care	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP019	Total Amount Paid for Behavioral Health	Required	Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP899	Record Type	Required	

5.9 Pharmacy Rebate File

NCP Data Layout™ Data Element #	Name	HPD Requirements	Notes
CDLPR001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLPR002	Payer Code	Required	Assigned by HCAI during registration.
CDLPR003	Reporting Period Start Date	Required	YYYYMM
CDLPR004	Reporting Period End Date	Required	YYYYMM
CDLPR005	Drug Code – NDC Product Code	Required	Do not include dashes.
CDLPR006	Drug Manufacturer	Required	
CDLPR007	Drug Name	Required	
CDLPR008	Brand/Generic Indicator	Required	See NCP Data Layout™ for specific valid values.
CDLPR009	Prescription Count	Required	
CDLPR010	Member Count	Required	Number of members filling a prescription during the reporting period.
CDLPR011	Total Paid Amount	Required	Total amount associated with this specific Drug Code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.

NCP Data Layout™ Data Element #	Name	HPD Requirements	Notes
CDLPR012	Rebates Received	Required	Total amount of the rebate received for the specified NDC code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR899	Record Type	Required	

5.10 Capitation File

NCP Data Layout™ Data Element #	Name	HPD Requirements	Notes
CDLCF001	Data Submitter Code	Required	Assigned by HCAI during registration.
CDLCF002	Payer Code	Required	Assigned by HCAI during registration.
CDLCF003	Reporting Period Start Date	Required	YYYYMM
CDLCF004	Reporting Period End Date	Required	YYYYMM
CDLCF005	Carrier Specific Unique Member ID	Required	
CDLCF006	Member Last Name	Required	
CDLCF007	Member First Name	Situational	Required when the member has a first name.
CDLCF008	Member Middle Initial	Situational	Required when the member has a middle initial.
CDLCF009	Member Sex	Required	
CDLCF010	Member Date of Birth	Required	
CDLCF011	Member Social Security Number	Situational	Required when available.
CDLCF012	Billing Provider ID	Required	
CDLCF013	Billing Provider NPI	Required	Must be a valid NPI.
CDLCF014	Billing Provider Tax ID	Required	Do not include punctuation.
CDLCF015	Billing Provider Last Name or	Required	

NCP Data Layout™ Data Element #	Name	HPD Requirements	Notes
	Organization Name		
CDLCF016	Billing Provider First Name	Situational	Required for individual providers.
CDLCF017	Insurance/Product Category Code	Required	
CDLCF018	Payment Subcategory	Required	See NCP Data Layout™ for specific valid values.
CDLCF019	Total Paid Amount	Required	Total amount associated with this specific Billing Provider. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). This field may contain a negative value.
CDLCF899	Record Type	Required	

ADOPT

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

RULEMAKING FILE
(Health Care Payments Data Program Data Collection)

Item 21:
INCORPORATED BY REFERENCE – *NCP DATA LAYOUT™: A DATA LAYOUT FOR NON-CLAIMS PAYMENTS, VERSION 1.0*

APCD All-Payer Claims Database COUNCIL
A program of NAHDO in partnership with the University of New Hampshire

Institute for Health Policy and Practice

NAHDO

NCP Data Layout™

A DATA LAYOUT FOR NON-CLAIMS PAYMENTS

Maintained by APCD Council
VERSION 1.0 | RELEASED (APRIL 2024)

Table of Contents

Acknowledgements

Development of the Non-Claims Payment Data Layout (NCP Data Layout™) was a collaborative effort of the APCD Council Leadership Team, NAHDO's APCD-CDL™ Steering Committee, and individuals representing APCD programs, vendors, and data suppliers.

Overview

All-Payer Claims Databases (APCDs) are large-scale databases that systematically collect healthcare payment data from the existing systems created to reimburse providers. APCDs exist as statewide, comprehensive databases managed by a state agency or its designee. APCDs are also created voluntarily for a region or specific stakeholders within a state, usually by nonprofit organizations such as healthcare-related employer business groups or community coalition organizations.

State agencies, employers, providers, consumers, health plans, and other researchers use APCDs for many purposes including, but not limited to:

- Examining healthcare cost, utilization, quality, and outcomes,
- Promoting transparency of healthcare costs,
- Evaluating value-based purchasing,
- Designing wellness programs,
- Trending and benchmarking.

