MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06 – *Maryland Medical Care Data Base and Data Collection*

MCDB

2017 MEDICAL CARE DATA BASE

DATA SUBMISSION MANUAL

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Released November 21, 2016

MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06 – MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION MANUAL

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DATA SUBMISSION MANUAL

INTRODUCTION

PURPOSE: The 2017 Medical Care Data Base (MCDB) Data Submission Manual (DSM) is designed to provide designated reporting entities with guidelines of technical specifications, layouts, and definitions necessary for filing the reports required under COMAR 10.25.06. This manual incorporates new information, as well as all recent updates. Changes from the 2016 manual are summarized in **Appendix A.** The MCDB is administered by the Maryland Health Care Commission (MHCC or Commission) and the manual and related documents are available on the Commission's website at: http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx.

Questions regarding MCDB policies and submission rules should be directed to:

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DESIGNATED REPORTING ENTITIES

The following entities are defined in COMAR 10.25.06.03 and designated by the Commission to provide data to the MCDB:

(1) Each payor whose total lives covered exceeds 1,000, as reported to the Maryland Insurance Administration;
(2) Each payor offering a qualified health plan, qualified dental plan, or qualified vision plan certified by the Maryland Health Benefit Exchange (MHBE), Insurance Article, §31-115, Annotated Code of Maryland; and
(3) Each payor that is a managed care organization participating in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

The Commission will post known reporting entities on its website at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx. Entities who meet the specifications in COMAR 10.25.06.03 are required to report, even if they are not explicitly listed on the website. A glossary of reporting entity definitions can be found in Appendix B.

REQUIRED REPORTS OVERVIEW

Each reporting entity shall provide the required reports and include all services provided to:

(1) Each Maryland resident insured under a fully insured contract or a self-insured contract; and
(2) Each non-Maryland resident insured under a Maryland contract.
(3) Due to *Gobeille v. Liberty Mutual* Supreme Court's (SCOTUS) ruling on March 1, 2016, Maryland will not be enforcing data collection from privately insured ERISA self-funded health plans. However, Maryland encourages payors of privately insured ERISA self-funded health plans to report data to the MCDB on a voluntary basis.

Claims for all Maryland residents covered by your company should be included regardless of where the contract is written; for example, if your company covers Maryland residents under a contract written in Virginia, the claims for these residents should be included in your submission. Similarly, all members covered under a Maryland contract must be included, regardless of their state of residence; for example, a member residing in Virginia and covered under a Maryland contract should be included in your submission.

Descriptions of the reports are provided below. The reports should follow the file layout and instructions provided in the 2017 Data File Record Layout Guide, available on the MHCC website at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx.

For membership information reported in the Eligibility Data Report, please provide information for all members who are eligible during the reporting period. For claims reported, please select claims based on the claims paid date. If there are substantial lags between adjudication date and paid date, or, you would like to make a case for selecting claims based on adjudication date, please submit a format modification request. Please ensure data consistency with the Finance and Actuarial Departments in your organization. For payors that participate in the sale of ACA compliant health insurance products on or off the Maryland Health Benefit Exchange (MHBE), membership and allowed claims data in the MCDB must be consistent with the membership and allowed claims data submitted by your company's Actuarial Pricing/Rating department to the Maryland Insurance Administration (MIA) via Actuarial Memorandums and rate filings. The Individual and Small Group markets (Non-Grandfathered Health Plans only) are affected by this MCDB versus MIA data reconciliation and will result in MCDB data resubmissions if discrepancies in the excess of 2.5% exist. Please refer to Appendix C for guidance on patient identifiers, and Appendix D for guidance on financial data elements. All reports must be submitted via the MCDB Portal. Instructions for the MCDB Portal are provided in Appendix E.

