Standard Layout
Covered California Healthcare Evidence Initiative (HEI)
Eligibility / Enrollment Functional Specification - QDP Issuers
1/19/2023

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
1/19/23	Chuck DePoy	Consolidated separate specs into Appendix F document
12/12/22	Elizabeth Wagner	Updated Race & Ethnicity Codes
10/31/22	Dan Lopez	Added additional guidance on race and ethnicity codes
4/28/22	Dan Lopez	Added additional race and ethnicity codes to valid values
3/4/22	Dan Lopez	Added additional language codes to valid values
12/17/21	Dan Lopez	Added a link to California rating regions documentation
9/30/21	Dan Lopez	Added directions for QDPs (Qualified Dental Plans)
3/3/20	Dan Lopez	Added PPO/EPO to the description of risk type code 5. Changed length of DMHC code field to 5 and added a separate field for DMHC Sub ID. Also added new tab for DMHC code more detailed information
2/14/20	Dan Lopez	Removed PCMH indicator and added descriptions of values for indicator fields
1/21/20	Dan Lopez	Added Federal Subsidy Amount
1/17/20	Katie Andrada-Bacorn	Updates for AB929 and Brand updating
1/13/20	Dan Lopez	Fixed length of product type code
10/22/19	Dan Lopez	Add new fields for off-exchange enrollees
1/8/18	Dan Lopez	Added new field, PCP Taxonomy Code
3/15/16	Dan Lopez	Field lenghts of race code increased to 3 bytes, added new field, Cost Share
6/12/15	Dan Lopez	Update after all data summits
5/26/15	Katie Andrada-Bacorn	Update after initial data summit
5/19/15	Dan Lopez	Updated after meeting with Covered CA and CalHEERS
5/11/15	Dan Lopez	Initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly enrollment file for QHP and QDP plan participants.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a "D" in the Record Type field), as well as a Trailer record layout (identified by a "T" in the Record Type field).

QHPs

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, the project requires historical data from January 1, 2014 -current. Merative expects to receive one file for every month from January 1, 2014 to current. Historical files may be cut by quarter or year if convenient for the QHP. Each file will contain one record per member per month. Ongoing file submissions would include one record for each member for the latest month only.

QDPs

Data will be provided in a monthly file that reflects the status as of the end of each month, i.e. a "snapshot" as of a point in time. For example, the project requires historical data from January 1, 2016 -current. Merative expects to receive one file for every month from January 1, 2016 to current. Historical files may be cut by quarter or year if convenient for the QDP. Each file will contain one record per member per month. Ongoing file submissions would include one record for each member for each month for the latest month only.

Annually, the QHP/QDP will need to supply a reference table spreadsheet with the following information about each plan offered by the QHP/QDP:

- plan number (16 Character HIOS Code)
- enrollment year
- plan description
- network type
- metal-tier (not applicable to QDPs; values are "high" or "low" actuarial value, only "high" at Covered CA)
- enhanced metal tier (not applicable to QDPs)

The spreadsheet will need to be provided prior to the beginning of each new calendar year

DATA SUBMISSION

The monthly data file submissions will be submitted to Merative via SFTP. Files should be submitted on or before the agreed upon date of the monthly file. Annual plan reference spreadsheet should be submitted via email attachment.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled or left space-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled or left space-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-001234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (underscore) , (comma)

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g., Policy Holder ID, we would like to have information copied down from the policy holder to the enrollee record. For others, e.g., Gender or Date of Birth, we would like the data to be specific to the person.

For each field, Merative has noted one of the three values below in the right-most column.

ENROLLEE-SPECIFIC (MEMBER SPECIFIC)	Information relevant to the enrollee (e.g., Date of Birth, Merative would like each enrollee's date of birth). Please populate on each record with the information specific to that enrollee.
POLICY-HOLDER-ONLY (SUBSCRIBER ONLY)	Information relevant to the policy holder that Merative would like on the contract holder, i.e., not copied onto the enrollee's records.
POLICY-HOLDER-SPECIFIC (SUBSCRIBER SPECIFIC)	Information relevant to the policy holder, but needs to be copied down to the enrollee. Please populate on each record with the information that has been copied from the policy holder.

