Subchapter TT. All-Payor Claims Database
28 TAC §§21.5401, 21.5403 - 21.5406

TEXT.

§21.5401. Applicability.

(a) This subchapter applies to a payor that issues, sponsors, or administers 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 that are subject to Insurance Code Chapter 38, Subchapter I, concerning Texas All Payor Claims Database, including:

(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 CFR §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, if the payor elects to submit such data;

(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) coverage for medical expenses provided under a self-insurance fund established under Government Code Chapter 2259, concerning Self-Insurance by Governmental Units;

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

(19) [~~(18)~~] a Medicaid managed care plan operated under Government Code, Title 4, Subtitle I, concerning Health and Human Services [~~Chapter 533, concerning Medicaid Managed Care Program~~];

(20) [~~(19)~~] the child health plan program operated under Health and Safety Code Chapter 62, concerning Child Health Plan for Certain Low-Income Children;

(21) [~~(20)~~] the health benefits plan for children operated under Health and Safety Code Chapter 63, concerning Health Benefits Plan for Certain Children;

(22) [~~(21)~~] a Medicare Advantage Plan providing health benefits under Medicare Part C as defined in 42 USC §1395w-21, *et seq*., concerning Medicare+Choice Program;

(23) [~~(22)~~] a Medicare Part D voluntary prescription drug benefit plan providing benefits as defined in 42 USC §1395w-101, *et seq*., concerning Voluntary Prescription Drug Benefit Program; and

(24) [~~(23)~~] a health benefit plan or dental plan subject to the Employee Retirement Income Security Act of 1974 (29 USC §1001 *et seq*.) if the plan sponsor or administrator elects to submit this [~~such~~] data.

(c) Data files required by this subchapter must include information with respect to all Texas resident members, as defined in §21.5402(16) of this title (relating to Definitions). Information on persons who are not Texas resident members is not required.

§21.5403. Texas APCD Common Data Layout and Submission Guide.

(a) Payors must submit complete and accurate data files for all applicable plans as required by this subchapter and consistent with the data elements found in the Texas APCD CDL v3.0.1 [~~v1.09, released May 20, 2022~~]. The Texas APCD CDL v3.0.1 is available on the Texas Department of Insurance's [~~the Center's~~] website. [~~and:~~]

[~~(1) is modeled on the "All-Payer Claims Database Common Data Layout" published by the National Association of Health Data Organizations and used with permission;~~]

[~~(2) identifies which data elements payors are required to submit in each data file and which data elements are optional, consistent with Insurance Code §38.404(c), concerning Establishment and Administration of Database; and~~]

[~~(3) identifies the record specifications, definitions, code tables, and threshold levels for each required data element.~~]

(b) If the Center adopts subsequent versions of the Texas APCD CDL, payors must submit data consistent with the requirements of each subsequent version, but this subchapter does not require the submission by payors of additional data elements that are not required in the Texas APCD CDL v3.0.1 or that do not fall within the scope of Insurance Code Chapter 38, Subchapter I, concerning Texas All Payor Claims Database. [~~The Center may issue technical guidance that provides flexibility regarding the existing requirements contained in the Texas APCD CDL, such as removing required data elements, clarifying specifications, increasing the maximum length, or decreasing the minimum threshold. However, such guidance may not modify statutory requirements, impose more stringent requirements, or increase the scope of the data being collected.~~]

(c) The Center will establish, evaluate, and update data collection procedures within a submission guide, consistent with Insurance Code §38.404(f), concerning Establishment and Administration of Database. Notwithstanding subsection (b) of this section, in the

event of an inconsistency between this subchapter and the submission guide, this subchapter controls.

§21.5404. Data Submission Requirements.

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

(1) The Texas Health and Human Services Commission may submit data on behalf of all applicable payors participating in a plan or program identified in §21.5401(b)(18) - (b)(21) [~~§21.5401(b)(17) - (b)(20)~~] of this title (relating to Applicability).

(2) A payor that acts as an administrator on behalf of a health benefit plan or dental plan for which reporting is optional per Insurance Code §38.407, concerning Certain Entities Not Required to Submit Data, may ask the plan sponsor whether it elects or declines to participate in or submit data to the Center and may include data for such plans within the payor's data submission. Both the inquiry to and response from the plan sponsor should be in writing.

(3) A payor providing Medicare Supplement benefit plans may elect to submit Medicare Supplement benefit plan data to the Center.

(b) Payors or their designees that are subject to this subchapter must register with the Center each year [~~to submit data~~], consistent with the instructions and procedures

contained in the submission guide. Payors must communicate any changes to registration information by contacting the Center within 30 days using the contact information provided in the submission guide. Upon registration, the Center will assign a unique payor code and submitter code to be used in naming the data files and provide the credentials and information required to submit data files.