ELIGIBILITY DATA REPORT: The **Eligibility** Data Report should include information on the characteristics of all enrollees covered for medical or pharmacy services under the plan during the reporting period (**COMAR 10.25.06.11**). For payors with Qualified Dental Plans, information about dental plan enrollment should also be included. Please provide an entry for each month that the enrollee was regardless of whether or not the enrollee received any covered services during the reporting

quarter. Based on quarterly reporting, an enrollee with 3 months of coverage will have 3 eligibility records; an enrollee with 1 month of coverage will only have 1 record.

As part of the eligibility data reporting, payors are required to report demographic data to develop the Master Patient Index (MPI), a technology used by the Chesapeake Regional Information System for Our Patients (CRISP), which identifies patients across all submitting MCDB payors. In addition, all payors are required to submit a Demographics File to CRISP, who will generate the MPI and provide an MPI to payor-encrypted ID cross-walk file to MHCC. Payors should leave the MPI field blank on the Eligibility Data Report. The enrollees in the CRISP Demographics file should match the enrollees in the Eligibility file.

PROFESSIONAL SERVICES DATA REPORT: The **Professional Services** Data Report should include all fee-for-service and capitated care encounters (e.g. CMS 1500 claims, HIPPA 870P, etc.,) for services provided by health care practitioners and office facilities to applicable insureds during the reporting period, regardless of the location of the service (e.g. include out of state services) (**COMAR 10.25.06.07**). This report should include services for claims paid in the reporting period, regardless of the date of service.

This does not include hospital facility services documented on UB-04 claims forms.

The following medical services must be included:

- Physician services
- Non-physician health care professionals
- Freestanding Office Facilities (e.g. radiology centers, ambulatory surgical centers, birthing centers, etc.)
- Durable Medical Equipment (DME)
- Dental – if services are provided under a medical benefit package
- Vision - if services are provided under a medical benefit package
- Tests and imaging services

All members with services in the Professional Services Data Report must be represented in the Eligibility Data Report for the reporting period corresponding to the date of service reported, but not necessarily corresponding to the date that the claim was paid. For example, if a service was provided during 2017 Q1 and the corresponding claim was paid in 2017 Q2, then the member's eligibility information must be in the Eligibility Data Report for 2017 Q1, and the claim should appear in the Professional Services Data Report for 2017 Q2. The member should only appear in the Eligibility Data Report for 2017 Q2 if the member was still eligibile for benefits during 2017 Q2.

INSTITUTIONAL SERVICES DATA REPORT: The **Institutional Services** Data Report should include all institutional health care services provided to applicable insureds during the reporting period (**COMAR 10.25.06.10**). This data file reports all institutional health care services provided to Maryland residents, whether those services were provided by a health care facility located in-State or out-of-State. This report should include services for claims paid in the reporting period, regardless of the date of service.

Unlike in previous years where institutional services claims were rolled-up for the entire report, in 2017 claims will be reported on a per-line basis (by revenue code for inpatient and by procedure code for outpatient claims).

For inpatient facility (hospital and non-hospital), each line would be defined by revenue code. Each line will have one revenue code. However, each revenue code can have more than one procedure or diagnosis code. For inpatient claims, all ICD procedure codes present on the same claim should be replicated for each line of the same claim.

For outpatient facility (hospital and non-hospital), each line would be defined by revenue code or CPT code, each in its own respective field. Each line will have one revenue code or at least one CPT code. If a revenue code is not available or applicable, the field should be left blank. However, such lines must be identified with at least a CPT code in the principal procedure code.

All diagnosis codes should be repeated on all lines of a claim, regardless of the type of facility.

PHARMACY DATA REPORT: The **Pharmacy** Data Report should include all pharmacy services provided to applicable insureds during the reporting period, whether the services were provided by a pharmacy located in Maryland or out-of State (**COMAR 10.25.06.08**). This report should include services for claims paid in the reporting period, regardless of the date of service. In addition to prescription drugs, this report should also include medical supplies.

DENTAL SERVICES DATA REPORT: The **Dental** Data Report should include all dental services provided to applicable insureds enrolled in Qualified Dental Plans (certified by the MHBE) during the reporting period, whether the services were provided by a practitioner or office facility located in Maryland or out-of State (**COMAR 10.25.06.13**). The format for this report is designed to be consistent with professional services claims and encounters, but modified to be specific to dental services. This report should include services for claims paid in the reporting period, regardless of the date of service.