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
1	Enrollment Snapshot Month	1	10	10	Date	First day of eligibility snapshot month	MM/DD/CCYY Format			Enrollee-Specific
2	Date of Birth	11	20	10	Date	Birth date of the person	MM/DD/CCYY format			Enrollee-Specific
3	Date of Death	21	30	10	Date	The Date of Death of the enrollee	Required per AB-929			Enrollee-Specific
4	**Note: all fields highlighted in green will be used to set the master person ID** **Required per AB-929 if available marker field used to set master person ID** Subscriber SSN	31	39	9	Character	The policy holder SSN	**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 if available marker field used to set master person ID			Policy Holder-Specific
5	CC Subscriber ID	40	59	20	Character	The Covered California subscriber Identifier	Covered California Subscriber ID Required for on-exchange enrollees marker field used to set master person ID			Policy Holder-Specific
6	Enrollee/member SSN	60	68	9	Character	The SSN of the individual enrollee.	Required per AB-929 if available marker field used to set master person ID			Enrollee-Specific
7	CC Member ID	69	88	20	Character	The Covered California member Identifier	Covered California Member ID Required for on-exchange enrollees marker field used to set master person ID			Enrollee-Specific
8	Plan Member ID	89	108	20	Character	The enrollee Identifier as identified by the issuer. The member ID used by the QHP or QDP system	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
9	Policy ID	109	128	20	Character	Identifier of the individual policy for the enrollee	Required per AB-929 marker field used to set master person ID			Policy -holder specific
10	Enrollee First Name	129	188	60	Character	The enrollee's first name.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
11	Enrollee Last Name	189	248	60	Character	The enrollee's last name.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
12	Enrollee Middle Initial	249	249	1	Character	The enrollee's middle initial	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
13	Enrollment End Reason Code	250	253	4	Character	The reason for termination of enrollment. Please include death as one of the reasons for termination.	Valid values: See Enr End Rsn tab			Enrollee-specific
14	Address 1	254	303	50	Character	The street address for the residence of the enrollee, for the most recent month of enrollment.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
15	Address 2	304	333	30	Character	The second part of the street address if needed for the residence of the person, for the most recent month of enrollment.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
16	City	334	363	30	Character	The city of the residence for the person	Required per AB-929 City of the member marker field used to set master person ID			Enrollee-Specific
17	State Code	364	365	2	Character	The state code of the residence of the person	Required per AB-929 State code of the member marker field used to set master person ID			Enrollee-Specific
18	Zip Code (5 digit)	366	370	5	Character	The 5 digit zip code of the residence of the member at the time of the eligibility month.	Zip code of the member residence			Enrollee-Specific
19	Zip Code plus 4 (last 4)	371	374	4	Character	The last 4 digits of the of the 9 digit zip code of the residence of the member at the time of the eligibility month.	Zip Plus 4 of the member residence			Enrollee-Specific
20	County Code	375	379	5	Character	The state/county FIPS code for the enrollee address of residence.	County code of the member			Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
21	Gender Code	380	380	1	Character	Gender of the enrollee.	Valid values are: M = Male F = Female N = Non-Binary U = Unknown			Enrollee-Specific
22	Relationship Code	381	385	5	Character	Code with values that specify the relationship of the enrollee to the policy-holder.	Member's relationship to the subscriber. Valid values are: 1 = Member / Employee / Self 2 = Spouse / Partner 3 = Child / Other Dependent			Enrollee-Specific
23	Race 1 Code	386	388	3	Character	A code specifying the race or ethnicity of the person.	See Race tab			Enrollee-Specific
24	Race 2 Code	389	391	3	Character	A code specifying the race or ethnicity of the enrollee.	See Race tab			Enrollee-Specific
25	Race 3 Code	392	394	3	Character	A code specifying the race or ethnicity of the person.	See Race tab			Enrollee-Specific
26	Ethnicity 1 Code	395	400	6	Character	code specifying the ethnicity of the enrollee	See Ethnicity tab			Enrollee-Specific
27	Ethnicity 2 Code	401	406	6	Character	code specifying the ethnicity of the enrollee	See Ethnicity tab			Enrollee-Specific
28	Ethnicity 3 Code	407	412	6	Character	code specifying the ethnicity of the enrollee	See Ethnicity tab			Enrollee-Specific
29	Language Written Code	413	416	4	Character	Code for the preferred written language of the enrollee	See Language Written tab			Enrollee-Specific
30	Language Spoken Code	417	420	4	Character	Code for the preferred spoken language of the enrollee	See Language tab			Enrollee-Specific
31	Coverage Start Date	421	430	10	Date	The effective date of the current coverage	MM/DD/CCYY Format			Enrollee-Specific
32	Coverage End Date	431	440	10	Date	The end date of the coverage	MM/DD/CCYY Format			Enrollee-Specific
33	Coverage Indicator Dental	441	441	1	Character	Indicator of Dental Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "Y"			Enrollee-Specific
34	Coverage Indicator Drug	442	442	1	Character	Indicator of Drug Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific
35	Coverage Indicator Hearing	443	443	1	Character	Indicator of Hearing Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific
36	Coverage Indicator Medical	444	444	1	Character	Indicator of Medical Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific
37	Coverage Indicator MHSA	445	445	1	Character	Indicator of MHSA Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific
38	Coverage Indicator Vision	446	446	1	Character	Indicator of Vision Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
39	PCP Type Code	447	450	4	Character	A code indicating the Primary Care Physician's specialty or type ex. General Practice, Family Practice, OB/GYN	See PCP Type tab Only needed for managed care plans Required if PCP Taxonomy code is not available QDPs should set this value to "7"			Enrollee-Specific
40	PCP Provider ID TIN	451	463	13	Character	The provider identifier of the Primary Care Physician.	For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated for that record.			Enrollee-Specific
41	Gross Premium	464	473	10	Numeric	The total value of the monthly premium paid for medical or dental benefits. QDPs should populate this field	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid for fully-insured plans and not premium equivalents. It should not be the net amount (minus policy-holder contribution) as this will be calculated within the IBM Watson Health product. It should be populated only on subscriber records for those subscribers enrolled in fully-insured medical plans. On all other records this field should be zero filled.			Policy Holder/Contract Holder Only
42	Net Premium	474	483	10	Numeric	The monthly amount contributed by the policy-holder for medical benefits QDP - please set to 0	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).			Policy Holder/Contract Holder Only
43	State Subsidy Amount	484	493	10	Numeric	The State government paid monthly premium for medical or dental benefits	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy holder records).			Policy Holder/Contract Holder Only
44	Product Type/Medical Plan Type	494	497	4	Character	The type of product in which the enrollee is enrolled. Examples include PPO, HMO, POS, etc.	Valid values are: HMO PPO DMO POS EPO			Enrollee-specific
45	Medical Fully Insured Indicator	498	498	1	Character	An indicator of fully insured medical coverage for the member or employee.	Y = Yes - Fully Insured N = No - Not Fully Insured For Covered CA this value will be set to "Y"			Enrollee-specific
46	Drug Fully Insured Indicator	499	499	1	Character	An indicator of fully insured drug coverage for the member or employee.	Y = Yes - Fully Insured drug coverage N = No - Not Fully Insured drug coverage For Covered CA this vale will be set to "Y"			Enrollee-specific
47	HIOS Plan Code	500	515	16	Character	The code for HIOS plan	16 characters - no dashes			Enrollee-Specific
48	Rating Region Code	516	520	5	Character	State-specific geographic rating areas, including specific geographic divisions for the Individual and small group market. CA rating regions are 01 through 19.	California Geographic Rating Areas: Including State Specific Geographic Divisions			Enrollee-Specific
49	Policy Structure Code/Coverage Tier Code	521	524	4	Character	The policy structure code/Family Size QDPs to leave blank	See Policy Structure tab			Policy Holder-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
50	Dental Plan Code	525	530	6	Character	The code for the dental plan in which the member is enrolled.	It's desirable to have a plan code explicitly identifying "Opt-outs".			Enrollee-Specific
51	Dental Policy Structure Code/Coverage Tier Code	531	534	4	Character	The Dental Policy Structure Code (if stand-alone, else Blank)	See Policy Structure tab			Enrollee-Specific
52	Monthly Policy Holder Dental Contribution	535	544	10	Numeric	The monthly amount contributed by the policy-holder for dental benefits (if stand-alone, else 0) QDPs should populate this field	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).			Policy Holder/Contract Holder Only
53	Monthly Dental Premium	545	554	10	Numeric	The total value of the monthly premium for dental benefits (stand-alone plans) QDPs should populate this field.	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the IBM Watson Health product. It should be populated only on policy-holder records for those enrolled in fully-insured dental plans. On all other records this field should be zero filled.			Policy Holder/Contract Holder Only
54	Vision Plan Code	555	560	6	Character	The code for the vision plan in which the member is enrolled. QDPs to leave blank	Vision plan code values will be identified in the **Data Dictionary**. It's desirable to have a plan code explicitly identifying "Opt-outs".		Yes	Enrollee-Specific
55	Vision Policy Structure Code/Coverage Tier Code	561	564	4	Character	Vision Coverage Tier Code QDPs to leave blank	values will be identified in the **Data Dictionary**.		Yes	Enrollee-Specific
56	Monthly Policy Holder Vision Contribution	565	574	10	Numeric	The monthly amount contributed by the policy-holder for their vision benefits QDPs to set ot 0	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on dependent records).			Policy Holder/Contract Holder Only
57	Monthly Vision Premium	575	584	10	Numeric	The total value paid monthly premium for vision benefits if standalone plan else 0 QDPs to set to 0	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the IBM Watson Health product. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled.			Policy Holder/Contract Holder Only

