Subchapter TT. All-Payor Claims Database
28 TAC §§21.5401 - 21.5406

TEXT.

§21.5401. Applicability and Exemptions.

(a) This subchapter applies to a payor that issues a plan subject to reporting under subsection (b) of this section;

(b) Payors must submit data files as required by this subchapter with respect to each of the following types of health benefit plans or dental benefit plans issued in Texas:

(1) a health benefit plan as defined by Insurance Code §1501.002, concerning Definitions;

(2) an individual health care plan that is subject to Insurance Code §1271.004, concerning Individual Health Care Plan;

(3) an individual health insurance policy providing major medical expense coverage that is subject to Insurance Code Chapter 1201, concerning Accident and Health Insurance;

(4) a health benefit plan as defined by §21.2702 of this title (relating to Definitions);

(5) a student health plan that provides major medical coverage, consistent with the definition of student health insurance coverage in 45 C.F.R. §147.145, concerning Student Health Insurance Coverage;

(6) short-term limited-duration insurance as defined by Insurance Code §1509.001, concerning Definition;

(7) individual or group dental insurance coverage that is subject to Insurance Code Chapter 1201 or Insurance Code Chapter 1251, concerning Group and Blanket Health Insurance;

(8) dental coverage provided through a single service HMO that is subject to Chapter 11, Subchapter W of this title (relating to Single Service HMOs);

(9) a Medicare supplement benefit plan under Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans;

(10) a health benefit plan as defined by Insurance Code Chapter 846, concerning Multiple Employer Welfare Arrangements;

(11) basic coverage under Insurance Code Chapter 1551, concerning Texas Employees Group Benefits Act;

(12) a basic plan under Insurance Code Chapter 1575, concerning Texas Public School Employees Group Benefits Program;

(13) a health coverage plan under Insurance Code Chapter 1579, concerning Texas School Employees Uniform Group Health Coverage;

(14) basic coverage under Insurance Code Chapter 1601, concerning Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System;

(15) a county employee health benefit plan established under Local Government Code Chapter 157, concerning Assistance, Benefits, and Working Conditions of County Officers and Employees;

(16) group dental, health and accident, or medical expense coverage provided by a risk pool created under Local Government Code Chapter 172, concerning Texas Political Subdivisions Uniform Group Benefits Program;

(17) the state Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program;

(18) a Medicaid managed care plan operated under Government Code Chapter 533, concerning Medicaid Managed Care Program;

(19) a Medicare Advantage Plan operated under 42 U.S.C., Subchapter XVIII, Part C, §§1395w-21 - 1395w-29;

(20) a Medicare Part D voluntary prescription drug benefit plan operated under 42 U.S.C. Subchapter XVIII, Part D, §§1395w-101 - 1395w-154; and

(21) a health benefit plan or dental plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), if the plan sponsor or administrator elects to submit such data.

§21.5402. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) Adjudicated claim or encounter--Any claim or encounter submitted by a provider or member for payment that has been received by a payor and processed to assess payment or denial per the terms of the benefit plan, provider contract, or coverage requirements.

(2) Allowed amount--Has the meaning assigned by Insurance Code §38.402, concerning Definitions.

(3) CDL--The standardized format, or common data layout, for All-Payor Claims Database (APCD) data files as approved by the National Association of Health Data Organizations.

(4) Center--The Center for Healthcare Data at the University of Texas Health Science Center at Houston.

(5) Data--Has the meaning assigned by Insurance Code §38.402.

(6) Database--Has the meaning assigned by Insurance Code §38.402.

(7) Data files--Files submitted under this subchapter, including dental claims files, enrollment and eligibility data files, medical claims data files, pharmacy claims data files, and provider files.

(8) Dental claims data file--A file that includes data about dental claims and other encounter information, according to the requirements contained in the submission guide.

(9) Enrollment and eligibility data file--A file that provides identifying data about a person who is enrolled and eligible to receive health care coverage from a payor, according to the requirements contained in the submission guide.

(10) Medical claims data file--A file that includes data about medical claims and other encounter information, submitted according to the requirements contained in the submission guide.

(11) Payor--Has the meaning assigned by Insurance Code §38.402.

(12) Pharmacy claims data file--A file that includes data about prescription medications and claims filed by pharmacies, including mail order and retail dispensaries, submitted according to the requirements contained in the submission guide.

(13) Provider file--A file that includes information about the individuals and entities that submitted claims that are included in the medical claims data file, submitted according to the requirements contained in the submission guide.

(14) Qualified research entity--Has the meaning assigned by Insurance Code §38.402.

(15) Stakeholder advisory group--Has the meaning assigned by Insurance Code §38.402.

