Healthcare Payments Data Program

Reporting Manual

March 2024

Version 2.1

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1 Revision History

Version	Date	Key Differences
2.1	03/11/2024	Race and Ethnicity reporting updates
2.0	11/20/2023	APCD-CDL™ Version 3.0.1 and Dental implementation updates
1.0	02/23/2022	Initial version

2 Introduction

The Department of Health Care Access and Information (HCAI) is tasked with implementing California's All-Payer Claims Database (APCD), as a part of the Healthcare Payments Data (HPD) Program.

This version of the reporting manual provides guidance for the HPD implementation of the All-Payer Claims Database Common Data Layout (APCD-CDL™), Version 3.0.1, as the file format for payers to transmit health care 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).

HCAI actively maintains a website (https://hcai.ca.gov/data-and-reports/cost-transparency/healthcare-payments/) with information about the HPD Program, including background, history, references to state statutes and regulations, links to this Reporting Manual, the Data Submission Guide (DSG), contact information, and other resources for submitters. The HPD Program staff are dedicated to working with all submitters to ensure full compliance with HPD statute and regulations.

2.1 Document Purpose

This Reporting Manual consists of discussion and comments related to the implementation of the regulations. In the case of any perceived conflict between non-regulatory material in this manual and any regulation, the regulation shall prevail. The Reporting Manual is intended for use by:

1. The HPD Program's mandatory submitters, including commercial health plans, commercial insurers, and public self-funded health plans.

2. Voluntary submitters, including private self-funded health plans, providers, and suppliers.

Although the HPD Program also integrates data from Medi-Cal and Medicare Fee-For-Service (FFS), the Reporting Manual does not cover the data submission processes for those data.

This Reporting Manual serves as a companion document to:

- The file formats covered by the APCD-CDL™ (submitters must contact the APCD Council and request a copy of the APCD-CDL™ at https://www.apcdcouncil.org/common-data-layout).

- The DSG is available at the following location:
  HPD Data Submission Guide – Version 2.0

- The HPD Regulations are available at the following location:
  California Code of Regulations (westlaw.com)

2.2 Background Information on the HPD Program

California Law (Chapter 8.5 of Part 2 of Division 107 of the California Health and Safety Code, Sections 127671 – 127674.1) describes the legislative intent of the HPD Program, identifies the types of data and submitters, and describes HCAI's responsibilities in administering the HPD Program.

California has a substantial public interest in the price, cost, utilization, equity, and quality of health care services. California is a major purchaser of health coverage through the Public Employees' Retirement System, the Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, the California Health Benefit Exchange, and other entities acting on behalf of a state purchaser. California also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

California has established the HPD Program to collect information and provide greater transparency regarding health care costs, utilization, quality, and equity. The information will be used to inform policy decisions regarding the provision of quality health care, improving public health, reducing disparities, advancing health coverage, reducing health care costs, providing oversight of the health care system and health care companies, and providing public benefit for Californians and the state, while preserving consumer privacy. It is the intent of the HPD Program to improve data transparency to achieve a sustainable health care system with more equitable access to affordable and quality health care for all.

The HPD Program encourages state agencies, researchers, health care service plans, health insurers, providers, suppliers, and other stakeholders to use this data to develop innovative approaches, services, and programs that may have the potential to deliver health care that is both cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.

2.3 References to HPD Statute

The HPD Program, including types of data and submitters, is broadly defined in California statute (Chapter 8.5 of Part 2 of Division 107 of the California Health and Safety Code, Sections 127671 – 127674.1). Additional detail about data and submissions is included in Chapter 11 of Division 7 of Title 22 of the California Code of Regulations, starting with Section 97300.

3 Contact Information

HCAI HPD Program and Data Management Vendor staff can answer questions regarding the process and mechanics of data submission and technical issues regarding the covered population, intent, or contents of data files and elements.

For program questions, such as compliance with regulation, the enabling statute, down-stream use of the data, and similar questions, please contact hpd@hcai.ca.gov.

For technical questions related to the use of the technical specifications being used, data submission questions, or questions about submission results, please contact the HPD Data Management Vendor at: hpd-support@onpointhealthdata.org.

4 Registration Requirements

This section provides an overview of HPD Program registration requirements and is intended for use by two different types of entity:

- Entities such as non-exempt health plans, health insurers, public self-insured organizations, and any voluntary participating entities– in HPD terminology these entities are referred to as "plans".

- Technical organizations who are responsible for the actual submission of the data to HPD – in HPD terminology these entities are referred to as "submitters".

It is understood and expected that in many circumstances a single entity will be performing both of these roles. In cases like this, the single entity would need to register once as the plan and once as the submitter.

Plan registration will take place during the month of January each year, while Submitter registration will take place during the month of February each year once plan registration has been completed.

Dental plans and submitters that are registering for the first time must complete their registrations by March 29, 2024.

It is understood that various situations will occur where the actual submission of data is delegated either upwards within a corporate ownership structure or downwards to a subcontracted entity. It is the responsibility of the plan for which the submitter is reporting data to ensure that all reporting relationships are correctly documented during the registration process.