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
58	SHOP Employee Status Code	585	589	5	Character	Customer-specific values of employee status.	Valid values are: 1 = Active Full Time 2 = Active Part Time / Seasonal 3 = Early Retiree 4 = Medicare Eligible Retiree 5 = Retiree (Medicare Status Unknown) 6 = COBRA Continuee 7 = Long Term Disability 8 = Surviving Spouse / Dependent 9 = Other / Unknown	X	Yes	Policy Holder-Specific
59	SHOP Employee Medicare Eligible Indicator	590	590	1	Character	A code indicating whether an employee is Medicare eligible.	Y = Yes N -No	X		Policy Holder-Specific
60	SHOP Part-Time/Full-time Indicator	591	591	1	Character	A code indicating whether an employee is full-time or part-time.	P = Part-time F - Full-time	X		Policy Holder-Specific
61	Plan Group Number	592	611	20	Character	The enrollee's group number as identified by the plan. This is the plan's internal value.		X		Enrollee-Specific
62	Plan Group Suffix	612	616	5	Character	The enrollee's group suffix as identified by the plan		X		Enrollee-Specific
63	Industry Classification Code (Group Coverage Flag Code)	617	622	6	Character	This field has been re-purposed to designate if the enrollee is in an individual or group coverage policy. Use value of "SBU" for all group coverage enrollees	SBU or IND			Enrollee-Specific
64	Cost Sharing Reduction	623	632	10	Numeric	The Cost Sharing Reduction	Note: If available, this should be the actual CSR, which may not be the same as the CSR amount on the 834.			Policy Holder-Specific
65	PCP Taxonomy Code	633	642	10	Character	The Taxonomy code of the PCP QDPs - only required for managed dental plan enrollees				Enrollee-Specific
66	**ALL fields in red text have been added to the layout for AB-929** PCP NPI	643	652	10	Character	The NPI of the PCP for the enrollee QDPs - only required for managed dental plan enrollees	**ALL fields in red text have been added to the layout for AB-929** added for AB-929			Enrollee-Specific
67	PCP Plan Provider ID	653	665	13	Character	The QHP or QDP system identifier of the PCP of the enrollee. The internal ID QDPs - only required for managed dental plan enrollees	added for AB-929			Enrollee-Specific
68	On-Exchange Indicator	666	666	1	Character	An indicator to determine if this enrollee is on the Covered California exchange or not	Set to: Y = when the enrollee record is on-exchange N = when the enrollee record is off-exchange added for AB-929			Enrollee-Specific
69	Plan Number	667	686	20	Character	Plan number identifying the plan selected by the enrollee as assigned by the QHP or QDP. The internal ID	added for AB-929		Yes	Enrollee-Specific
70	ACO Identifier	687	716	30	Character	Unique Accountable Care Organization identifier assigned by plan. Use this field to identify members who were assigned to an ACO during the period of the enrollment segment. Please provide a data dictionary with code and name. Code should identify the specific ACO and ACO program as relevant to the plan.	added for AB-929		Yes	Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
71	DMHC Code	717	721	5	Character	The California Department of Managed Health Care's identifier of the Physician Group to which the PCP belongs. This should be the 5 digit DMHC ID, please do not include the 2 digit SubID in this field (used to identify specific locations). This field should be populated for members of HMOs only. Not required for QDPs **More Detailed explanation can be found on the DMHC Code Info tab in this workbook	added for AB-929			Policy Holder/Contract Holder Only
72	DMHC Sub-ID	722	723	2	Character	This field is not being requested at this time. Default to spaces if not available.	added for AB-929			Enrollee-Specific
73	Risk Type Code	724	724	1	Character	Indicates the type of financial arrangement under which providers are contracted to provide care to the enrollee. See Risk Type Code tab	added for AB-929			Enrollee-Specific
74	Network Type	725	744	20	Character	Network Type Code (not currently in use)	added for AB-929 TBD - may be used for Off-exchange in the future		Yes	Enrollee-Specific
75	Agent License Number	745	751	7	Character	The agent CDI license number for the broker responsible for enrollment	added for AB-929			Enrollee-Specific
76	PCP Assignment Selection Code	752	752	1	Character	Identify if the PCP was auto-assigned by the issuer or selected by the enrollee QDPs - only required for managed dental plan enrollees	Added for AB-929 Valid values are: A- Auto Assigned S- Selected by enrollee O- Other U - Unknown			Enrollee-Specific
77	Other Member Insurance Identifier	753	777	25	Character	Any other member level insurance identifier (not used at this time)	added per AB-929 marker field used to set master person ID			Enrollee-Specific
78	Federal Subsidy Amount	778	787	10	Numeric	The Federal government paid monthly premium for medical or dental benefits	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy holder records).			Enrollee-Specific
79	Filler	788	999	212	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
80	Record Type	1000	1000	1	Character	Record type identifier	Hard Code to "D"			Enrollee-Specific
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row										

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Merative Fields							
1	Eligibility Start Date	1	10	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2015 This will represent the 1st day of the month for which data is provided.
2	Eligibility End Date	11	20	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2015 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Filler	31	999	969	Character	Reserved for future use	Fill with Blanks
5	Record Type	1000	1000	1	Character	Record Type Identifier	Hard Code 'T'

--- Enr End Rsn ---

Code	Description
1	Birth
2	Change of Location
3	Death
4	Disability
5	Divorce
6	Marriage
7	No Reason Given
8	Non Payment
9	Plan Change
10	Termination of Benefits
11	Termination of Employment
12	Voluntary Withdrawal
13	Other

Code	Description	834 Value	834 Description	Notes
1	Cuban	2182-4	Cuban	
2	Mexican/Mexican American/Chicano	2148-5	Mexican	
		2149-3	Mexican American	
		2150-1	Mexicano	
		2151-9	Chicano	
		2152-7	La Raza	
		2153-5	Mexican American Indian	
3	Other Hispanic/Latino/Spanish	2137-8	Spaniard	Carrier should also populate this Column A Merative value if it has any other CDC NCHS ethnicity codes not listed in Column C. See Table 2 - Ethnicity Concepts and Codes, pp. 37-38 at https://www.cdc.gov/nchs/data/dvs/race_ethnicity_codeset.pdf.
		2155-0	Central American	
		2165-9	South American	
		2178-2	Latin American	
		2184-0	Dominican	
4	Puerto Rican	2180-8	Puerto Rican	
5	Multiple Ethnicities			If carrier receives (from CalHEERS 834) or maintains more than one ethnicity code for a given enrollee, it should populate this Column A Merative value in addition to translating the ethnicity code values to Merative counterparts in Ethnicity 2-3 fields.
6	Hispanic or Latino	2135-2	Hispanic or Latino	If carrier receives (from CalHEERS 834) or maintains Hispanic / Latino Indicator = "Y", it should populate this Column A Merative value in Ethnicity1 field. If carrier receives or maintains additional ethnicity codes for a given enrollee, it should translate the additional ethnicity code values to their Merative counterparts in Ethnicity 2-3 fields.
7	Not Reported / Unknown			Replaces other similar codes as of Dec. 2022.
10	Declined to State			
11	Guatemalan	2157-6	Guatemalan	
12	Salvadoran	2161-8	Salvadoran	
13	Not Hispanic or Latino	2186-5	Not Hispanic or Latino	Carrier should populate this Column A Merative value when it receives Hispanic / Latino Indicator = "N" in 834 transaction from CalHEERS or when it makes a similar non-Hispanic, non-Latino determination based on its own data collection from enrollee.

Convert 834 values received from CalHEERS to the Merative Ethnicity Codes in Column A.

