Texas All-Payor Claims Database

August Submitter Forum

Center for Health Care Data

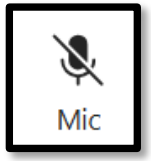
Presented to submitters on August 18, 2026

UTHealth® Houston

School of Public Health

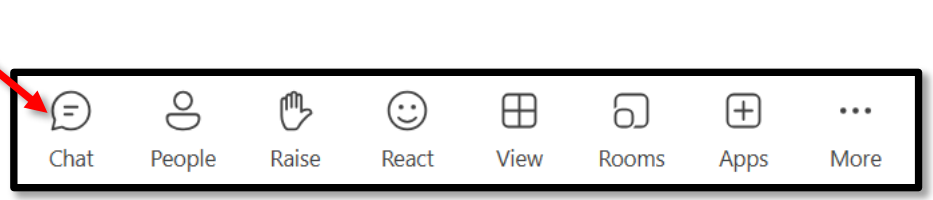
Welcome

- Welcome and housekeeping
  - Thank you!
  - Please place your audio on mute.
  - This meeting will be transcribed for our notes.
  - Slides and notes will be made available on our website.



Teams & Chat

- **Reminder:** Please enter all questions in the Chat.
- The “Chat” function in Teams can be found on the menu ribbon at the top of your screen.



Agenda

- Medical Claim Dollar Amounts from CDL
- Reporting Medicare Advantage Members
- Information for MA Members
- AES-256 Encryption

Medical Claim Dollar Amounts from CDL

Typical Uses in Research

Cost of Health Care

Cost here means payment – what is paid by all parties for health care services

Reporting Purposes

- PMPY
- Total Payments Per Claim or Line or Service
- Mean or Median Utilization Costs
- Cost/Price Variation

Medical Claim Dollar Amounts from CDL

Key Element is "Allowed Amount"

Allowed amount is used as the total amount paid or eligible for payment from all parties:

- The plan
- The consumer/patient (deductible, copay, coinsurance)
- Other coverage (COB)

Note: *Withhold is not included in allowed amount*

Medical Claim Dollar Amounts from CDL

Allowed Amount

- The allowed amount is considered the negotiated rate for in-network or eligible payment for out-of-network
- General Rule Formula: Plan Paid Amount + CoPay Amount + Coinsurance Amount + Deductible Amount + COB/TPL Amount

CDLMC131	Allowed Amount	int	12	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, set to 0. When payment arrangement type in CDLMC132 is equal to 02 for fee-for-service, report the maximum amount contractually allowed that a carrier will pay to a provider for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters].MC132 is equal to 01 for capitated services, set to 0. [Not required on encounters.]

Medical Claim Dollar Amounts from CDL

Charged amount or billed amount – the amount submitted by a provider for reimbursement for services

CDLMC123	Charge Amount	int	12	The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.]

- General Rule: Charged amount should be greater or equal to Paid Amount or Allowed Amount
- Rare Exception: DRG payment

Medical Claim Dollar Amounts from CDL

Out of Pocket Amounts

The payment amounts that are the responsibility of the insured person:

- CoPay Amount
- Coinsurance Amount
- Deductible Amount

CDLMC126	Copay Amount	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the copay amount on the first claim line. Report 0 if there is no copay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.]
CDLMC127	Coinsurance Amount	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025) [Not required on encounters.]
CDLMC128	Deductible Amount	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.]

Payment Amount from Another Payor

CDLMC129	Other Insurance Paid Amount	Amount already paid by another carrier. Report the amount that a prior payor has paid for this claim line. Indicates the submitting payor is not the primary payor. Only report “0” if the prior payor paid 0 toward this claim line; or if there is no prior payor. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).. May be reported as a negative. [Not required on encounters.]
CDLMC130	COB/TPL Amount	Amount due from a secondary carrier. Report the amount that another payor is liable for after submitting payor has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.]

Medical Claim Dollar Amounts from CDL

Finally…the Plan Paid Amount

The amount paid for a health care service after all plan benefit provisions, including out of pocket, coordination of benefits and other deductions are applied.

CDLMC125	Plan Paid Amount	This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.]

Medical Claim Dollar Amounts from CDL

CDLPC036	Charge Amount	NCPDP refers to this as Gross Amount Due.
CDLPC037	Plan Paid Amount	NCPDP refers to this as Net Amount Due. Includes all health plan payments and excludes all member payments. For capitated claims, set to 0.
CDLPC038	Allowed Amount	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee-for-service for a prescription. Report 0 if there is no allowed amount.
CDLPC043	Copay Amount	Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no copay amount.
CDLPC044	Coinsurance Amount	The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount.
CDLPC045	Deductible Amount	The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount.
CDLPC046	COB/TPL Amount	Amount due from a secondary carrier. Report the amount that another payor is liable for after submitting payor has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount.
CDLPC047	Other Insurance Paid Amount	Amount already paid by another carrier. Report the amount that a prior payor has paid for this claim line. Indicates the submitting payor is not the primary payor. Only Report “0” if the prior payor paid 0 toward this claim line or if there is no prior payor. May be reported as a negative.
CDLPC048	Member Self-pay Amount	Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report “0” if there is no member Self-Pay Amount.