These use cases inform APCD design. Most are structured to create a single de-identified person identifier across payers to create a longitudinal record of services rendered and all provider reimbursements without duplication.

Purpose

The files in this guidance can be used to collect non-claims payment (NCP) data not captured by using the APCD Common Data Layout (APCD-CDL™).[1] This layout aims to harmonize NCP data collection efforts across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs, and improve accuracy in healthcare payment data.

States determine submission requirements, such as the scope of plans required to submit and which files are required, member inclusion criteria, submission frequency, and due dates, including how much run-out will be allowed and whether to refresh previous years' data.

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[1] *APCD Common Data Layout Version 3.0.1*, APCD Council, NAHDO and University of New Hampshire, April 2023, https://www.apcdcouncil.org/sites/default/files/media/2023-09/apcd-cdl-v3.0.1_errata_public.pdf (accessed April 2024).

Technical Specifications

FILE CONTENT

This layout contains numbered data elements with a data type, maximum length, and description, often including valid values, for collecting non-claims payment data from healthcare payers and pharmaceutical manufacturers.

Variations from any file layout can cause data processing delays and errors, requiring additional resources to bring non-compliant submissions into the APCD. Therefore, exceptions should only be granted when data submitter compliance is unfeasible. Programs typically only give exceptions for the shortest time possible.

This guidance is intentionally silent on establishing 1) definitions for "primary care" and "behavioral health" and 2) data quality thresholds to allow states flexibility during testing and implementation. Both will vary across state-designated agencies due to policy and technical capability differences. Care definitions and data quality can also vary by data supplier within a state. For this reason, states typically establish data quality thresholds based on submission testing, expectations setting with data suppliers, and in consultation with other state agencies collecting these data. Exceptions to data quality thresholds might be negotiated and adjusted over time to improve data quality in compliance with submission requirements.

Financial Amounts

Financial amount data elements assume the following:

- The amount paid for each payment record is mutually exclusive.
- For non-claims payment records (i.e., annual, pharmacy rebates, and capitation), round or truncate to the nearest dollar and report as an integer.

Payment Categories

The California Department of Health Care Access and Information (HCAI) and Freedman HealthCare LLC developed the Expanded Non-Claims Payment Framework (or Expanded Framework) in consultation with Bailit Health, the author of a Millbank Memorial Fund paper

categorizing non-claims primary care spending.[2,3] This guidance adds to the Expanded Framework two values for capturing the fee-for-service payments and the member count.

NON-CLAIMS PAYMENT DATA LAYOUT

Annual Payment File (AP)

This file accommodates data on contractually based non-claims payments made by a payer to a provider.

Pharmacy Rebate (PR)

This file accommodates data on prescription drug rebate payments. "Pharmacy rebates" means payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system for drugs identified using the National Drug Code (NDC) labeler and product codes.

Capitation File (CF)

This file accommodates data on payments made by a payer to a provider for member-attributable services under a capitation arrangement.

FROM APCD-CDL™

Header and Trailer Records

Each annual payment, pharmacy rebate, and capitation file submission must contain header and trailer records. The header record is the first row of each separate file submission, and the trailer record is the last. The layout of the header and trailer records should match those in the APCD-CDL™.[4]

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[2] V. Pegany, M. Brandt, N. Tran, M. Valle, and C. Krawcyzk, *A New Standard for Categorizing and Collecting Non-Claims Payment Data,* March 2024, https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/ (accessed April 2024).

[3] E. Taylor, M. Bailit, and D. Kanneganti, *Measuring the Prevalence and Drivers of Non-Claims-Based Care in Commercially Insured Populations*, Milbank Memorial Fund, April 2021, https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf (accessed April 2024).

[4] *APCD Common Data Layout Version 3.0.1*, APCD Council, NAHDO and University of New Hampshire, April 2023, https://www.apcdcouncil.org/sites/default/files/media/2023-09/apcd-cdl-v3.0.1_errata_public.pdf (accessed April 2024).

Member Eligibility File (ME)

Users should reference the member eligibility file in the APCD-CDL™. The eligibility file is only relevant to the Capitation File but is necessary for member-attributable payments. It may not need to be submitted more than once.

Consistent Inter-file Identifier

Providing a consistent person identifier across files for all members, providers, and plans is critical. A data submitter and any contracted entity acting on their behalf shall ensure that member identifiers for the same individuals are unique and consistent across capitation and member eligibility files.