(16) Submission guide--The document entitled "The Texas All-Payor Claims Database Data Submission Guide," created by the Center, that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables,

and edit specifications for payor submission of eligibility data files, medical, dental, and pharmacy claims data files, and provider files to the database. The submission guide may also contain any data collection procedures or other standards necessary to establish and administer the database.

§21.5403. Submission Guide.

Payors must submit complete and accurate data files for all applicable plans as required by this subchapter and consistent with the scope and guidance provided in the submission guide published by the Center [*version to be released with formal proposal*] and the Common Data Layout for All-Payor Claims Databases (APCD-CDL Version 2.1, released July 1, 2021), or subsequent versions of the submission guide or APCD-CDL as directed by Commissioner order. The submission guide will:

(1) be modeled on the CDL;

(2) identify which data fields payors are required to submit in each data file and which data fields are optional;

(3) identify the formatting requirements and thresholds for each required data field; and

(4) provide data collection procedures or other standards necessary to establish and administer the database.

§21.5404. Data Submission Requirements.

(a) Payors must submit the data files required by subsection (c) of this section to the Center using a secure electronic portal that is established by the Center and according to the schedule provided in §21.5405 of this title (relating to Timing and Frequency of Data Submissions).

(b) Payors are responsible for submitting or arranging to submit all applicable data under this subchapter, including data with respect to benefits that are administered or adjudicated by another contracted or delegated entity, such as carved-out behavioral health benefits or pharmacy benefits administered by a pharmacy benefit manager. Payors may arrange for a third-party administrator or delegated or contracted entity to submit data on behalf of the payor, but may not submit data that duplicates data submitted by a third party. Payors with Medicaid managed care plans may arrange for the Texas Health and Human Services Commission to submit data on those plans on behalf of those payors.

(c) Payors must submit the following files:

(1) enrollment and eligibility data files;

(2) medical claims data files;

(3) pharmacy claims data files;

(4) dental claims data files;

(5) provider files; and

(6) other files as identified in the submission guide.

(d) Data files must include information, consistent with the data submission guide and the CDL, that enables the data to be analyzed based on the market category, product category, coverage type, and other factors relevant for distinguishing types of plans.

(e) Payors must include data in medical, pharmacy, and dental claims data files for a given reporting period based on the date the claim is adjudicated, not the date of service associated with the claim. For example, a service provided in March, but adjudicated in April, would be included in the second-quarter data report. Likewise, any claim adjustments must be included in the appropriate data file based on the date the adjustment was made. Payors must report medical, pharmacy, and dental claims at the

visit, service, or prescription level. Payors must also include claims for capitated services with all medical, pharmacy, and dental claims data file submissions.

(f) Payors must include all payment fields specified as required in the CDL and submission guide. With respect to medical, pharmacy, and dental claims data file submissions, payors must also:

(1) include coinsurance and copayment data in two separate fields;

(2) clearly identify claims where multiple parties have financial responsibility by including a Coordination of Benefits, or COB, notation; and

(3) include denied claims and identify a denied claim either by a denied notation or assigning eligible, allowed, and payment amounts of zero. When a claim contains both fully processed or paid service lines and partially processed or denied service lines, the payor must include all service lines as part of the claims data file.

(g) Every data file submission must include a control report that specifies the count of records and, as applicable, the total allowed amount and total paid amount.

(h) Unless otherwise specified, payors must use the code sources listed and described in the CDL within the member eligibility and enrollment data file and medical, pharmacy, and dental claims data file and provider file submissions. When standardized values for data fields are available and stated within the CDL, a payor may not submit data that uses a unique coding system.

(i) Payors must use the members' social security number as a unique member identifier (ID) or assign an alternative unique member ID as provided in this subsection.

(1) If a payor collects only the social security number for the subscriber, the payor must assign a discrete two-digit suffix for each member under the subscriber's contract.

(2) If a payor does not collect the subscriber's social security number, the payor must assign a unique member ID to the subscriber and the member in its place.

The payor must also use a discrete two-digit suffix with the unique member ID to associate members under the same contract with the subscriber.

(3) A payor must use the same unique member ID for the member's entire period of coverage with that payor. A payor must use the same unique member ID, even if the member's name, plan type, or other enrollment information changes. If a change in the unique member ID or the use of two different unique member IDs for the same individual is unavoidable, the payor must provide documentation linking the member IDs in the form and method provided by the Center.

(4) When standardized values for data variables are available and stated within the CDL, no specific or unique coding systems will be permitted as part of the health care claims data set submission.

(5) Within the enrollment and eligibility data files, payors must report member enrollment and eligibility information at the individual member level. If a member is covered as both a subscriber and a dependent on two different policies during the same month, the payor must submit two member enrollment and eligibility records. If a member has two contract numbers for two different coverage types, the payor must submit two member enrollment and eligibility records.