The HPD Program will assign a unique Payer Code to each registered plan and will assign a unique Data Submitter Code to each registered submitter. Both the Data Submitter Code and Payer Code must be used within the submission data. See the APCD-CDL™, Version 3.0.1, for additional detail.

Refer to Appendix B ("Plan and Submitter Registration Scenarios") for detailed examples of registration scenarios.

Submitters are required to annually update their registration via the Submitter Portal, by the last calendar day in February. In addition to this required annual update, submitters also are required to update their registration information whenever there is a change to their organizational information, their organization's contacts, or the HPD-related responsibilities of those contacts.

5 Submission Requirements

This section provides an overview of HPD Program data submission requirements and is intended for use by individuals within data submitter organizations responsible for generating and submitting conforming files. This section includes information regarding required file types, submitter registration instructions, timelines for file submissions, file submission instructions (including coordination of submissions), and data quality evaluation and notification processes.

All submitter interactions will occur via a secure Submitter Portal, which is the platform for submitter registration, data submission, and submission status and response information.

5.1 Transition to APCD-CDL™ Version 3.0.1

Since the initial implementation of HPD used APCD-CDL™, Version 2.1, there must be a transition to using Version 3.0.1 as required by regulation. This transition was required for all submitters and occurred following the expected submission of data for

December 2023, due to HPD by February 1, 2024. To minimize the disruption between calendar submissions, HPD submitters had two weeks following the December 2023 data submission deadline to continue submitting data under APCD-CDL™, Version 2.1 specifications. Starting February 17, 2024, all submitters were required to send submissions and resubmissions using the APCD-CDL™, Version 3.0.1.

Data for any months in 2024 and onwards must be submitted using APCD-CDL™, Version 3.0.1.

If submitters desired to send test data formatted in the APCD-CDL™, Version 3.0.1 specifications prior to February 17, 2024, they were able to do so by contacting Onpoint (hpd-support@onpointhealthdata.org) to initiate a testing request. Only submitters who have successfully submitted data through December 2023 using the APCD-CDL™, Version 2.1 specifications were permitted to test the updated specifications prior to February 17, 2024. Test files submitted prior to February 17, 2024 must have:

- Indicated their test file status using the Test File Flag (CDLHD008) submitted within each file's header.

- Utilized APCD-CDL™, Version 2.1, format for the header and trailer.

- Should your organization have questions or concerns surrounding the standard testing procedure outlined above, please reach out to Onpoint's Data Operations team at hpd-support@onpointhealthdata.org; the Onpoint team will work with you to ensure your team's testing needs are met.

- January 2024 data formatted using the APCD-CDL™, Version 3.0.1 specifications, is due March 1, 2024.

5.2 Files and Technical Specifications

Submitters shall submit the following files and adhere to the specifications in the Common Data Layout for state APCDs (APCD-CDL™, Version 3.0.1):

- Member Eligibility File

- Medical Claims File

- Pharmacy Claims File

- Dental Claims File

- Provider File

Submitted files must have a file type of .txt and the data must be pipe-delimited ("|"). No pipe character can be included in the submitted data. If no data value is being submitted in a specific data element, do not include any character between the preceding pipe and the succeeding pipe (i.e., do not include a blank; instead, report a null value as follows: "||").

Always submit one line-item per row. Each row is delimited by the carriage return and a line feed combination. Do not include carriage returns or line feed characters as a part of line-item data.

Each submitted file must include both a valid header record and a valid trailer record, along with detail records.

The reporting period is defined in the file header (CDLHD006 and CDLHD007).

a) **Member Eligibility File**

Include a monthly record for each California resident member who was eligible for a defined set of benefits for one or more days within the reporting period of the file. If a specific member had more than one distinct policy, include a record for each policy. If the reporting period of the file spans multiple months, the member must be reported with one record per month of eligibility.

b) **Medical Claims File**

Include a record for each service line for every claim or encounter processed during the reporting period. Claims and encounters should be submitted regardless of the location/state where the service was delivered. Do not include fully denied claims. Any records previously paid and reported to the HPD Program and subsequently reversed or denied must be provided to the HPD Program.

c) **Pharmacy Claims File**

Include a record for each service line for every claim or encounter processed during the reporting period. Claims and encounters should be submitted regardless of the location/state where the prescription was dispensed. Do not include fully denied claims. Any records previously paid and reported to the HPD Program and subsequently reversed or denied must be provided to the HPD Program. Only include records that have a valid NDC code (CDLPC025).

d) **Dental Claims File**

Include a record for each service line for every claim or encounter processed during the reporting period. Claims and encounters should be submitted

regardless of the location/state where the service was delivered. Do not include fully denied claims. Any records previously paid and reported to the HPD Program and subsequently reversed or denied must be provided to the HPD Program.

e) Provider File

Include a record for each provider that is included in any of the reported claim's files (Medical, Pharmacy and Dental) and the eligibility file, for the reporting period. Provider types would include Primary Care Provider, Rendering Provider, Billing Provider, Referring Provider, Attending Provider, Prescribing Physician, and Pharmacy. For larger submitters, contact HPD technical support at hpd-support@onpointhealthdata.org to discuss the possibility of providing an annual roster of providers and then a monthly update file.