ANNUAL PAYMENTS (AP) FILE

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLAP002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLAP003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLAP004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLAP005	Contract Number	varchar	80	The unique number identifying a contract between the submitter and the billing provider for the reported payment model.
CDLAP006	Contract Type	char	1	Use this field to indicate whether the payments reported were administered as part of a medical benefits contract or a dental benefits contract. The only valid codes for this field are: M = Medical: Payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage. D = Dental: Payments made under a dental benefits contract; this should include only payments made to providers for members on dental stand-alone coverage.

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP007	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.
CDLAP008	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CDLAP009	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.
CDLAP010	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CDLAP011	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLAP012	Payment Category	char	1	A = Population health and practice infrastructure payments B = Performance payments C = Payments with shared savings and recoupments D = Capitation and full risk payments E = Other non-claims payments X = Fee for service Z = Member count Select a corresponding Payment Subcategory based on the initial character in the Payment Category.

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP013	Payment Subcategory	char	2	A1 = Care management/care coordination/population health/medication reconciliation A2 = Primary care and behavioral health integration A3 = Social care integration A4 = Practice transformation payments A5 = EHR/HIT infrastructure payments B1 = Retrospective/prospective incentive payments: pay-for-reporting B2 = Retrospective/prospective incentive payments: pay-for-performance C1 = Procedure-related, episode-based payments with shared savings C2 = Procedure-related, episode-based payments with risk of recoupments C3 = Condition-related, episode-based payments with shared savings C4 = Condition-related, episode-based payments with risk of recoupments C5 = Risk for total cost of care (e.g., ACO) with shared savings C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments D1 = Primary care capitation D2 = Professional capitation D3 = Facility capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems X9 = Fee for service Z9 = Member count

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP014	Member Count	int	12	The total number of members enrolled during the reporting period. Report when Payment Category (CDLAP012) = 'B', 'D', or 'Z': 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for submitters entire book of business for the year). This record is not expected to have any dollar any associated dollar amounts reported.
CDLAP015	Member Months	int	12	Total number of members months during the reporting period, expressed in months of membership. Only report members for whom the data submitter is the primary payer. Report with Payment Category (CDLAP012) = 'B', 'D', or 'Z': 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for submitters entire book of business for the year). This record is not expected to have any associated dollar amounts reported.
CDLAP016	Total Amount Paid/Allowed	int	12	Total of all payments made to the billing provider during the Reporting/Performance Period. For non-fee-for-service payments, this is the amount paid to the provider by the insurer. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP017	Total Member Responsibility Amount	int	12	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP018	Total Amount Paid for Primary Care	int	12	Total of all payments made to a billing provider for primary care services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP019	Total Amount Paid for Behavioral Health	int	12	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Round to the nearest dollar (e.g., $1,000.25 converted to 1000). If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLAP899	Record Type	char	2	Value = AP

PHARMACY REBATES (PR) FILE

PHARMACY REBATE FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLPR001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLPR002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLPR003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLPR004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLPR005	Drug Code - NDC Product Code	varchar	9	Report the National Drug Code (NDC) product code, which includes the first 8 or 9 digits and excludes the last one or two digits (package code) of the NDC. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix H: External Code Source, United States Food and Drug Administration.
CDLPR006	Drug Manufacturer	varchar	50	Use this field to report the manufacturer of the drug.
CDLPR007	Drug Name	varchar	80	Use this field to report the text name of the drug.
CDLPR008	Brand/Generic Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01=Branded drug 02=Generic drug

PHARMACY REBATE FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLPR009	Prescription Count	int	12	Number of prescription fills for each drug. Includes original prescriptions and refills.
CDLPR010	Member Count	int	12	Number of members filling a prescription during the reporting period.
CDLPR011	Total Paid Amount	int	12	Total of all payments made during the Reporting/Performance Period. Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR012	Rebates Received	int	12	Report the total amount of the rebate received for the specified NDC code. Round to the nearest dollar (e.g., $1,000.25 converted to 1000. If the value for this field is zero, report as "0", not as null. This field may contain a negative value.
CDLPR899	Record Type	char	2	Value = PR

CAPITATION FILE (CF)

CAPITATION FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLCF001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLCF002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLCF003	Reporting Period Start Date	integer	6	YYYYMM. Beginning of reporting period covered for contract performance.
CDLCF004	Reporting Period End Date	integer	6	YYYYMM. End of reporting period covered for contract performance.
CDLCF005	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation.
CDLCF006	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.
CDLCF007	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.
CDLCF008	Member Middle Initial	varchar	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.