Code	Description
1	Arabic
2	Armenian
3	Cambodian
4	Cantonese
5	English
6	Farsi
7	Hmong
8	Korean
9	Mandarin
10	Russian
11	Spanish
12	Tagalog
13	Vietnamese
15	French
16	Japanese
17	Chinese
18	Gujarti
19	Hindi
20	Khmer
21	Panjabi
22	Portuguese
23	Tamil
24	Thai
25	American Sign Language

Code	Description
1	Arabic
2	Armenian
3	Cambodian
4	Cantonese
5	English
6	Farsi
7	Hmong
8	Korean
9	Mandarin
10	Russian
11	Spanish
12	Tagalog
13	Vietnamese
14	Traditional Chinese Characters
15	French
16	Japanese
17	Chinese
18	Gujarti
19	Hindi
20	Khmer
21	Panjabi
22	Portuguese
23	Tamil
24	Thai

Code	Description
A	Family
B	Subcriber and Spouse/Partner
C	Subsriber Only
D	Subscriber and Dependents
E	Spouse/Partner and Dependents
F	Spouse/Partner Only
G	Dependents Only

--- Enr PCP Type ---

Code	Description
1	General Practice
2	Family Practice
3	OB/GYN
4	Pediatrics
5	Internal Medicine
6	Health Center
7	Other

Code	Description	834 Value	834 Description	Notes
1	American Indian / Alaska Native	1002-5	American Indian or Alaska Native	
2	Asian Indian	2029-7	Asian Indian	
3	Black or African American	2054-5	Black or African American	
4	Chinese	2034-7	Chinese	
5	Filipino	2036-2	Filipino	
6	Guamanian or Chamorro	2086-7	Guamanian or Chamorro	
7	Japanese	2039-6	Japanese	
8	Korean	2040-4	Korean	
9	Multiple Races			If carrier receives or maintains more than one race code for an enrollee, it should populate 9 - Multiple Races in Race1 field in addition to translating the additional race code values to Merative counterparts in Race 2-3 fields.
10	Native Hawaiian	2079-2	Native Hawaiian	
11	Other Race	2131-1	Other	
12	Other Asian	2028-9	Other Asian	
13	Other Pacific Islander	2500-7	Other Pacific Islander	
14	Samoan	2080-0	Samoan	
15	Vietnamese	2047-9	Vietnamese	
16	White	2106-3	White	
17	Cambodian	2033-9	Cambodian	
18	Hmong	2037-0	Hmong	
19	Laotian	2041-2	Laotian	
21	Declined to State			
22	Not Reported / Unknown			Replaces other similar codes as of Dec. 2022.

Convert 834 values received from CalHEERS to the Merative Race Codes in Column A.

Code	Description
1	Professional Capitation Only (no hospital capitation)
2	Facility Capitation Only (no professional capitation)
3	Professional and Facility capitation - plan has separate capitation contracts for professional services (i.e., with PCP or Physician Group) and facility services (i.e., with hospital)
4	Global Capitation (contract with Physician Group for both professional and facility services)
5	No capitation, fee-for-service only (Includes PPO/EPO plans)

Explanation of DMHC ID Code

The DMHC ID code is assigned by the Department of Managed Health Care which is a State organization that oversees HMOs. HMOs capitate physician organizations which then "bear risk" (risk bearing organizations). The code is a consistent identifier (across plans) that is being used to identify the physician organization that is responsible for the member . Specifically, the physician organization that provides the members primary care under a capitation contractual agreement for HMO plans.

In California, the physician organization typically provides other care including specialty physician care, lab, imaging etc. as specified in the Division of Financial Responsibility agreement between the plans and the physician organization. The term physician organization includes physician groups and IPAs.

The DMHC ID enables us to identify the same physician organization across multiple plans since it is a common State identifier.

Below is a link to a website that explains the DMHC role

https://www.dmhc.ca.gov/LicensingReporting/RiskBearingOrganizations.aspx

From that page, there is a link to the list of organizations and their DMHC code as of May 2022

https://www.dmhc.ca.gov/Portals/0/Docs/OFR/sb260CapitatedProviders%20May%202022%20Accessible.pdf?ver=PXhGkP0rd-epeivA9OA_RQ%3d%3d

For plans that participate in the Integrated Healthcare Association's (IHA) Value-Based Pay-for-Performance program, in the spring, health plan staff create a mapping of plan-specific identifiers to the DMHC ID. This is done only for physician organizations participating in the IHA program. Some physician organizations do not participate in the program. This process is also known as creating the "AMP PO Master".

If your plan is participating in the IHA Value-Based Pay-for-Performance program, the IT staff that support that data pull may have a crosswalk that you can apply to the Covered California data to fill the DMHC ID data field in the enrollment layout.

Again, this only applies to HMO plans.

Standard Layout
Covered California Healthcare Evidence Initiative (HEI) Dental Claim / Encounter Functional Specification - QDP Issuers

1/17/2023

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
8/23/17	Cherie Hicks	In the General Information tab I included "and" in the list of invalid characters
5/1/18	Mariam Abbas Aoude	In the General Information tab I removed "and" from the list of invalid characters.
8/10/18	Mariam Abbas Aoude	Rebranded document
12/18/18	Mariam Abbas Aoude	Added HRA and HSA Amounts to the detail layout
9/8/21	Dan Lopez	Added Covered California specific fields
12/13/21	Dan Lopez	Added supplemental payment indicator field
1/17/23	Elizabeth Wagner	Changed branding to Merative

DESCRIPTION/GENERAL INFORMATION	
This interface is designed to produce a dental claims / encounters file for plan participants administered through multiple QDPs.	
FILE/DATA FORMATTING AND SUBMISSION	
DATA SUBMISSION	Merative supports a number of file submission options including: Secure FTP, Web Submission, as well as physical media, although Secure FTP is preferred The data will be submitted to Merative monthly, on or before the 15th of the month following.
FILE FORMAT	• Fixed-Record Length, ASCII File • Contains Detail (Data) Layout and Trailer Layout for each layout group
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
DATE FIELDS	• Format of all dates should be MM/DD/CCYY
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position. For example: "-001234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (underscore) , (comma)

DEFINITIONS

- **Fee-for-service claims:** Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records:** Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Dental Data:** Dental data includes all services rendered by a dental provider. The basis for the requirements of dental data is the information found on the standard ADA Dental Claim Form (e.g., J430).
- **Fee-for-Service Equivalents:** Financial amounts for services rendered under a capitated arrangement found within encounter records.

DISCUSSION ITEMS

- If both fee-for-service claims and encounter records are included on the data file, Merative will rely on the data supplier to explain how to differentiate them, preferably using the field Capitated Service Indicator.
- If encounter records contain fee-for-service equivalents, it is essential for Merative to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.

PROFESSIONAL RECORD CONTENT

Merative does not store separate header/claim-level and detail/service-level information for professional claims. Merative requires the following:

- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Taxonomy, etc.) on each record is necessary.

One professional claim with two service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Procedure Code**	**Service Count**	**Net Payment**
13331	621262121	100	1	D1201	1	$ 100.00
13331	621262121	100	2	D1330	1	$ 150.00

DISCUSSION ITEMS - PROVIDER

- Merative requires unique provider identifiers and associated names. Merative would like both the identifier and the name to be specific to each provider, rather than group level information. NPI is preferred for the identifier.
- If providers within group practices use a single TAXID, Merative would prefer an additional qualifier that would make each identifier and name unique.
- If only the group name is available with the associated TIN, and a qualifier is not available, Merative prefers another identifier for dental claims. NPI is preferred for the alternate identifier. In this case the TAXID is still requested in addition to the NPI or alternate identifier.