5.3 Medi-Cal and Medicare Fee-For-Service

Claims and encounters for Medi-Cal (California Medicaid) are being collected directly from the Department of Health Care Services; Medicare FFS claims are provided to the HPD in files provided directly from the U.S. Centers for Medicare & Medicaid Services (CMS). If submitters have any of this data, they should exclude these two types of data in their claims file submissions.

5.4 Medicare Advantage

Medicare Advantage claims/encounters must be submitted by commercial health plans and commercial insurers administering Medicare Advantage plans.

5.5 Behavioral Health Claims and Encounters

Behavioral health claims and encounters should be submitted in the Medical Claims file.

5.6 Physician Administered Drugs

Physician administered drugs (PADs) should be submitted in the Medical Claims file.

5.7 File Submission Instructions

a) Authorized submitters will authenticate themselves within the Submitter Portal and upload data.

b) Files submitted to the HPD System will be either accepted or rejected based on criteria detailed in Section 5 of the DSG ("File Intake Specifications"). Once intake submission checks and validations have been executed, the submitter will be notified of file acceptance or rejection. The following aspects of submitted files

are verified during the review process and may result in rejection if they do not meet the specified criteria:

- File format, including required layout, field lengths, and data types.

- Time (or reporting) periods do not match the reporting period identified in the header record (CDLHD006 and CDLHD007). Examples in each file type include the following data elements:

    – Member Eligibility File: Eligibility Year/Eligibility Month (CDLME005, CDLME006)

    – Medical Claims File: Paid date (CDLMC024)

    – Pharmacy Claims File: Paid date (CDLPC024)

    – Dental Claims File: Paid Date (CDLDC023)

- Valid values for required or situationally required data elements– unless a Data Variance has been approved by the HPD Program.

- Data quality validations that evaluate the data element relationships and the data integrity in each file.

c) If the file is rejected, the submitter will be notified of all errors found in the submission. The submitter shall correct submission errors and resubmit the file.

5.8 Denied Claims and Service Lines

Fully denied claims, in which all service lines have been denied, should not be submitted to the HPD. When a claim is partially denied, the entire claim should be submitted and those service lines that were denied should be indicated by sending a value for the Denied Claim Line Indicator (CDLMC158) = "1", service lines that were not denied should be indicated by sending a value for the Denied Claim Line Indicator (CDLMC158) = "2".

5.9 Data Quality

The quality of submitted data is of primary importance to the HPD Program. Submitters may review data quality of their submissions in the Data Portal. The usefulness of submitted data is directly related to its quality, including the completeness, accuracy, reasonableness, and timeliness of the data. Data quality can only be fully assessed over time and with analysis that brings related data together. Data quality cannot be completely assessed at the time of submission. After submitted files have been accepted, the HPD Program uses several processes to measure and improve the quality of the HPD System data over time, including:

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discard

discard

Prior to initial testing each submitter will be contacted by HPD support staff and submitters will provide details about the standard approach used within their adjudication systems to consolidate claims. These details will be used to assign appropriate consolidation methods within the Portal to each submitter. Only a single consolidation method is assigned to each submission. A high-level view of each approach follows:

- **Aggregation:** This method uses the Claim Line Type (CDLMC160, CDLPC066 and CDLDC084). All adjustments are provided for each record, including negative dollar and quantity amounts for reversals.

- **Versioning:** Versioning methods require consistent and properly incremented Version Numbers (CDLMC007, CDLPC007, CDLDC007) and final values for all fields provided in the APCD-CDL™ for each updated record. The initial Version Number value of an original claim/encounter that has never been submitted before would be reported as "0". Any subsequent submissions that include updated versions of that specific claim/encounter would increment the value reported in the Version Number field by one (e.g., "1" then "2" then "3", etc.). The final record for each claim's service line would be reported with the highest version number.

5.12 Submitter Testing

Submitters are encouraged to submit test files as early as possible in implementation to validate their extract and submission processes. Systematic reports of submission results will be available for review by submitters.

Test files must be submitted using appropriate values within the file header, including the indication of a test file using a "T" for the "Test File Flag" (CDLHD008).

Submitters may break up, at their discretion, historical or multi-month catch-up files into monthly or multi-month reporting periods. Submitters must, in coordination with HCAI and the HPD Data Management Vendor, develop a schedule of intermediate steps for data file testing and submission that satisfies the deadlines listed below.

Non-Dental plans were expected to complete testing by July 31, 2022.

Dental plans must successfully complete the testing process by July 31, 2024.

5.13 Production Submission of Historical Data Files

All non-dental historical data for the period June 29, 2017 through December 2021 were due to be submitted to HPD by October 28, 2022.

All dental data for the period June 29, 2017 through December 2021 must be

submitted to HPD by October 31, 2024.

5.14 Production Submission of 2022 "Catch-Up" Files

Production non-dental "catch-up" data files containing data for January 2022 through the month prior to the first monthly production submission were expected to be submitted to HPD on or before February 1, 2023.