PROVIDER DIRECTORY REPORT: The **Provider Directory** Report should include information on all Maryland and out-of-State health care practitioners and suppliers that provided services to applicable insureds during the reporting period. (**COMAR 10.25.06.09**). The Provider Directory must contain all providers identified in the Professional Services, Institutional Services, Pharmacy, and Dental Services Data Reports. The Provider Directory must have a crosswalk between your internal practitioner (individual or organization) ID and the NPI.

CRISP Demographics Report: The **CRISP Demographics** Report should include information on the characteristics of all enrollees covered for medical or pharmacy services under the plan during the reporting period. For payers with Qualified Dental Plans, information about dental plan enrollment should also be included. Payors are required to submit data to CRISP following the data specifications and Carrier Onboarding Process specified in Appendix C. Please see Appendix C for a description of the different member identifiers to be included in the data reports.

PLAN BENEFIT DESIGN REPORT: The **Plan Benefit Design** Report **(COMAR 10.25.06.12)** will report details of coverage and benefits for all enrollees. This report is under development. Reporting entities that are required to provide this report will be provided an opportunity to participate in the development and testing of this report.

NON-FEE-FOR-SERVICE MEDICAL EXPENSES REPORT: The **Non-Fee-for-Service Medical Expenses** Report **(COMAR 10.25.06.14)** will report details of non-fee-for-service payments made to providers. These may include shared savings payments, incentive or performance payments, fixed transformation payments, etc. This report is under development. Reporting entities that are required to provide this report will be provided an opportunity to participate in the development and testing of this report.

REQUIRED REPORTS FOR REPORTING ENTITIES:

Reporting Entities	Professional Services	Pharmacy Services	Provider Directory	Institutional Services	Eligibility	Dental Services	CRISP Demographics	Plan Benefit Design	Non-FFS Medical Expenses
Payors	X	X	X	X	X	-	X	Testing only	Testing only
Qualified Health Plans	X	X	X	X	X	-	X		
Qualified Dental Plans	-	-	X	-	X	X	X		
Qualified Vision Plans	X	-	X	-	X	-	X		
Medicaid Managed Care Organizations *	X	X	X	X	X	-	X		
Third Party Administrators (General Benefit Plans)	X	X	X	X	X	-	X	Testing only	Testing only
Third Party Administrators (Behavioral Health Services)	X	X	X	X	X	-	X	Testing only	Testing only
Pharmacy Benefit Managers	-	X	-	-	X	-	X	Testing only	Testing only

*Data for Medicaid Managed Care Organizations are currently submitted by The Hilltop Institute.

2017 MCDB DATA SUBMISSION SCHEDULE:

All data reports for each quarter of data are due two months after the end of the quarter. The deadline is for the final date of submission, with initial submissions and format modifications being completed in the preceding month. If a reporting entity does not submit complete and accurate data that clears all validation steps by the date of the deadline or approved extension, MHCC may fine the entity up to $1,000/day per report (COMAR 10.25.12). Each of the reports defined in the Required Reports Overview above are considered an independent report, for which fines may apply.

2017 Medical Care Data Base Submission Schedule				
MCDB Data Reporting	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reporting Period (Based on Paid Date)	01/01/17 – 03/31/17	04/01/17 – 06/30/17	07/01/17 – 09/30/17	10/01/17– 12/31/17
Annual File Waiver Requests Due	01/15/2017	01/15/2017	01/15/2017	01/15/2017
Portal Submissions Begin Format Modification Requests Begin	4/1/2017	7/1/2017	10/1/2017	1/1/2018
Test Data Submissions Due Extension Requests Due	04/30/2017	07/31/2017	10/31/2017	01/31/2018
Format Modification Requests Due	05/15/2017	08/15/2017	11/15/2017	02/15/2018
Final Data Submissions Due	**05/31/2017**	**08/31/2017**	**11/30/2017**	**02/28/2018**