CAPITATION FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLCF009	Member Sex	char	1	Sex of the member. M=Male F=Female U=UNKNOWN Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).
CDLCF010	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.
CDLCF011	Member Social Security Number	char	9	The member's Social Security Number. If the member is the subscriber, report the subscriber's Social Security Number. Do not include dashes. Leave blank if not collected.
CDLCF012	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.
CDLCF013	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CDLCF014	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.

CAPITATION FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLCF015	Billing Provider Last Name or Organization	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CDLCF016	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLCF017	Insurance/Product Category Code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.
CDLCF018	Payment Subcategory	char	2	D1 = Primary care capitation D2 = Professional capitation D3 = Facility Capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems
CDLCF019	Total Paid Amount	integer	12	Total of all payments made to a contractor during the Reporting/Performance Period. Round to the nearest dollar (e.g., $1,000.25 converted to 1000). This field may contain a negative value.
CDLCF899	Record Type	char	2	Value = CF

Appendix G1 - Insurance Type/Product Code

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs (Commercial Coverage)
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Is Primary
AP	Auto Insurance Policy
C1	Other Commercial (Not Specified Elsewhere)
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage PPO
MP	Medicare Primary (not to be used for commercial plans)

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE

This is a list of codes used by state APCDs. To be used for claims and eligibility.

Code	Description
MT	Medicaid CHIP
OT	Other
PE	Property Insurance – Personal
PL	Personal
PP	Personal Payment (Cash – No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan - Institutionalized
S3	Medicare Special Needs Plan – Dual Eligible
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WC	Workers' Compensation
WU	Wrap Up Policy
11	Other Non-Federal Programs
DM	Dental Maintenance Organization

APPENDIX G1 - INSURANCE TYPE/PRODUCT CODE	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	CHAMPUS
CI	Commercial Insurance Company
LB	Liability
LM	Liability Medical
OF	Other Federal Program
TV	Title V
SL	Standalone limited (for example, vision only, hearing only)
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Appendix H - External Code Sources

APPENDIX H - EXTERNAL CODE SOURCES
Accredited Standards Committee (ASC) ASC X12 Directories SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard AVAILABLE FROM: Data Interchange Standards Association, Inc. (DISA) 7600 Leesburg Pike Ste 430 Falls Church, VA 22043 http://store.x12.org/store Washington Publishing Company **http://www.wpc-edi.com/reference/** ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.
Centers for Medicare and Medicaid Services National Provider Identifier SOURCE: National Plan and Provider Enumeration System AVAILABLE FROM: Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244-1850 **https://nppes.cms.hhs.gov/** ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

APPENDIX H - EXTERNAL CODE SOURCES

National Council for Prescription Drug Programs (NCPDP)

National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings
AVAILABLE FROM:
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260-7518
www.ncpdp.org

ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Council for Prescription Drug Programs (NCPDP)

Uniform Healthcare Payer Data
SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide
AVAILABLE FROM:
National Council for Prescription Drug Programs
9240 East Raintree Drive
Scottsdale, AZ 85260
www.ncpdp.org

ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.

National Uniform Billing Committee (NUBC)

NUBC Codes
SOURCE: National Uniform Billing Committee Official Data Specifications Manual
AVAILABLE FROM:
National Uniform Billing Committee American Hospital Association
155 N Wacker Drive
Chicago, IL 60606
www.nubc.org

APPENDIX H - EXTERNAL CODE SOURCES
National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code Set SOURCE: Washington Publishing Company AVAILABLE FROM: National Uniform Claim Committee nuccinfo@nucc.org http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40
United States Food and Drug Administration (FDA) National Drug Codes SOURCE: National Drug Data File AVAILABLE FROM: U.S. Food and Drug Administration Center for Drug Evaluation and Research Division of Data Management and Services 10903 New Hampshire Avenue Silver Spring, MD 20993 www.fda.gov or www.accessdata.fda.gov/scripts/cder/ndc/default.cfm