Dental data for the period beginning January 2022 through October 2024 must be submitted to HPD by February 1, 2025.

5.15 Submission of Ongoing Production Monthly Files

Non-dental production monthly submissions were expected to begin no later than January 2, 2023 (for the November 2022 reporting period).

Dental data monthly submissions must be initiated by January 2, 2025 for the (November 2024 reporting period). Monthly dental data submissions may be implemented prior to this date (with an earlier month of data) at the submitter's discretion.

For reporting periods following the first monthly production file, submitters shall submit ongoing monthly data file submissions by the first day of the second month following the completion of the reporting period, unless that day falls on a weekend or state holiday, in which case the due date is the next working day. For example, data for the January monthly reporting period is due by March 1.

Reporting Period	Submission is Due By
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1

Reporting Period	Submission is Due By
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

5.16 File Naming Convention

Every file submitted to the HPD System shall be a standard text file and conform to the APCD-CDL™, Version 3.0.1, format. The format of the file name is at the discretion of the submitter, but it is highly recommended that both a date of submission and a version number for the specific file being submitted be included in the file name to facilitate file identification when researching data anomalies or questions. If a file is a resubmission it is recommended to be noted as such in the file name.

5.17 Submitters Acting as a Third-Party Administrator

Submitters may submit data for multiple payers. This may include a submitter in the role of a Third-Party Administrator (TPA), which includes Pharmacy Benefit Managers (PBMs), for a self-insured entity.

Since each "payer" must be registered with the HPD Program, submitters that are TPAs should contact HCAI and provide either registration information for each "payer" that they represent or contact information for each self-insured entity. The ability to submit data for different payers in the same physical dataset has not yet been confirmed.

5.18 Fee-For-Service Equivalents for Encounters/"Zero Pay" Claims

For capitated encounters, submitters are requested to indicate what the charge amount of the encounter would have been if it had been claimed under a fee-for-service arrangement. Per the common data layout, FFS equivalents are reported in the Allowed Amount field in the Medical Claims (CDLMC131) and Pharmacy Claims files (CDLPC038) when the reported Payment Arrangement Type field (CDLMC132, CDLPC049) equals "01" to indicate capitated services. FFS equivalents should reflect the total amount that a provider would be paid for a claim (i.e., the sum of insurer and member responsibilities) by calculating the median cost of the claim at the service line

(defined at the level of the APC, CPT, DRG, HCPCS, etc.). The median cost is to be based on plan fee schedules (often used for tracking patient out of pocket spending relative to deductible amounts) for comparable providers/facilities paid using FFS arrangements.

5.19 Product Category Code (CDLME004)

Submitters are directed to use the most granular choice available. In cases where more than one product code may be applicable to a specific member, the following subset of Product Codes (excerpted from the APCD-CDL™, Version 3.0.1 Appendix G1) are anticipated to be the most relevant for reporting to HPD:

Code	Description
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
IN	Indemnity
MD	Medicare Part D
MO	Medicare Advantage PPO
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)

5.20 Race and Ethnicity Data Elements

Submitters are requested to submit race and ethnicity data for all members. Self-identified information collected directly from the member and allowing selection of multiple races for self-identification are preferred for race and ethnicity data collection.

As noted in Appendix H of the APCD-CDL™, Version 3.0.1, the following reference is given for race and ethnicity data elements:

PHIN VADS - Search All Vocabulary (cdc.gov)

Select "CDC Race Category and Ethnicity Group" for the current reference dataset for race and ethnicity codes. APCD-CDL™, Version 3.0.1, uses Version 1.2 of the CDC system data files to reference race and ethnicity codes.

https://www.cdc.gov/phin/resources/vocabulary/documents/PH_RaceAndEthnicity_CDC_v1.2.xlsx

The importance of the quality and completeness of race and ethnicity data reaches far beyond HPD Program. This data will also be important in the production of Health Equity and Quality Measure Reporting as required by DMHC. HCAI works closely with DMHC and looks forward to continuing to build on improvements in this crucial data over time.

Determination of Race and Ethnicity

Reliance on determinants such as the member's family member's name, physical attributes, place of birth, or primary language deteriorates the quality of race and ethnicity data. If a member is unable to respond, a family member may declare the member's race and ethnicity. Parents may be designated to declare the race and ethnicity of a newborn, with the mother's information being suitable, if parental declaration is unattainable.

Race – CDLME029, CDLME030 and CDLME031

Submitters should use the code that best represents the race of the member. Concept codes used should be six characters in length and be as granular as possible. Only concept codes with a hierarchical code value that begins with "R" should be used in these race code fields. Any concept code values with a hierarchical code value that begins with "E", should be coded as 2131-1 (Other Race), and the concept code used for the Ethnicity specific fields listed below. For example: use concept code 1002-5 for American Indian or Alaska Native, 1021-5 for Arapaho, 2028-9 for Asian, 2039-6 for Japanese, or 2054-5 for Black or African American. For Hispanic values such as: Mexican, Cuban, Puerto Rican, etc., a race value of 2131-1 (Other Race) must be used.

The value 'UNKNOW' should only be reported when a member self-reports their race as unknown; leave the race fields null if a member's race was not collected or available for reporting.