Provider Example 1
When providers in group practices use the same TAXID, a qualifier is needed to insure unique provider names.

Claim ID	TAXID	Qualifier	Provider Name	Prov Type	Service Count		Net Payment
11111	121212121	2222	Dr. Brown	25	2	$	2,000.00
22222	121212121	3333	Dr. Smith	35	1	$	100.00

Provider Example 2
The following is an example of what is not desired.

Claim ID	TAXID	Provider Name	Prov Type	Svc Count		Net Payment
11111	121212121	Dr. Brown	25	2	$	2,000.00
22222	121212121	Dr. Smith	35	1	$	100.00
33333	232323232	XYZ	25	1	$	125.00
22222	232323232	XYZ	35	1	$	110.00

DISCUSSION ITEMS - PROVIDER

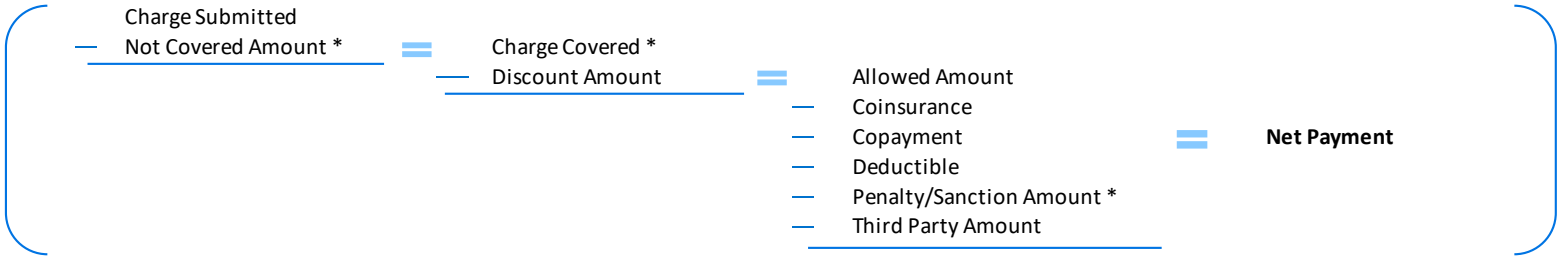
Provider Example 3

When only the groups name is available with TAXID, NPI is requested in addition to TAXID.

Claim ID	TAXID	Group Name	NPI	Prov Name	Prov Type	Svc Count	Net Payment
11111	121212121	XYZ Pediatrics	2222222222	Dr Brown	25	2	$ 2,000.00
22222	121212121	XYZ Pediatrics	3333333333	Dr Smith	35	1	$ 100.00

FINANCIAL RELATIONSHIP

Merative defines the relationship among financial fields as follows. Those marked with an asterisk are desirable, but not required for the data extract.



CORRECTIONS TO PAID CLAIMS

Data suppliers should use Void/Replacement records to make corrections to finalized claims. Merative defines this as follows:

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 25.00	$ -	$ 50.00

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
1	Adjustment Type Code	1	1	1	Character	A code for the designating the claim adjustment type, for example void, adjustment and original.		Valid Values 1 = adjustment 2 = void (backout) 3 = original or replacement 4 = bulk adjustment
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 - digit, implied decimal)
3	Billing Provider NPI	12	21	10	Character	The National Provider ID number for the billing provider.		
4	Billing Provider TIN	22	30	9	Character	The federal tax ID of the billing provider. Tax IDs for medical groups are necessary.		Please do not include dashes
5	Capitated Service Indicator	31	31	1	Character	An indicator that this service (encounter record) was capitated		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
6	Charge Submitted	32	41	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 - digit, implied decimal)
7	Claim ID	42	56	15	Character	The supplier-specific identifier of the claim.		
8	Co-Insurance	57	66	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
9	Copayment	67	76	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 - digit, implied decimal)
10	Date of Birth	77	86	10	Date	The birth date of the member.		MM/DD/CCYY format
11	Date of First Service	87	96	10	Date	The date of the first service reported on the claim or authorization record.		MM/DD/CCYY format
12	Date of Last Service	97	106	10	Date	The date of the last service reported on the claim or authorization record.		MM/DD/CCYY format
13	Date Paid	107	116	10	Date	The date the claim or data record was paid. This may be the check date or finalized date in some systems		MM/DD/CCYY format
14	Deductible	117	126	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 - digit, implied decimal)
15	Diagnosis Code Principal	127	134	8	Character	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
16	**Note: all fields highlighted in green will be used to set the master person ID** Subscriber SSN	135	143	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 if available marker field used to set master person ID
17	CC Subscriber ID	144	163	20	Character	The subscriber ID as assigned by Covered California		Required for on-exchange enrollees. marker field used to set master person ID. Not expected to be populated for off-exchange enrollees.
18	Patient SSN	164	172	9	Character	Member's Social Security Number		Required per AB-929 if available marker field used to set master person ID
19	CC Member ID	173	192	20	Character	The patient's member ID as assigned by Covered California		Required for on-exchange enrollees. marker field used to set master person ID. Not expected to be populated for off-exchange enrollees.
20	Plan Member ID	193	212	20	Character	The patient's member ID as assigned by the plan		Required per AB-929 marker field used to set master person ID
21	Policy ID	213	232	20	Character	Identifier of the individual policy for the patient as assigned by health plan		Required per AB-929 marker field used to set master person ID The policy ID may be the same as the plan member ID for some data suppliers.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
22	Patient First Name	233	292	60	Character	The patient's first name		added per AB-929 marker field used to set master person ID
23	Patient Last Name	293	352	60	Character	The patient's last name		added per AB-929 marker field used to set master person ID
24	Patient Middle Initial	353	353	1	Character	The patient's middle initial		added per AB-929 marker field used to set master person ID
25	Patient Address 1	354	403	50	Character	The street address of the patient's residence		added per AB-929 marker field used to set master person ID
26	Patient Address 2	404	433	30	Character	The second part of the patient's residence street address		added per AB-929 marker field used to set master person ID
27	Patient City	434	463	30	Character	The city of the residence of the patient		added per AB-929 marker field used to set master person ID
28	Patient State	464	465	2	Character	The state code of the residence of the patient		added per AB-929 marker field used to set master person ID
29	Patient Zip Code	466	470	5	Character	The 5 digit zip code of the residence of the patient		added per AB-929 marker field used to set master person ID
30	Patient Zip Plus 4	471	474	4	Character	The last 4 digits of the 9 digit zip code of the patient		added per AB-929 marker field used to set master person ID
31	Other Patient Insurance Identifier	475	499	25	Character	Any other member level insurance identifier (not used at this time)		added per AB-929 marker field used to set master person ID Not being used at this time, pleas leave blank
32	Gender Code	500	500	1	Character	The member's gender code.		Valid values are: M = Male F = Female N = Non-Binary U = Unknown
33	Line Number	501	503	3	Numeric	The detail line number for the service on the claim		
34	Line Status	504	505	2	Character	Line Status Code - Expected values are 'D' or 'P'. No fully denied claims, but paid claims may have denied lines.		D = Denied Line P = Paid Line
35	Net Payment	506	515	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
36	Network Paid Indicator	516	516	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level		"Y" or "N"
37	Network Provider Indicator	517	517	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs		"Y" or "N"
38	On-Exchange Indicator	518	518	1	Character	An indicator used to determine if this Patient is on the Covered California exchange or not		Y = patient's coverage is on-exchange N = patient's coverage is off-exchange
39	Ordering Provider ID	519	531	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.		The physician's Federal Tax ID (TIN) is preferred, but data supplier specific code could be substituted if NPI is well populated.
40	Ordering Provider NPI	532	541	10	Character	The National Provider ID number for the Ordering provider.		
41	Ordering Provider First Name	542	571	30	Character	The First Name of the provider who referred the patient or ordered the test or procedure.		
42	Ordering Provider Last Name	572	601	30	Character	The Last Name of the provider who referred the patient or ordered the test or procedure.		
43	Ordering Provider Middle Initial	602	602	1	Character	The Middle Initial of the provider who referred the patient or ordered the test or procedure.		
44	Ordering Provider Zip Code	603	607	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
45	Ordering Provider Zip Plus 4 Code	608	611	4	Character	The 4 digit zip code extension code of the ordering provider		