(c) Payors must submit the following files, consistent with the requirements of the Texas APCD CDL:

(1) enrollment and eligibility data files;

(2) medical claims data files;

(3) pharmacy claims data files;

(4) dental claims data files; and

(5) provider files.

(d) Payors must package all files being submitted into zip files that are encrypted according to the standard provided in the submission guide. Payors must submit the encrypted zip files to the Center using one of the following file submission methods:

[~~(1) save the files on a Universal Serial Bus (USB) flash drive and use a secure courier to deliver the USB drive to the database according to delivery instructions provided in the submission guide;~~]

(1) [~~(2)~~] transmit the files to the Center's Managed File Transfer servers using the Secure File Transport Protocol (SFTP) and the credentials and transmittal information provided upon registration;

(2) [~~(3)~~] upload files from an internet browser using the Hypertext Transfer Protocol Secure (HTTPS) protocol and the credentials and transmittal information provided upon registration; or

(3) [~~(4)~~] transmit the files using a subsequent electronic method as provided in the data submission guide.

(e) Payors must name data files and zip files consistent with the file naming conventions specified by the Center in the submission guide.

(f) Payors must format all data files as standard 8-bit UCS Transformation Format (UTF-8) encoded text files with a ".txt" file extension and adhere to the following standards:

(1) use a single line per record and do not include carriage returns or line feed characters within the record;

(2) records must be delimited by the carriage return and line feed character combination;

(3) all data fields are variable field length, subject to the constraints identified in the Texas APCD CDL, and must be delimited using the pipe (|) character (ASCII=124), which must not appear in the data itself;

(4) text fields must not be demarcated or enclosed in single or double quotes;

(5) the first row of each data file must contain the names of data columns as specified by the Texas APCD CDL;

(6) numerical fields (e.g., ID numbers, account numbers, etc.) must not contain spaces, hyphens, or other punctuation marks, or be padded with leading or trailing zeroes;

(7) currency and unit fields must contain decimal points when appropriate;

(8) if a data field is not to be populated, a null value must be used, consisting of an empty set of consecutive pipe delimiters (||) with no content between them.

(g) Data files must include information consistent with the Texas APCD 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.

(h) 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 April data report. Likewise, any claim adjustments must be included in the appropriate data file based on the date the adjustment was made and include a reference that links the original claim to all subsequent actions associated with that claim. Payors must report medical, pharmacy, and dental claims data 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.

(i) Payors must include all payment fields specified as required in the Texas APCD CDL. 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 specified types of denied claims and identify a denied claim either by a denied notation or assigning eligible, allowed, and payment amounts of zero. The data submission guide will specify the types of denied claims that must be included on the basis of the claim adjustment reason code associated with the denial. In general, denied claims are not required when the reason for the denial was incomplete claim coding or duplicative claims. Denied claims are required when they accurately reflect care that was delivered to an eligible member but not covered by a plan due to contractual terms, such as benefit maximums, place of service, provider type, or care deemed not medically necessary or experimental or investigational. Payors are not required to include data for rejected claims or claims that are denied because the patient was not an eligible member.

(j) 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.

(k) Unless otherwise specified, payors must use the code sources listed and described in the Texas APCD 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 Texas APCD CDL, a payor may not submit data that uses a unique coding system.~~]

(l) Payors must use the member's 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 the social security number for the subscriber only, 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 under a particular plan. 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, if available, linking the member IDs in the form and method provided by the Center.

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

(n) 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 different policies for two different coverage types, the payor must submit two member enrollment and eligibility records.

(o) Payors must include a header and trailer record in each data file submission according to the formats described in the Texas APCD 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 monthly data files according to the following schedule:

(1) January data must be submitted no later than March [~~May~~] 7 of that year;

(2) February data must be submitted no later than April [~~June~~] 7 of that year;

(3) March data must be submitted no later than May [~~July~~] 7 of that year;

(4) April data must be submitted no later than June [~~August~~] 7 of that year;

(5) May data must be submitted no later than July [~~September~~] 7 of that year;

(6) June data must be submitted no later than August [~~October~~] 7 of that year;

(7) July data must be submitted no later than September [~~November~~] 7 of that year;

(8) August data must be submitted no later than October [~~December~~] 7 of that year;

(9) September data must be submitted no later than November 7 of that [~~January 7 of the following~~] year;

(10) October data must be submitted no later than December 7 of that [~~February 7 of the following~~] year;

(11) November data must be submitted no later than January [~~March~~] 7 of the following year; and

(12) December data must be submitted no later than February [~~April~~] 7 of the following year.[~~;~~]

(b) Payors must submit test data files as provided in the submission guide:

(1) after registering for the first time with the Center as a payor that is subject to reporting under this subchapter;

(2) after a merger, acquisition, divestiture, or other change of ownership that requires an update to a payor's registration; and

(3) before the effective date of a new version of the TX APCD CDL, consistent with §21.5403 of this title (relating to Texas APCD Common Data Layout and Submission Guide) that contains additional data elements.