Hispanic Indicator - CDLME032

Submitters should follow the directions in the APCD-CDL™, Version 3.0.1, for valid values for this field:

- "Y" if the ethnicity is any of the Ethnicity values listed in Table 2 *Ethnicity Concepts and Codes* from the CDC code set referenced in the APCD-CDL™.

- "N" if the ethnicity is known and is NOT one of these values.

- "U" if not known.

Ethnicity – CDLME033, CDLME034 and CDLME035

Valid 6-character values for these fields are determined by the Concept Code column defined in the CDC dataset: (https://www.cdc.gov/phin/resources/vocabulary/documents/PH_RaceAndEthnicity_CDC_v1.2.xlsx).

Only concept code values with a hierarchical code value that begins with "E" (see the CDC reference dataset), should be used as values for ethnicity data elements, for example: 2156-8 = Costa Rican, 2180-8 = Puerto Rican. Any data value that is related to a concept code with a hierarchical code value that begins with "R", should be coded as 2186-5 (Not Hispanic or Latino).

The value 'UNKNOW' should only be reported when a member self-reports their ethnicity as unknown; leave the ethnicity fields null if a member's ethnicity was not collected or available for reporting.

5.21 Medical Claims File Data Element CDLMC157 – Claim Status

Per the definition in the APCD-CDL™, Version 3.0.1, the values provided in this field must be consistent with the X12 835 definition provided in 2100 CLP02. The values allowed in CDLMC157 have changed from v2.1 to v3.0.1 of the APCD CDL™, submitters should verify their submission mapping to ensure compliance. The most common values to be used in this data element would be:

- "01" – Primary

- "02" – Secondary

- "03" – Tertiary

Other values can be used, see the X12 835 2100 CLP02 definition for details.

5.22 Pharmacy Claims File Data Element CDLPC065 – Record Status Code

Per the definition in the APCD-CDL™, Version 3.0.1, the values provided in this field must be consistent with the NCPDP definition provided in field A88. The valid values for

CDLPC065 have not changed from Version 2.1 to Version 3.0.1. These values indicate status of the claim, valid values in this field are:

- "1" – Paid

- "2" – Denied

- "3" – Reversed

- "4" – Adjusted

5.23 Submitting Historical Eligibility Data

Historical data can be submitted in any of the following increments:

- Annual

- Quarterly

- Monthly

When reporting eligibility data, a record is required for each member for each month included in the increment. For example, if a historical file is submitted for a quarterly period, assuming that each member was eligible for benefits for the entire time, there would be three records per member included in the data – one for each month in the quarter.

Record Type	Data Submitter Code	Data Submitter Name	File Type	Period Beginning Date	Period Ending Date
HD	CACXXXX	Submitter A	ME	202101	202103

CDLME005	CDLME006	CDLME020	CDLME021	CDLME050	CDLME051
Eligibility Year of Submission	Eligibility Month of Submission	Member Last Name	Member First Name	Plan Effective Date	Plan Term Date
Example 1					
2021	01	Wind	Augusta	20191015	
2021	02	Wind	Augusta	20191015	
2021	03	Wind	Augusta	20191015	
Example 2					
2021	01	Ringing	Isabelle	20200101	
2021	02	Ringing	Isabelle	20200101	20210215
Example 3					
2021	03	Sideways	Eileen	20210331	

Example 1 - Augusta Wind has active coverage for all 3 months of the reporting period and so has a record for each month in the reporting period. The member's effective date of coverage is 10/15/2019 and is still active as of the end of the reporting period, so Plan Term Date is reported as null.

Example 2 - Isabelle Ringing has active coverage for 2 months of the reporting period and so has a record for each applicable month in the reporting period. The member's effective date of coverage is 01/01/2020 with a termination date of 02/15/2021.

Example 3 - Eileen Sideways has active coverage for 1 month during the reporting period and so has 1 record in the quarterly file. The member's effective date of coverage is 03/31/2021 and is still active as of the end of the reporting period, so Plan Term Date is reported as null. This member had at least one day of active coverage during this reporting period and would be reported accordingly.

5.24 Accountable Care Organization (ACO) Data

There are two situational fields included on the Eligibility file that are Accountable Care Organization (ACO) focused. These fields are 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)

For members who are attributed to an ACO, plans should use their own internal identifier and name for the ACO contract. The internal identifier and name should be the same month-over-month for the same ACO contract.

Appendix A – Intake Specifications

A.1 File Acceptance

Files submitted to the HPD System will be accepted or rejected. Examples of reasons for rejection include the following:

- File format, including required layout, field lengths, and data types.

  - Time (or reporting) periods do not match the reporting period identified in the header record (CDLHD006 and CDLHD007). Examples in each file type include the following data elements:

    – Member Eligibility File: Eligibility Year/Eligibility Month (CDLME005, CDLME006)

    – Medical Claims File: Paid Date (CDLMC024)

    – Pharmacy Claims File: Paid Date (CDLPC024)

    – Dental Claims File: Paid Date (CDLDC023)

- Valid values for required data elements – unless a Data Variance has been approved by the HPD Program.