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
46	Ortho Ind	612	612	1	Character	Expected Values 'Y' : if the claim is an orthodontia 'N' : if the claims is not an orthodontia		
47	Penalty Amount	613	622	10	Numeric	Penalty amount on the claim. This could be a charge for a service that was not pre-authorized or a charge for deviation from plan design.		Format 9(8)v99 (2 - digit, implied decimal)
48	Place of Service Code	623	624	2	Character	CMS code for the place of service.		https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
49	Plan Number	625	644	20	Character	Plan number identifying the plan selected for the patient as assigned by the QDP - Sixteen byte HIOS code (no dashes) is preferred		
50	Procedure Code	645	651	7	Character	The procedure code for the service record. Expanded from 5 to 7 for future use.		ADA codes expected
51	Procedure Modifier Code	652	653	2	Character	The 2-character code of the first procedure code modifier on the dental claim.		
52	Provider ID	654	666	13	Character	The identifier for the provider of service.		The physician Federal Tax ID (TIN) is preferred, but data supplier specific code could be substituted if NPI is well populated.
53	Provider NPI	667	676	10	Character	The National Provider ID number for the Servicing provider.		
54	Provider First Name	677	706	30	Character	The First Name of the servicing provider.		
55	Provider Last Name	707	736	30	Character	The Last Name of the servicing provider.		
56	Provider Middle Initial	737	737	1	Character	The Middle Initial of the servicing provider.		
57	Provider Address 1	738	787	50	Character	The current street address1 of the provider of service.		
58	Provider Address 2	788	817	30	Character	The current street address2 of the provider of service.		
59	Provider City	818	847	30	Character	The current city of the provider of service.		
60	Provider State	848	849	2	Character	The current state of the provider of service.		
61	Provider County Code	850	854	5	Character	FIPS State/County code of the servicing provider		
62	Provider Zip Code	855	859	5	Character	The 5-digit zip code corresponding to the servicing Provider ID		
63	Provider Zip Plus 4 Code	860	863	4	Character	The 4 digit zip code extension code of the servicing provider		
64	Provider Taxonomy Code	864	873	10	Character	The Taxonomy code of the servicing provider		
65	Provider Type Code Claim	874	876	3	Numeric	The provider type code must be populated if the taxonomy code is not provided. This field doesn't need to be populated if the provider taxonomy code is populated.		See Prov Type Codes tab
66	Replaced Claim ID	877	926	50	Character	If the source system issues a new claim ID when voiding or adjusting a claim, provide the replaced claim ID here else set to spaces.		
67	Third Party Amount	927	936	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 – digit, implied decimal)
68	Units of Service	937	940	4	Numeric	Quantity of services or units		
69	Tooth Code	941	990	50	Character	The standard ADA tooth code for the dental claim record.		See Tooth Codes tab for code values
70	Tooth Surface Code	991	995	5	Character	The tooth surface code for dental claims.		See Tooth Surface Codes tab for code values
71	ICD Version	996	996	1	Character	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis codes.		
72	Withhold Amount	997	1006	10	Numeric	The amount that is deducted from the payment to the physician group/physician that may or may not be returned depending on specific predetermined factors. This could be an amount being withheld until an agreed upon quality goal is met. This may be part of an ACO agreement.		

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
73	Payment Arrangement Code	1007	1008	2	Character	Indicates that this record is a supplemental payment for a high value procedure code. Currently used by Liberty Dental only.		Valid value is <blank> or SP SP = supplemental payment record If this is a FFS or encounter (non-supplemental payment) Please leave this field blank
74	Filler	1009	1499	491	Character	Reserved for future use		Fill with blanks
75	Record Type	1500	1500	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row								

Dental Claim / Encounter Functional Specification - QDP Issuers
--- Clm Trl Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Fixed-Record Length							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1499	1455	Character	Reserved for future use	Fill with Blanks
6	Record Type	1500	1500	1	Character	Record Type Identifier	Hard Code 'T'

End of Layout - Do not remove this row - All field additions to be inserted above the Filler row

Tooth Cd	Description
1	Upper Right Third Molar (Wisdom Tooth)
2	Upper Right Second Molar
3	Upper Right First Molar
4	Upper Right Second Premolar (Second Bicuspid)
5	Upper Right First Premolar (First Bicuspid)
6	Upper Right Canine (Cuspid)
7	Upper Right Lateral Incisor
8	Upper Right Central Incisor
9	Upper Left Central Incisor
10	Upper Left Lateral Incisor
11	Upper Left Canine (Cuspid)
12	Upper Left First Premolar (First Bicuspid)
13	Upper Left Second Premolar (Second Bicuspid)
14	Upper Left First Molar
15	Upper Left Second Molar
16	Upper Left Third Molar (Wisdom Tooth)
17	Lower Left Third Molar (Wisdom Tooth)
18	Lower Left Second Molar
19	Lower Left First Molar
20	Lower Left Second Premolar (Second Bicuspid)
21	Lower Left First Premolar (First Bicuspid)
22	Lower Left Canine (Cuspid)
23	Lower Left Lateral Incisor
24	Lower Left Central Incisor
25	Lower Right Central Incisor
26	Lower Right Lateral Incisor
27	Lower Right Canine (Cuspid)
28	Lower Right First Premolar (First Bicuspid)
29	Lower Right Second Premolar (Second Bicuspid)
30	Lower Right First Molar
31	Lower Right Second Molar
32	Lower Right Third Molar (Wisdom Tooth)
A	Upper Right Second Primary Molar
B	Upper Right First Primary Molar
C	Upper Right Primary Canine (Cuspid)
D	Upper Right Primary Lateral Incisor
E	Upper Right Primary Central Incisor
F	Upper Left Primary Central Incisor
G	Upper Left Primary Lateral Incisor
H	Upper Left Primary Canine (Cuspid)
I	Upper Left First Primary Molar
J	Upper Left Second Primary Molar
K	Lower Left Second Primary Molar
L	Lower Left First Primary Molar

Tooth Cd	Description
M	Lower Left Primary Canine (Cuspid)
N	Lower Left Primary Lateral Incisor
O	Lower Left Primary Central Incisor
P	Lower Right Primary Central Incisor
Q	Lower Right Primary Lateral Incisor
R	Lower Right Primary Canine (Cuspid)
S	Lower Right First Primary Molar
T	Lower Right Second Primary Molar