ANNUAL FILE WAIVER, FORMAT MODIFICATION, and EXTENSION REQUESTS

Payors may apply for annual file waivers (COMAR 10.25.06.17A) to seek exemption from reporting one or all files for the entire year or reporting quarter; format modifications (COMAR 10.25.06.17B) to request variances on threshold requirements or field lengths; and extensions (COMAR 10.25.06.16) to seek a delay in the submission deadline. All requests must be submitted via the MCDB Portal. For further instructions, see MCDB Portal Instructions in Appendix D. The MHCC staff assesses each payor's request(s) based on that payor's particular circumstances. Payors must provide detailed explanations and plans for remediation for each request.

Typically, annual file waivers are only provided if the payor is able to document that they do not meet the reporting threshold or that the regulations do not apply to them. Extension requests will be considered only as exceptions and in the case of extraordinary circumstances.

Payors are reminded to submit format modification requests only for those data elements that have an assigned threshold value. It is important that payors reference the MCDB Data Quality Reports (DQR) before submitting their data element and modified threshold requests. The DQRs will be provided within the MCDB Portal and are designed to provide payors with a comparison of information reported and threshold values assigned, as well as detailed changes in key measures including total number of recipients, services, and payments from the previous submission. Payors are encouraged to respond to the DQRs on the MCDB Portal with feedback related to their data submission. Values labeled as "Unknown" or "Not Coded" do not

contribute to meeting required threshold values. In the event that your submission includes enough of these values that it would fail to meet the required threshold, please request a format modification for these fields. Submissions that do not meet the specific thresholds listed in the DSM File Record Layout Guide will be rejected unless a format modification was obtained.

FORMATTING NOTES

- **LAYOUT**
  - Files can be submitted in one of three layouts: Flat file, delimited with pipe (|), or delimited with comma (,).
  - Each record (row) must have the same length if using the flat format.
  - Match the layout of the file submission with the appropriate data report specifications.
  - If a delimiter is applied to a file, each record (row) must have the same count of the chosen delimiter.
- **NUMERIC FIELDS**
  - **RIGHT** justify all NUMERIC fields
  - **POPULATE** any NUMERIC field for which you have no data to report with **ZEROS**—except the financial fields for capitated/global contract services (see below).
  - If an entry is less than the allowed field length for that field, then insert spaces to represent the empty positions so that the specified field length is fulfilled. Do not add leading zeroes or any other characters except a negative sign when applicable.
  - **DO NOT** add leading zeroes to amount/financial fields.
  - **Financial fields** for capitated or global contract services that lack data are to be filled with -999. Do NOT use -999 as a filler unless the field is absolutely capitated (the record status must be equal to 8). If you have the patient liability information (patient co-pay, patient deductible, other patient obligation) for these services, you must report the patient liability values, even though the other financial fields (billed charge, allowed amount, reimbursement amount) are lacking data.
- **ALPHANUMERIC FIELDS**
  - **LEFT** justify all ALPHANUMERIC fields.
  - Leave **BLANK** any ALPHANUMERIC fields for which you have no data to report. If utilizing a flat format rather than a delimited-format, pad the field with spaces up to the allowed field length to help ensure that each record has the same length.
  - **DO NOT** use filler values to indicate blank fields, such as "U", "*", "UNKNOWN", or "N/A", etc.

Other qualitative data needed by MHCC to analyze the data will be collected via the MCDB Portal. These data will be updated once a year.

Each field will be analyzed for completion and accuracy, even those without threshold guidelines. Payors will be expected to provide explanations and plans for mitigation regarding fields which seem incomplete, as well as fields which demonstrate a trend of deterioration.

DOCUMENTATION FOR 2017 SUBMISSION DATA

There will be no documentation necessary for 2017 submission data, however, payors will be prompted to look at the data quality reports and confirm that the summary data are consistent with their business experiences.