- Data quality validations that evaluate the data element relationships and the data integrity in each file – unless a Data Variance has been approved by the HPD Program (see Section 5.10).

A.2 Required Data Content

a) **Service Line Level Data**

In the case where a claim or encounter includes multiple service lines, the submitter shall send all service line level data to the HPD System.

This includes unbundled service lines, where the procedure code originally reported on one service line has been broken into and paid under two or more separate (possibly different) procedure codes or when the units of service originally reported on one service line have been broken into two or more service lines and paid under different reimbursement rates.

b) **Institutional and Professional Claims/Encounters**

An institutional claim/encounter is one that would have been billed using an ASC X12 837 Institutional (837I) electronic claim format.

A professional claim/encounter is one that would have been billed using an ASC X12 837 Professional (837P) electronic claim format.

c) **Inpatient and Outpatient Claims/Encounters**

For all institutional claims/encounters, the Bill Type ASC X12 837I CLM05-2 determines if the claim/encounter should be designated as inpatient or outpatient. The Uniform Billing Claim Form Bill Type codes contained in this field are defined by the National Uniform Billing Committee (NUBC). To determine if a claim/encounter should be designated as "inpatient" or "outpatient" refer to the list of valid codes defined by NUBC.

A.3 Data Element Format

Each data element must comply with the APCD-CDL™, Version 3.0.1, specifications. Failure to comply with APCD-CDL™ data element specifications will result in file rejection unless a Data Variance request has been approved by the HPD Program.

A.4 Required/Situational Data Elements

Unless a Data Variance has been approved for a specific field, data elements designated in the DSG as "Required" must be populated at all times. Failure to provide a valid value in a required field without an approved Data Variance will result in the rejection of the submitted file.

Data elements designated as "Situational" must be populated under specific circumstances. Unless a Data Variance has been approved 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 Admission Date field (CDLMC025) is designated as "Situational" and is required when the claim/encounter is "inpatient.

** Refer to the APCD-CDL™ (Version 3.0.1) for data format specifications.

Appendix B – Plan and Submitter Registration Scenarios

All names used in the following scenarios are fictitious. Examples that apply to health plans licensed through the DMHC also apply to insurers licensed through the CDI and vice versa.

B.1 A Plan Submitting Its Own Data

My Health Plan is a licensed health plan with DMHC and intends on submitting data to the HPD Program without any delegation.
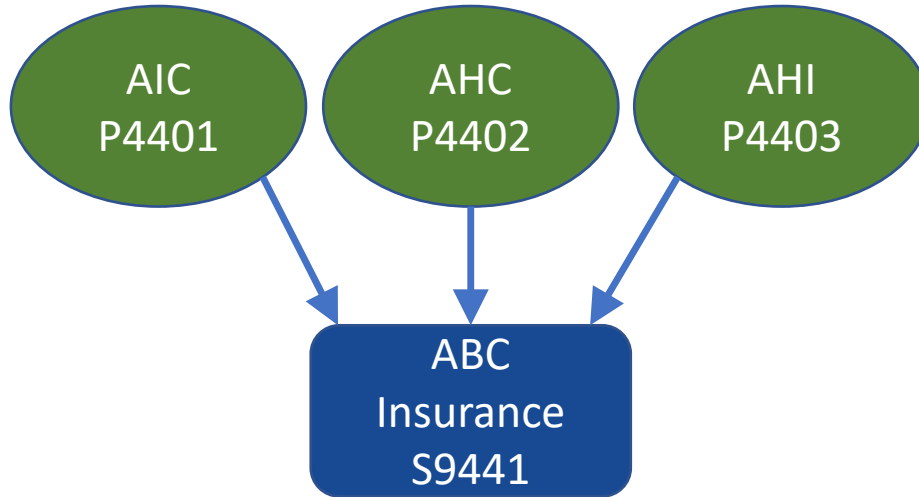
My Health Plan would register as a plan and receive a unique Payer Code (P0010). My Health Plan also would register as a submitter and receive a unique Submitter Code (S9010).
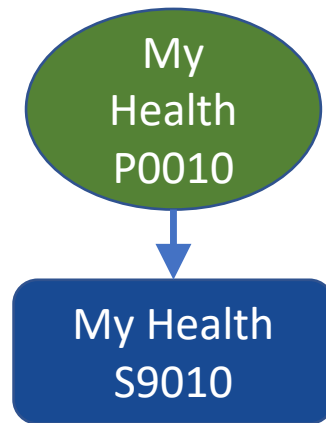
B.2 An Insurer with Multiple Licenses Submitting Its Own Data

ABC Insurance has three licenses, ABC Insurance Company (AIC), ABC Holding Co. (AHC), and About Health Inc. (AHI) with CDI and intends on submitting data to the HPD Program without any delegation. Each license covers over 40,000 lives.

ABC Insurance would register each license separately and would receive a unique Plan Code per license, AIC (P4401), AHC (P4402) and AHI (P4403). ABC Insurance also would register as a submitter and receive a unique Submitter Code (S9441).