Guidance from the CDL

- Report dollar amounts without decimal points: $1000.25 should be submitted as 100025, and $100 should be 10000
- Payment Arrangement Type Indicator may affect payment amount:
  - If Capitation, then set all payment fields to “0”
  - If DRG, Global Payment, or Bundled Payment: one line will record all payment amounts and other lines will be set to “0” with the payment arrangement type indicator code

CDLMC132	Payment Arrangement Type Indicator	char	2	Indicates the payment methodology. Valid codes are: 01= Capitation; 02 = Fee-for-Service; 03 = Percent of Charges; 04 = DRG; 05 = Pay for Performance; 06 = Global Payment; 07 = Other; 08 = Bundled Payment.

Medical Claim Dollar Amounts from CDL

General Rule	Relationship	Difference
Charge Amount vs Allowed Amount	Charge amount is almost always higher than Allowed amount	Charge Amount is Adjusted due to Contractual discount, Negotiated or Reasonable and Customary
Allowed Amount vs Plan Paid Amount	Allowed amount is equal to or higher than Plan Paid amount	Difference is due to payment or expected payment from other than Plan, such as Patient's responsibility (deductible/copay, coinsurance) or COB
Charge Amount vs Plan Paid Amount	Charge amount is almost always significantly higher than Plan Paid amount	Difference is due to Discounts or Other Payments

Issues Found

Decimals Errors:

- Decimals dropped: $100 should be 10000 but is entered as 100 and therefore converts to 1
- Decimal shift: Three digits after implied decimal $1000.25 becomes 1000250 or 10002500: most often seen in allowed amount

Medical Claim Dollar Amounts from CDL

Issues Found

- 0 in Allowed Amount but Plan Paid Amount has a positive value, i.e., 0 in Allowed Amount and Plan Paid Amount is 53482 ($524.82)

  Possibly a capitated claim, but then Plan Paid Amount should also be 0

- Plan Paid Amount is greater than Allowed Amount
- Only one line on facility claim for an inpatient stay that should have many lines with revenue codes/procedure codes, etc.

  Most likely reflecting an all-inclusive payment using a room/bd code or all-inclusive revenue code

Medical Claim Dollar Amounts from CDL

Issues Found

- False values such as $999,999,999.99 (submitted as 9999999999).
  - Often submitted in Allowed Amount with a Reasonable value shown in Plan Paid Amount.

  Probably place holder amount
- Service Units: required field that reports the count of services performed, generally important for cpt codes such as anesthesia codes that have a rate per 15 minutes. For example, if the contract rate is $50 for every 15 minutes and the plan paid amount is 15000 ($150.00), then the service units should be 3.

Reporting Medicare Advantage Members

- The Medicare Advantage cohort is a very important one for numerous research studies.
- Accurate identification of Medicare Advantage members is very important.
- In the March 2025 Submitter Forum, we asked submitters to populate the following fields:
  - Member Insurance/Product Category Code (CDLME004, CLDMC004, CDLPC004, CDLDC004)
  - Member Medicare Beneficiary Identifier (CDLME075)
- However, there is still a sizeable gap between what is being reported and the monthly enrollments published by CMS at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data.

Information for MA Members

- To identify the source of the gap, we need to clarify three fields in the ME file which will allow us to link the reported data to the monthly CMS enrollment data.
- CDLME003 (Plan ID) – all Medicare Advantage plans registered with CMS and enrolling members are assigned a Plan ID, usually numeric but may have leading zeros.
- CDLME011 (Plan Specific Contract Number) – all Medicare Advantage plans are assigned a contract number often starting with a letter (like E, H, or S) followed by four numbers (digits).
- TXME1029 (Plan Name) – as part of a contract, each Medicare Advantage plan has a specific plan name. This field has been required at 100% since CDL v3.0.1. When the plan being reported is part of an MA contract, please report the specific plan name.

Example Data

county	state	data_period	parent_organization	plan_name	plan_id	contract_number	organization_type	offers_part_d	plan_type
Honolulu	HI	202608	Kaiser Foundation Health Plan, Inc.	Kaiser Permanente Senior Advantage Basic (HMO)	003	H1230	HMO	Yes	Medicare Advantage
Honolulu	HI	202608	Kaiser Foundation Health Plan, Inc.	Kaiser Permanente Senior Advantage Enhanced (HMO)	001	H1230	HMO	Yes	Medicare Advantage
Honolulu	HI	202608	Kaiser Foundation Health Plan, Inc.	Kaiser Permanente Dual Complete Oahu (HMO D-SNP)	015	H1230	HMO	Yes	Medicare Advantage

AES-256 Encryption

- In Section 6.3.3 of the Technical Guide (https://go.uth.edu/TG), when creating a ZIP package for submission, submitters are asked to use AES-256 encryption when using symmetric encryption (shared key).
- After processing thousands of packages since the TX-APCD started collecting data, we have found that a little under 25% of file packages are encrypted using a variation of ZipCrypto.
- ZipCrypto is well known to be a very weak algorithm with many guides available online on how to break the encryption.
- Using any encryption method other than AES-256 puts data at risk.
- Starting **January 1, 2027**, encryption method on submitted file packages will be validated and will be rejected if not using a variation of AES-256.

Questions?

- Questions:
  - Please submit via Chat.
  - If your question is specific to your organization, for:
    - General questions – send email inquiries to txapcd@uth.tmc.edu.
    - Portal and data submission questions – please enter a ticket via the submitter portal at https://txapcd.org.