(j) Payors must include a header and trailer record in each data file submission according to the formats described in the CDL. The header record is the first record of each separate file submission, and the trailer record is the last.

§21.5405. Timing and Frequency of Data Submissions.

(a) Payors must submit quarterly data files according to the following schedule:

(1) first-quarter data, for a reporting period of January 1 to March 31 of each year, must be submitted no later than [month, day];

(2) second-quarter data, for a reporting period of April 1 to June 30 of each year, must be submitted no later than [month, day];

(3) third-quarter data, for a reporting period of July 1 to September 30 of each year, must be submitted no later than [month, day]; and

(4) fourth-quarter data, for a reporting period of October 1 to December 31 of each year, must be submitted no later than [month, day].

(b) Payors must submit test data files containing 2021 calendar year data in the form and method provided by the Center. The Center will provide notice of the timeline for submitting test data no later than XX days before the data is due and the data will be due no sooner than XX days after the effective date of this section.

(c) Payors must begin making quarterly data submissions according to the schedule provided in subsection (a) of this section. The Center will provide notice of the timeline for submitting quarterly data no later than XX days before the data is due and the data will be due no sooner than XX days after the effective date of this section.

(d) At the time of the first quarterly data submission, payors must also submit historical data files that reflect reporting periods spanning from January 1, 2019, to the most recent quarterly reporting period.

(e) A payor that is unable to meet the reporting schedule provided by this section may submit a request for an extension to the Center before the reporting due date.

(f) The Center will assess each data submission to ensure the data files are complete, accurate, and formatted correctly.

(g) The Center will communicate receipt of data, inform the payor of the data quality assessments, and specify any required data corrections and resubmissions.

(h) Upon receipt of a resubmission request, the payor must respond within 14 calendar days with either a revised and corrected data file or an extension request.

(i) If a payor fails to submit required data or fails to correct submissions rejected due to errors or omissions, the Center will provide written notice to the payor. If the payor fails to provide the required information within 30 calendar days following receipt of said written notice, the Center will notify the department of the failure to report. The department may pursue compliance with this subchapter via any appropriate corrective action, sanction, or penalty that is within the authority of the department.

§21.5406. Stakeholder Advisory Group Terms.

(a) Except as provided by subsection (c) of this section, members of the stakeholder advisory group designated under Insurance Code §38.403(b)(2)-(4) serve fixed terms of three years.

(b) Initial terms of the stakeholder advisory group will end December 31, 2024.

(c) Initial redesignations of the stakeholder advisory group will begin January 1, 2025, and will be staggered as follows:

(1) two members representing the business community, as provided by Insurance Code §38.403(b)(4)(A); and two members representing consumers, as provided by Insurance Code §38.403(b)(4)(B), with terms to expire December 31, 2026.

(2) the member designated by the Teacher Retirement System of Texas; two members representing hospitals, as provided by Insurance Code §38.403(b)(4)(C); and two members representing health benefit plan issuers, as provided by Insurance Code §38.403(b)(4)(D), with terms to expire December 31, 2027.

(3) the member designated by the Employees Retirement System; two members representing physicians, as provided by Insurance Code §38.403(b)(4)(E); and two members not professionally involved in the purchase, provision, administration, or review of health care services, supplies, or devices, or health benefit plans, as provided by Insurance Code §38.403(b)(4)(F), with terms to expire December 31, 2028.

(d) All subsequent terms will be for a period of three years.

(e) If a member does not complete the member's three-year term, a replacement member must be designated to complete the remainder of the term. A member designated by the Center to serve a partial term of less than two years will not be prevented from serving for an additional two consecutive terms.

(f) Except as provided by subsection (e) of this section, members designated by the Center under Insurance Code §38.403(b)(4) may not serve more than two consecutive terms.

(g) Members and prospective members of the stakeholder advisory group are subject to the conflicts of interest and standards of conduct provisions in paragraphs (1) – (4) of this subsection.

(1) A prospective member of the stakeholder advisory group must disclose to the designating entity any conflict of interest before being designated to the group.

(2) A member of the stakeholder advisory group must immediately disclose to the Center and the member’s designating entity any conflict of interest that arises or is discovered while serving on the group.

(3) A conflict of interest means a personal or financial interest that would lead a reasonable person to question the member's objectivity or impartiality. An example of a conflict of interest is employment by or financial interest in an organization with a financial interest in work before the stakeholder advisory group, such as evaluating data requests from qualified research entities under Insurance Code §38.404(e)(2), concerning Establishment and Administration of Database.

(4) A member of the stakeholder advisory group must comply with Government Code §572.051(a), concerning Standards of Conduct, to the same extent as a state officer or employee.

(h) A member may be removed from the stakeholder advisory group for good cause by the member's designating entity.