Tooth Surface Cd	Description
D	Distal
DF	Distal-Facial
DFI	Distal-Facial Incisal
DFIL	Distal-Facial Incisal LinguaL
DL	Distal-Lingual
DO	Distal-Occlusal
DOF	Distal-Occlusal Facial
DOL	Distal-Occlusal Lingual
DOLF	Distal-Occlusal Lingual Facial
F	FaciaL
FO	Facial-Occlusal
FOL	Facial-Occlusal Lingual
I	Incisal
L	Lingual/Palatal
M	Mesial
MDFIL	Mesial-Distal Facial Incisal Lingual
MFC	Mesial-Facial-Distal
MFI	Mesial-Facial Incisal
MFIL	Mesial-Facial Incisal Lingual
ML	Mesial-Lingual
MLD	Mesial-Lingual-Distal
MLF	Mesial-Lingual-Facial
MO	Mesial Occlusal
MOD	Mesial-Occlusal Distal
MODF	Mesial-Occlusal Distal Facial
MODLF	Mesial-Occlusal Distal Lingual Facial
MOF	Mesial-Occlusal Facial
MOL	Mesial-Occlusal Lingual
MOLF	Mesial-Occlusal Lingual Facial
O	Occlusal
OL	Occlusal Lingual

Prvdr Type Cd	Description
1	Acute Care Hospital
5	Ambulatory Surgery Centers
6	Urgent Care Facility
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep NEC
21	Mental Health Facilities
22	Chemical Depend Treatment Ctr
23	Mental Hlth/Chem Dep Day Care
25	Rehabilitation Facilities
30	Longterm Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Continuing Care Retirement Com
37	Day/Night Care Center
38	Hospice Facility
40	Other Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
100	Dentist - MD & DDS (NEC)
105	Dental Specialist
120	Chiropractor/DCM
130	Podiatry
140	Pain Mgmt/Pain Medicine
145	Pediatric Anesthesiology
150	Anesthesiology
160	Nuclear Medicine
170	Pathology
175	Pediatric Pathology
180	Radiology
185	Pediatric Radiology
200	Medical Doctor - MD (NEC)
202	Osteopathic Medicine
204	Internal Medicine (NEC)
206	MultiSpecialty Physician Group
208	Proctology
210	Urology
215	Dermatology
220	Emergency Medicine
225	Hospitalist
227	Palliative Medicine

Prvdr Type Cd	Description
230	Allergy & Immunology
240	Family Practice
245	Geriatric Medicine
250	Cardiovascular Dis/Cardiology
260	Neurology
265	Critical Care Medicine
270	Endocrinology & Metabolism
275	Gastroenterology
280	Hematology
285	Infectious Disease
290	Nephrology
295	Pulmonary Disease
300	Rheumatology
320	Obstetrics & Gynecology
325	Genetics
330	Ophthalmology
340	Otolaryngology
350	Physical Medicine & Rehab
355	Plastic/Maxillofacial Surgery
360	Preventative Medicine
365	Psychiatry
380	Oncology
400	Pediatrician (NEC)
410	Pediatric Specialist (NEC)
413	Pediatric Nephrology
415	Pediatric Ophthalmology
418	Pediatric Orthopaedics
420	Pediatric Otolaryngology
423	Pediatric Critical Care Med
425	Pediatric Pulmonology
428	Pediatric Emergency Medicine
430	Pediatric Allergy & Immunology
433	Pediatric Endocrinology
435	Neonatal-Perinatal Medicine
438	Pediatric Gastroenterology
440	Pediatric Cardiology
443	Pediatric Hematology-Oncology
448	Pediatric Infectious Diseases
450	Pediatric Rheumatology
453	Sports Medicine (Pediatrics)
455	Pediatric Urology
458	Child Psychiatry
460	Pediatric Medical Toxicology
500	Surgeon (NEC)

Prvdr Type Cd	Description
510	Colon & Rectal Surgery
520	Neurological Surgery
530	Orthopaedic Surgery
535	Abdominal Surgery
540	Cardiovascular Surgery
545	Dermatologic Surgery
550	General Vascular Surgery
555	Head and Neck Surgery
560	Pediatric Surgery (Surgery)
565	Surgical Critical Care
570	Transplant Surgery
575	Traumatic Surgery
580	Cardiothoracic Surgery
585	Thoracic Surgery
805	Dental Technician
810	Dietitian
815	Medical Technician
820	Midwife
822	Nursing Services
824	Psychiatric Nurse
825	Nurse Practitioner
827	Nurse Anesthetist
830	Optometrist
835	Optician
840	Pharmacist
845	Physician Assistant
850	Therapy (Physical)
853	Therapists (Supportive)
855	Therapists (Alternative)
857	Renal Dialysis Therapy
860	Psychologist
865	Acupuncturist
870	Spiritual Healers
900	Health Educator/Agency
905	Transportation
910	Health Resort
915	Hearing Labs
920	Home Health Organiz/Agency
925	Imaging Center
930	Laboratory
935	Pharmacy
940	Supply Center
945	Vision Center
950	Public Health Agency

Prvdr Type Cd	Description
960	Case Manager

Standard Layout
Covered California Healthcare Evidence Initiative (HEI)
Capitation Functional Specification - QDP Issuers
01/26/2022

REVISION HISTORY		
DATE	AUTHOR	DESCRIPTION OF ACTIVITY
1/26/22	Dan Lopez	Updated general tab to reflect monthly submission of cap files for both Medical and Dental data
9/30/21	Dan Lopez	Updated to include Dental data
3/9/20	Dan Lopez	Added more detailed description for Withhold Amount field.
2/17/20	Dan Lopez	Added expected values for indicator fields
1/17/20	Katie Andrada-Bacorn	Updated fields for AB-929 and brand updates
1/7/20	Dan Lopez	Further Clarification on AB-929 fields
12/2/19	Dan Lopez	Updated for AB-929
6/12/15	Dan Lopez	Updated based on all data summits
5/27/15	Katie Andrada-Bacorn	Updated descriptions based on data summit
5/21/15	Katie Andrada-Bacorn	Initial Documentation

DESCRIPTION/GENERAL INFORMATION

This interface is designed to capture monthly capitation claims. Specifically, this will contain a monthly record for each capitation payment.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a "D" in the Record Type field), as well as a Trailer record layout (identified by a "T" in the Record Type field).

DATA SUBMISSION

QHPs and QDPs - The data will be submitted to Merative via SFTP on a monthly basis. Monthly files should be submitted on or before the 15th of the month following the close of each month.

- **Historical/Implementation** – Initially, Merative is interested in receiving historical data. Historical data can be submitted in annual or quarterly files encompassing all the financial transactions for the full history timeframe requested.
- **Ongoing** – The financial files will be submitted by the data supplier to Merative on a monthly basis, on or before the agreed upon date of the month following the close of each month.