[~~(b) Except as provided in subsections (c) and (d) of this section, payors must submit test data files, historical data files, and monthly data files according to the dates specified by the Center, subject to the following requirements:~~]

[~~(1) the Center will provide notice of the timeline for payors to submit registration and test data no later than 90 days before the data is due, and test data will be due no sooner than October 1, 2022;~~]

[~~(2) the Center will provide notice of the timeline for submitting historical data, which must include data for reporting periods spanning from January 1, 2019, to the most recent monthly reporting period, no later than 120 days before the data is due, and historical data will be due no sooner than January 1, 2023; and~~]

[~~(3) the Center will provide notice of the timeline for submitting monthly data no later than 180 days before the commencement of the monthly data submission, and the first monthly data submission date will be no sooner than March 1, 2023.~~]

[~~(c) A payor with fewer than 10,000 covered lives in plans that are subject to reporting under this subchapter as of December 31 of the previous year must begin reporting no later than 12 months after the dates otherwise required, as specified by the Center, consistent with subsection (a) of this section. The payor must register with the Center to document the payor's eligibility for this extension.~~]

(c) [~~(d)~~] A payor may request a temporary exception or extension of time from complying with one or more requirements of this subchapter or the Texas APCD CDL by submitting a request to the Center, as provided in the submission guide posted on https://go.uth.edu/DSG, no less than 15 [~~30~~] calendar days before the date the payor is otherwise required to comply with the requirement.

(1) The [~~Except as provided in paragraph (2) of this subsection, the~~] Center may grant an exception or extension for good cause at its discretion for not more than 12 consecutive months, but an [~~if the payor demonstrates that compliance would impose an unreasonable cost or burden relative to the public value that would be gained from full compliance.~~]

[~~(1) An exception may not last more than 12 consecutive months.~~]

[~~(2) An~~] exception may not be granted from any requirement contained in Insurance Code Chapter 38, Subchapter I, concerning Texas All Payor Claims Database.

(2) A payor that registers with the Center and demonstrates that it has fewer than 10,000 covered lives in plans subject to this subchapter qualifies for an extension under this subsection for the payor's first required reporting. The Center may grant an extension for new payors for not more than 12 consecutive months.

(3) The Center may request additional information from a payor in order to make a determination on an exception or extension request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar

days from the date the payor's request is received. The deadline for data submission is tolled while the Center makes a determination on an exception or extension request.

(4) A request for an exception or extension that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under paragraph (3) of this subsection, the 14-day timeline begins the day after the payor submits the [~~such~~] information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an exception or extension may be deemed withdrawn by the Center at the end of the 14-day 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. The Center may grant a request for good cause at its discretion.~~]

[~~(1) The Center may request additional information from a payor in order to make a determination on an extension request. A request for additional information must be in writing and must be submitted to the payor within 14 calendar days from the date the payor's request is received.~~]

[~~(2) A request for an extension that is neither accepted nor rejected by the Center within 14 calendar days from the date the payor's request is received will be deemed accepted. If the Center has requested additional information from a payor under paragraph (1) of this subsection, the 14-day timeline begins the day after the payor submits such information. If a payor does not respond to or fails to provide the Center with additional information as requested, the payor's request for an extension may be deemed withdrawn by the Center at the end of the 14-day period.~~]

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

(e) [~~(g)~~] The Center will communicate receipt of data within 14 calendar days, inform the payor of the data quality assessments, and specify any required data corrections and resubmissions.

(f) Payors must provide reasonable follow-up information requested by the Center, limited to ensuring that the payor submitted complete and correct information.

(g) [~~(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.

(h) [~~(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 the [~~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.

(i) The reporting schedule under subsection (a) of this section applies to monthly data submissions due on or after March 7, 2025, containing data for months beginning January 1, 2025. Payors must submit data for November and December 2024 at the same time as January 2025 data.

Note: TDI intends to adjust the implementation date so that payors have at least 90 days to transition to reporting data 30 days after adjudication instead of 90 days.

§21.5406. Stakeholder Advisory Group Terms.

(a) Except as otherwise provided in [~~by subsections (b) and (c) of~~] this section, the term of office for seats on the [~~members of the~~] stakeholder advisory group, as specified by [~~designated under~~] Insurance Code §38.403 [~~§38.403(b)(2) - (4)~~], concerning Stakeholder Advisory Group, is [~~serve fixed terms of~~] three years.

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

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

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

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

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

(d) The term of office for a member representing an institution of higher education is one year.

(e) Except as provided by subsection (f) of this section, members may not serve for more than six consecutive years.

(f) [~~(d)~~] If a member does not complete their [~~the member's three-year~~] term, a replacement member may [~~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.~~]

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

(g) [~~(f)~~] 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; State Agency Ethics Policy, to the same extent as a state officer or employee.

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