B.3 A Plan with Multiple Licenses Submitting Its Own Data (Various Thresholds)

XYZ Health Plan has three licenses with DMHC and intends on submitting data to the HPD Program without any delegation. Two of their licenses cover over 40,000 lives (RST Health and PQR Health), but the third (UVW Health) covers only 35,000 lives.

XYZ Health Plan would register RST Health and PQR Health separately. XYZ Health Plan would not register the license for UVW Health as it is below the mandatory reporting threshold. RST Health and PQR Health would each receive a unique Payer Codes (P3005 and P3010). XYZ Health Plan would also register as a submitter and receive a unique Submitter Code (S3999).
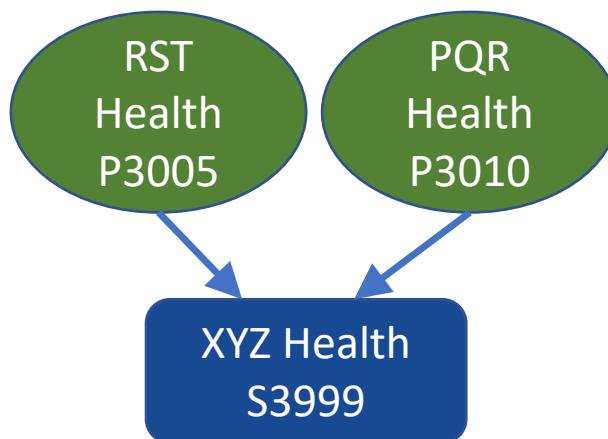
B.4 A Public Self-Insured Entity with Two Contracted Entities

Largeville Unified School District (LUSD) is a public self-insured entity that covers 75,000 lives. LUSD contracts with Alpha Health to provide medical and pharmacy benefits and with Beta Health to provide behavioral health benefits.

LUSD would register as a plan and indicate Alpha Health and Beta Health as LUSD's delegated submitters. LUSD would receive a unique Payer Code (P1001). Alpha Health would register as a submitter, would indicate that they will be submitting data on behalf of LUSD, and would be responsible for submitting all four data file types (i.e., Member Eligibility, Medical Claims, Pharmacy Claims, and Provider). Alpha Health would be assigned a unique Submitter Code (S1005). Beta Health would register as a submitter, would indicate that they will be submitting data on behalf of LUSD, and would be responsible for submitting only Eligibility, Medical Claims, and Provider data files. Beta Health would be assigned a unique Submitter Code (S1010).
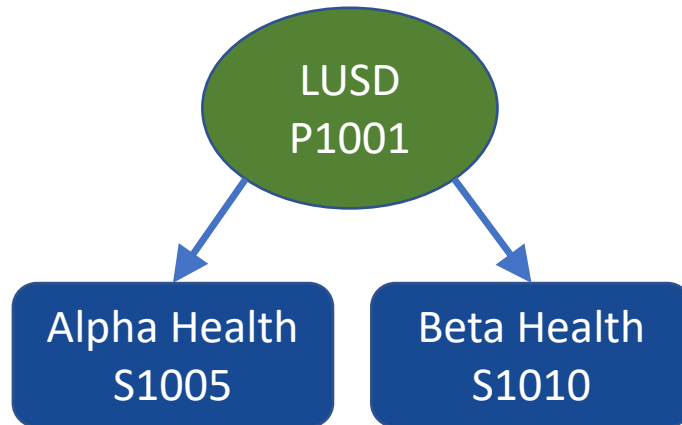
B.5 A Plan Acting in Different Roles with Multiple Other Entities

Bravo Health is a licensed health plan with DMHC and intends on submitting data to the HPD Program without any delegation. Bravo Health would register as a plan and receive a unique Plan Code (P1234). Bravo Health would also register as a submitter and receive a unique Submitter Code (S2345).

Smallville Unified School District (SUSD) is a public self-insured entity that covers 41,000 lives. SUSD contracts with multiple entities: Bravo Health to provide medical benefits, Capitol Pharmacy as a Pharmacy Benefits Manager (PBM), and Lima Health to provide behavioral health benefits. SUSD would register as a plan and indicate Bravo Health, Capitol Pharmacy, and Lima Health as delegated submitters. SUSD would

receive a unique Payer Code (P3456). Capitol Pharmacy would register as a submitter, would indicate that they will be submitting data on behalf of SUSD, and would be responsible for submitting only Eligibility, Pharmacy Claims, and Provider data files. Capitol Pharmacy would be assigned a unique Submitter Code (S4567). Lima Health would register as a submitter, would indicate that they will be submitting data on behalf of SUSD, and would be responsible for submitting only Eligibility, Medical Claims, and Provider data files. Lima Health would be assigned a unique Submitter Code (S5678). Bravo Health would update their previous registration for Submitter Code S2345 and add SUSD as a plan on whose behalf they will be submitting data, indicating that they will be submitting Eligibility, Medical Claims, and Provider data files for Payer Code P3456 (i.e., Smallville Unified School District).