RECORD LAYOUT and FILE SPECIFICATIONS

The record layout and data element specifications are available for download at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx, and are an integral part of this manual. A Frequently Asked Questions guide (FAQ) about the data submission process has been provided in Appendix F.

Field IDs are given file designations in order to allow payers and MHCC to communicate problems with fields that exist in multiple files. For example, Patient Year and Month of Birth in the Professional Services file is known as Field ID P004, while the same field in the Institutional file is Field ID I004. Please note that field index IDs are consistent across years. For example, Fields I145 through Field I166 were removed from the layout in 2016, thus these index numbers do not exist in 2016 and later years.

SPECIAL CONSIDERATIONS for 2017 MCDB DATA SUBMISSIONS

Values labeled as "Unknown" or "Not Coded" do not contribute to meeting required threshold values. In the event that your submission includes enough of these values that it would fail to meet the required threshold, please request a waiver for these fields.

Source System may no longer be left blank. If only reporting for one source system, use the default value of "A."

Date of Disenrollment should no longer be left blank if active. Instead, use the value "20991231."

The reporting of financial fields have been streamlined across all files. Report all financial fields as whole numbers without decimal places, rounded to the nearest whole digit. For example, if a financial field was collected as "154.95," it would be reported as "155", because 155 is the nearest whole dollar amount.

Prior to 2016, financial fields in the Pharmacy file were reported with two implied decimal places. Please discontinue using this format and report the financial fields as whole numbers as in the example above. Additionally, report the allowed amount. This is the maximum amount contractually allowed. This is generally equal to the sum of patient liability and payor reimbursement. Also include separately the amount paid by other insurance.

APPENDICES

- APPENDIX A – CHANGE LOG (2016-2017)
- APPENDIX B – GLOSSARY OF REPORTING ENTITY DEFINITIONS
- APPENDIX C – PATIENT, PLAN, AND PAYOR IDENTIFIERS
- APPENDIX D – FINANCIAL DATA ELEMENTS
- APPENDIX E – MCDB PORTAL INSTRUCTIONS
- APPENDIX F – FREQUENTLY ASKED QUESTIONS (FAQ)

Appendix A – Change Log (2016-2017)

Major Changes to 2017 Data Submission Manual:

- **New and Modified in 2017 DSM (Page numbers reference 2017 DSM)**
  - Updated primary contact for MHCC to Kenneth Yeates-Trotman (page 1).
  - Added explanation regarding future MIA filings (page 2).
  - Added note regarding collection of privately insured ERISA self-funded health data (page 2).
  - Clarified explanation regarding the reporting of procedure codes on the Institutional Services file (page 3).
  - Clarified Pharmacy file should include medical supplies (page 3).
  - Added explanation of the CRISP Demographics report (page 4).
  - Updated "Required Reports for Reporting Entities" table for each type of payor (page 4).
  - Simplified "2017 Medical Care Data Base Submission Schedule deadlines" (page 5).
  - Changed name of Annual Waiver to "Annual File Waiver (page 5).
  - Added "UNKNOWN" to list of unacceptable filler values (page 6).
  - Added clarification regarding internal field ID numbers (page 7).
  - Updated primary contact for CRISP files to Matthew Edelen (page 13).
  - For institutional file, relabeled the field "Coordination of Benefits Savings or Other Payor Payments" as "Amount Paid by Other Insurance", and inserted the field into professional, pharmacy, and dental reports (page 14).
  - Updated definitions of some Financial Data Elements (page 14).
  - Added "Amount Paid by Other Insurance" to Financial Data Elements (page 15).
  - Updated FAQ to incorporate last year of frequently asked questions. (page 18).