DEFINITIONS AND DISCUSSION ITEMS

- Capitation Payments contain information regarding payments made to a physician, facility or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record should be included in the medical claims data.
- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred
- **QHPs** - This file should contain a record/transaction for each capitation payment made by the data supplier for the covered (medical coverage)
- **QDPs** - This file should contain a record/transaction for each capitation payment made by the data supplier for the covered (dental coverage) population.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-001234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (underscore) , (comma)

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Merative Fields								
1	**Note: all fields highlighted in green will be used to set the master person ID** Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 marker field used to set master person ID
2	CC SubscriberID	10	29	20	Character	Unique code assigned by CC to the subscriber		marker field used to set master person ID
3	Enrollee SSN	30	38	9	Character	Member's Social Security Number		Required per AB-929 marker field used to set master person ID
4	CC MemberID	39	58	20	Character	Unique code assigned by CC to the member		marker field used to set master person ID
5	Plan MemberID	59	78	20	Character	Unique code assigned by health plan to identify a member		Required per AB-929 marker field used to set master person ID
6	Policy ID	79	98	20	Character	Policy ID assigned by health plan		Required per AB-929 marker field used to set master person ID
7	Capitation Amount	99	108	10	Numeric	The pre-paid amount paid to plans or providers under risk-based managed care contracts.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
8	Capitation Type Code	109	109	1	Character	This field identifies the type of capitation payment record: • 1 – Professional • 2 – Facility • 3 – Mental Health • 4 – Drug • 5 – Dental • 6 – Vision • 7 – Hearing • 8 – Blended		
9	Date Paid	110	119	10	Date	The date the transaction was paid.		MM/DD/YYYY Format
10	Date of Service	120	129	10	Date	The date/period of service for the transaction. If the period of service is a month, this can be populated with the first day of that month.		MM/DD/YYYY Format
11	Gender Code	130	130	1	Character	The member's gender code.		Valid values are: M = Male F = Female N = Non-Binary U = Unknown
12	Date of Birth	131	140	10	Date	The birth date of the person.		MM/DD/YYYY format
13	Adjustment Type Code	141	141	1	Character	This field identifies the type of adjustment for the capitation payment record: • 1 – Adjustment • 2 – Void • 3 – Original or Replacement • 4 – Bulk Adjustment		
14	Provider Type Code	142	144	3	Character	This field contains the provider specialty code. This field only needs to be populated if the provider taxonomy code is not available.		See the Provider Type tab
15	Provider TIN	145	157	13	Character	The unique identifier for the provider. Providers include facilities, physicians, PCPs, pharmacies, and professionals.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs should be provided on payments to a facility.

Capitation Functional Specification - QDP Issuers

--- Cap Det Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Merative Fields								
16	Provider NPI	158	167	10	Character	The National Provider Identifier for the provider.		
17	Withhold Amount	168	177	10	Numeric	The amount that is deducted from the payment to the physician group/physician that may or may not be returned depending on specific predetermined factors. This could be an amount being withheld until an agreed upon quality goal is met. This may be part of an ACO agreement.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
18	Provider Taxonomy	178	187	10	Character	The taxonomy code of the provider of payment		
19	**All Fields in red text have been added to the layout for AB-929** On-Exchange Indicator	188	188	1	Character	An indicator used to determine if this enrollee is on the Covered California exchange or not		**All Fields in red text have been added to the layout for AB-929** Added per AB-929 Set to: Y = when the enrollee record is on-exchange N = when the enrollee record is off-exchange
20	Plan Number	189	208	20	Character	Plan number identifying the plan selected by the enrollee as assigned by the QHP or QDP. This is the internal plan ID		added per AB-929
21	Enrollee First Name	209	268	60	Character	The enrollee's first name		added per AB-929 marker field used to set master person ID
22	Enrollee Last Name	269	328	60	Character	The enrollee's last name		added per AB-929 marker field used to set master person ID
23	Enrollee Middle Initial	329	329	1	Character	The enrollee's middle initial		added per AB-929 marker field used to set master person ID
24	Enrollee Address 1	330	379	50	Character	The street address of the enrollee		added per AB-929 marker field used to set master person ID
25	Enrollee Address 2	380	409	30	Character	The second part of the street address of the enrollee		added per AB-929 marker field used to set master person ID
26	Enrollee City	410	439	30	Character	The city of the residence of the enrollee		added per AB-929 marker field used to set master person ID
27	Enrollee State	440	441	2	Character	The state code of the residence of the enrollee		added per AB-929 marker field used to set master person ID
28	Enrollee Zip Code	442	446	5	Character	The 5 digit zip code of the residence of the enrollee		added per AB-929 marker field used to set master person ID
29	Enrollee Zip Plus 4	447	450	4	Character	The last 4 digits of the 9 digit zip code of the enrollee		added per AB-929 marker field used to set master person ID
30	Other Member Insurance Identifier	451	475	25	Character	Any other member level insurance identifier (not used at this time)		added per AB-929 marker field used to set master person ID
31	Filler	476	699	224	Character	Reserved for future use		Fill with blanks
32	Record Type	700	700	1	Character	Record type identifier		Hard Code to "D"

Capitation Functional Specification - QDP Issuers
--- Cap Trl Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Merative Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	999	955	Character	Reserved for future use	Fill with Blanks
6	Record Type	1000	700	1	Character	Record Type Identifier	Hard Code 'T'

Prvdr Type Cd	Description
1	Acute Care Hospital
5	Ambulatory Surgery Centers
6	Urgent Care Facility
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep NEC
21	Mental Health Facilities
22	Chemical Depend Treatment Ctr
23	Mental Hlth/Chem Dep Day Care
25	Rehabilitation Facilities
30	Longterm Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Continuing Care Retirement Com
37	Day/Night Care Center
38	Hospice Facility
40	Other Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
100	Dentist - MD & DDS (NEC)
105	Dental Specialist
120	Chiropractor/DCM
130	Podiatry
140	Pain Mgmt/Pain Medicine
145	Pediatric Anesthesiology
150	Anesthesiology
160	Nuclear Medicine
170	Pathology
175	Pediatric Pathology
180	Radiology
185	Pediatric Radiology
200	Medical Doctor - MD (NEC)
202	Osteopathic Medicine
204	Internal Medicine (NEC)
206	MultiSpecialty Physician Group
208	Proctology
210	Urology
215	Dermatology
220	Emergency Medicine
225	Hospitalist
227	Palliative Medicine

Prvdr Type Cd	Description
230	Allergy & Immunology
240	Family Practice
245	Geriatric Medicine
250	Cardiovascular Dis/Cardiology
260	Neurology
265	Critical Care Medicine
270	Endocrinology & Metabolism
275	Gastroenterology
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295	Pulmonary Disease
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450	Pediatric Rheumatology
453	Sports Medicine (Pediatrics)
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458	Child Psychiatry
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Prvdr Type Cd	Description
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550	General Vascular Surgery
555	Head and Neck Surgery
560	Pediatric Surgery (Surgery)
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570	Transplant Surgery
575	Traumatic Surgery
580	Cardiothoracic Surgery
585	Thoracic Surgery
805	Dental Technician
810	Dietitian
815	Medical Technician
820	Midwife
822	Nursing Services
824	Psychiatric Nurse
825	Nurse Practitioner
827	Nurse Anesthetist
830	Optometrist
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850	Therapy (Physical)
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900	Health Educator/Agency
905	Transportation
910	Health Resort
915	Hearing Labs
920	Home Health Organiz/Agency
925	Imaging Center
930	Laboratory
935	Pharmacy
940	Supply Center
945	Vision Center
950	Public Health Agency

Prvdr Type Cd	Description
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