Bravo Health owns a subsidiary company, Bravo Insurance Company (BIC), that holds a CDI license as an insurer and covers 55,000 lives. Bravo Health intends to submit the data for BIC. BIC would register as a plan and indicate Bravo Health as a delegated submitter. BIC would receive a unique Payer Code (P6789). Bravo Health would update their previous registration for Submitter Code S2345 and add BIC as a plan on whose behalf they will be submitting data, indicating that they will be submitting all four data file types for Payer Code P6789.

These relationships could be displayed as follows:
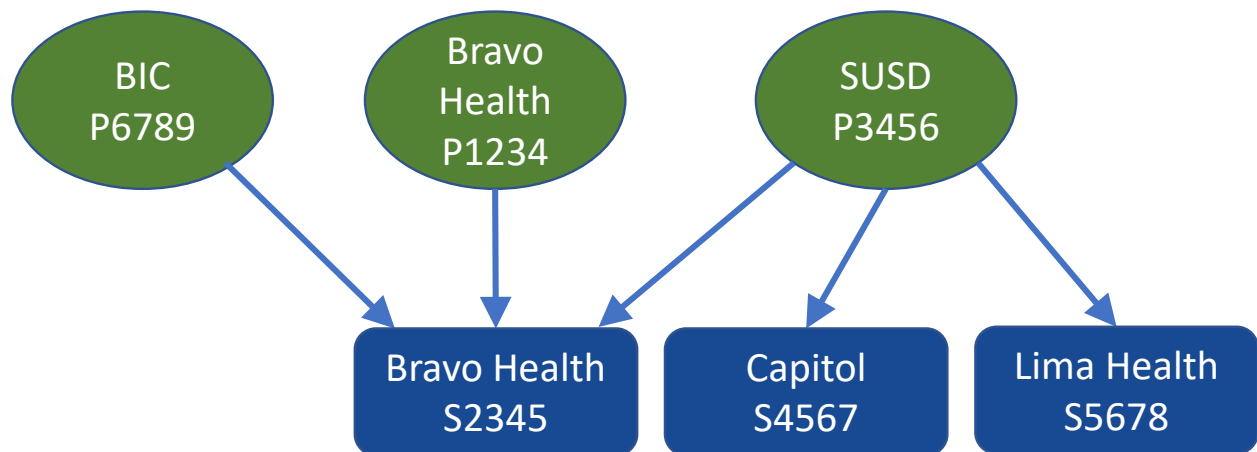
Appendix C – Claim and Service Line Submission Scenarios

This section takes a number of different claim and service line scenarios and discusses the course of action required in each.

C.1 A Partially Denied Claim

An original claim has four service lines, three lines were accepted and paid as primary, and one service line was denied. The entire claim should be submitted to HPD as follows.

Claim Line Type: "O" = Original, "D" = Denied

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
ABC1234	0	1	15	12000	2	O
ABC1234	0	2	20	800	2	O
ABC1234	0	3	97	0	1	O
ABC1234	0	4	5	135567	2	O

C.2 A Partially Denied Claim is Adjusted

The same claim described in C.1 is subsequently adjusted. The previously submitted information must be voided, and then replacement records must be submitted.

Since claim adjustments are being reported as reversals and replacements, the version number continues to be reported as 0 (Claim versions are not used in this method of reporting adjustments).

Claim Line Type "V" = Void, "R" = Replacement

Depending upon specific Health Plan processing, the Claim Line Type (CDLMC160) could also be reported as "B" = Back-out.

When reporting adjustments as reversals:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
ABC1234	0	1	-15	-12000	2	V
ABC1234	0	2	-20	-800	2	V
ABC1234	0	3	-97	0	1	V
ABC1234	0	4	-5	-135567	2	V
ABC1234	1	1	15	12000	2	R
ABC1234	1	2	20	800	2	R
ABC1234	1	3	7	14700	2	R
ABC1234	1	4	5	135567	2	R

C.3 A Fully Denied Claim

A claim with PCCN = XYZ8765 has two service lines and both were denied. This claim should not be submitted to HPD.

Claim XYZ8765 is then adjusted and is approved for payment as a secondary claim. Since no original was submitted to HPD for denied claim, no void is required. Instead, the following original claim details are sent:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
XYZ8765	0	1	25	2675	2	O
XYZ8765	0	2	2	1571	2	O

C.4 An Approved Claim is Subsequently Fully Denied

A claim with PCCN = FGH0001 has three service lines and all were accepted. This claim would be submitted to HPD as follows:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
FGH0001	0	1	3	65000	2	O
FGH0001	0	2	1	143550	2	O
FGH0001	0	3	19	9755	2	O

This claim is reviewed and all service lines are subsequently denied. The original three service lines must all be voided. Since there were no further actions taken, no further records would be sent after the voided records.

When reporting this action using aggregation (see Section 5.11):

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
FGH0001	0	1	-3	-65000	1	V
FGH0001	0	2	-1	-143550	1	V
FGH0001	0	3	-22	-9755	1	V

When reporting this action using incremental claim versioning (see Section 5.11), all quantities and dollars must still be negated and the claim version incremented by 1:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
FGH0001	1	1	-3	-65000	1	V

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
FGH0001	1	2	-1	-143550	1	V
FGH0001	1	3	-22	-9755	1	V