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Major Changes to 2017 File Record Layout Guide:

- **Added CRISP Demographics file to File Record Layout Guide.**
- **Added CRISP Demographics file to Field Index.**
- **All Files –**
  - Allowed Amount – Updated definition
- **Professional Services –**
  - Amount Paid by Other Insurance – Added field
  - Allowed Amount – Modified description for clarity
- **Pharmacy Services –**
  - Allowed Amount – Added field
  - Patient Covered by Other Insurance Indicator – Added Field
  - Amount Paid by Other Insurance – Added field.
- **Institutional** -
  - Allowed Amount – Modified description for clarity
  - Patient Covered by Other Insurance Indicator – Added threshold
  - Coordination of Benefits Savings or Other Payor Payments – renamed field as "Amount Paid by Other Insurance"
- **Eligibility –**
  - Coverage Type – Modified description for clarity
  - Date of Disenrollment – Removed threshold
  - Date of First Enrollment – Removed threshold
  - Metal Level Plan Indicator – Modified field contents
  - Cost-Sharing Reduction Indicator – Modified field contents
- **Dental Services –**
  - Amount Paid by Other Insurance – Added field

Appendix B – Glossary of Reporting Entity Definitions

Payor - (a) An insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in Maryland; (b) a health maintenance organization (HMO) that holds a certificate of authority in Maryland; or (c) Third Party Administrator registered as an administrator under Title 8, Subtitle 3 of the Insurance Article.

Qualified Health Plan (QHP) - A general health benefit plan that has been certified by the Maryland Health Benefit Exchange to meet the criteria for certification described in §1311(c) of the Affordable Care Act and Insurance Article, §31-115, Annotated Code of Maryland.

Qualified Dental Plan (QDP) - A dental plan certified by the Maryland Health Benefit Exchange that provides limited scope dental benefits, as described in § 1311(c) of the Affordable Care Act and Insurance Article, §31-115, Annotated Code of Maryland.

Qualified Vision Plan (QVP) - A vision plan certified by the Maryland Health Benefit Exchange that provides limited scope vision benefits, as described in the Insurance Article, §31-108(b)(3) Annotated Code of Maryland.

Third Party Administrator (TPA) - A person (entity, etc.,) that is registered as an administrator under Title 8, Subtitle 3 of the Insurance Article, whose total lives covered on behalf of Maryland employers exceeds 1,000, as reported to the Maryland Insurance Administration. The TPA definition includes Behavioral Health Administrators and Pharmacy Benefit Managers.

A Pharmacy Benefit Manager (PBM) - A person (entity, etc.,) that performs pharmacy benefit management services, a term that includes: the procurement of prescription drugs at a negotiated rate for dispensation to beneficiaries; the administration or management of prescription drug coverage, including mail service pharmacies, claims processing, clinical formulary development, rebate administration, patient compliance programs, or disease management programs.

Managed Care Organization (MCO) - A certified health maintenance organization or a corporation that is a managed care system that is authorized to receive medical assistance prepaid capitation payments, enrolls only program recipients or individuals or families served under the Maryland Children's Health Program, and is subject to the requirements of Health-General Article §15-102.4, Annotated Code of Maryland.

Metal Actuarial Value (Metal AV) – The AV used to determine benefit packages that meet defined metal tiers for all non-grandfathered individual and insured employer-sponsored small-group market plans. In the individual and small-group markets, the metal AV is expected to be used by consumers to compare the relative generosity of health plans with different cost-sharing attributes. For standard plan designs, health plan will determine AV using a Human Health Services (HHS)-developed AV calculator. This calculator will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discount or utilization estimates). If an issuer (payor) determines that a material aspect of its plan design cannot be accommodated by the AV Calculator, HHS allows for alternative calculation methods supported by certification from an actuary.

Non-Grandfathered Health Plans – Health plans offered in the individual and small group markets (inside and outside of the Exchanges) must cover the essential health benefits package, which includes (1) Covering essential health benefits (EHB), (2) Meeting certain actuarial value (AV) standards and (3) Meeting certain limits on cost sharing.

Grandfathered Health Plans – Please see definition in HHS rules 45-CFR-147.140 at: https://www.federalregister.gov/select-citation/2013/06/03/45-CFR-147.140

Appendix C – Patient, Plan, and Payor Identifiers

The MCDB here are several patient, plan, and payor identifiers included in the MCDB data reports. Payor ID, Plan or Product ID #, Subscriber ID #, and Encrypted Contract or Group # are defined as follows: (a) Payor ID is assigned by MHCC and helps identify the reporting company; (b) Plan or Product ID # is an internal (payor) ID for the claims adjudication system and would be the main linker to the benefit design information; (c) Encrypted Contract or Group # is the ID/number associated with the group (e.g. State of Maryland, Business ABC, etc.,) policy number (could be the individual contract number in the case of individual market); and (d) Subscriber ID # is the individual's policy number (usually the same within a family policy).

There are three patient identifiers included in the MCDB data reports: (a) Payor Encrypted Patient Identifier is the payor's internal identifier for the member; (b) the Universally Unique Identifier (UUID) is generated by the payor using an encryption algorithm provided by MHCC; and (c) the Master Patient Index (MPI) is created by the State Designated Health Information Exchange (HIE) on behalf of the MHCC based on data provided by the payor to the HIE. The payor encrypted ID and UUID are reported on the eligibility and claims files. While there is a field allocated for the MPI, payors will not be required to submit it as part of their report. Instead, payors will be required to submit a demographic file to the HIE, who will generate the MPI and provide a cross-walk of the payor-encrypted ID and MPI to the MHCC. Additional details and instructions regarding the UUID and MPI are provided below.

UNIVERSALLY UNIQUE IDENTIFIER (UUID) – Cross Payor Encryption Algorithm

In order to maintain a consistent and unique identifier for each patient across providers, payors, and services, the MHCC shall, as necessary, provide each reporting entity with an encryption algorithm, **Universally Unique Identifier (UUID)**, using one-way hashing consistent with the Advanced Encryption Standard (AES) recognized by the National Institute of Standards and Technology. Each reporting entity shall maintain the security and preserve the confidentiality of the UUID encryption algorithms provided by MHCC.

A Universally Unique Identifier (UUID) uniquely identifies information in a decentralized system; using the same algorithm across distributed systems will result in the same unique ID for the same value; information labeled with UUIDs can be combined into a single database without needing to resolve name conflicts.

UUIDs will be 12 character positions in length and constructed from information obtained at birth including: The policy holder's or beneficiary's Social Security Number, Date of Birth, Month of Birth, Year of Birth, Sex, First Name.

Each payor shall utilize the software and accompanying password provided by MHCC to create new patient/enrollee identifiers in such a manner that each unique combination of Social Security Number, Date of Birth, Month of Birth, Year of Birth, Sex, First Name produces an identical unique encrypted data element called the **Encrypted Enrollee's IdentifierU**.

Each payor shall continue to use their current encrypted identifier **(Encrypted Enrollee's IdentifierP)** coincident with the new identifier. If a change in encryption method is absolutely necessary, a full crosswalk of the old and new IDs will need to be provided to MHCC for all previously submitted IDs.

Using two identifiers will: 1) provide the means to perform trend analysis by cross referencing the two identifiers, and 2) increase the efficacy of the identifiers in the event encryption of one of the algorithms is compromised.

The full encryption software documentation, source code, and executables are bundled into a ZIP file. That software can be downloaded directly from the Commission's website at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb_mcdb_uuid.aspx. The file is password protected. The password will be forwarded to the payor contact via e-mail.
The Commission strongly encourages all carriers to consider the simple implementation of the software for the 2017 MCDB submission. That implementation is simply a standalone program that reads in the precursor variables and outputs those same variables, plus the UUID.

Questions regarding the Universally Unique Identifier (UUID) Cross Payor Encryption Algorithm should be directed to Mr. Adrien Ndikumwami at (301) 628-3262 or by email at ANdikumwami@s-3.com.

MASTER PATIENT INDEX (MPI) – CRISP Hashed Unique Identifier

The MCDB currently uses a software algorithm to generate Universally Unique ID's (UUIDs) for each person across payors; however, this algorithm is limited by its over-reliance on Social Security Number. This is particularly problematic for self-insured plans with carve-outs for pharmacy plans, where SSN is often not available. The Master Patient Index (MPI) technology used by the Chesapeake Regional Information System for Our Patients (CRISP), Maryland's statewide health information exchange (HIE), is not as reliant on the SSN and will establish a consistent patient identifier across all submitting MCDB payors.

In 2014, selected submitters were required to submit a Demographics File to CRISP, as part of a pilot test project. Beginning in 2015, all payors were required to participate. Moving forward, this will remain the standard requirement. Payors are required to provide limited identifiable data to CRISP, who will generate the MPI and provide an MPI to payor-encrypted ID cross-walk file to MHCC. Payors are also required to submit data to CRISP following their data specifications and Carrier Onboarding Process. The details of the file specifications and process are available at:
http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx.

Questions regarding the MPI and the CRISP onboarding process should be directed to Matthew Edelen at matthew.edelen@crisphealth.org.

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Appendix D – Special Instructions for Financial Data Elements

FINANCIAL DATA ELEMENTS – Billing and Reimbursement Information

Each of the financial data elements listed must be recorded by line item.

Professional and Dental Services file – A line item is defined as a single line entry on a bill/claim for each health care service rendered. The line item contains information on each procedure performed including modifier (if appropriate), service dates, units (if applicable), and practitioner charges. The line item also includes billed charges, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations, reimbursement amount, and amount paid by other insurance. The value represented by each financial field **must be rounded to whole dollars** (i.e., no decimals).

- *All Fee-for-Service records ("Record Status = 1")*
- *For Capitated/Global Contract Services ("Record Status = 8") billed charge, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations and reimbursement amount must be reported when available.*

Institutional Services file – A record is defined as a single claim line corresponding to the revenue code or procedure code used for billing during during a stay or visit at an institution. The billed charges, allowed amount, and amounts paid by the payor and patient should reflect the charges for the revenue code or procedure on the claim. The value represented by each financial field **must be rounded to whole dollars** (i.e., no decimals).

Pharmacy file – A line item is defined as a single line entry on a prescription service. The line item contains information on each prescription filled, including date filled, drug quantity and supply. This line item also includes allowed amount, billed charge, patient deductible, patient coinsurance/co-payment, other patient obligations, reimbursement amount, and amount paid by other insurancefor each prescription. **For 2017, all financial data elements must be rounded to whole dollars (i.e. no decimals).**

FINANCIAL DATA ELEMENTS	Professional, Dental, and Institutional Services Data	Pharmacy Data
Billed Charge	*Dollar amount as billed by the practitioner/institution for health care services rendered.*	*Prescription retail price including ingredient cost, dispensing fee, tax, and administrative expenditures. Payors must provide the retail price.*
Allowed Amount	*The maximum amount that a health insurer carrier is willing to pay for a specific service, including the patient's liable amount. For in-network providers the allowed amount is a negotiated discounted fee based on the contracts with the providers.*	*Maximum amount contractually allowed (discounted amount). This is generally equal to the sum of patient liability and payor reimbursement.*
Patient Deductible	*Fixed amount that the patient must pay for covered services before benefits are payable.*	*Fixed amount that the patient must pay for covered services before benefits are payable.*
Patient Coinsurance/ Patient Co-payment	*Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.*	*Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.*

FINANCIAL DATA ELEMENTS	Professional, Dental, and Institutional Services Data	Pharmacy Data
Other Patient Obligations	*Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.*	*Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.*
Note: Patient Deductible, Patient Coinsurance/Patient Co-payment, and Other Patient Obligations are used to calculate Total Patient Liability. Please make an effort to provide this financial information.		
Reimbursement Amount	*Amount paid to a practitioner, other health professional, office facility, or institution.*	*Amount paid to the pharmacy by the payor.*
Amount Paid by Other Insurance	*Amount paid by the primary payor if the payor is not the primary insurer.*	*Amount paid by the primary payor if the payor is not the primary insurer.*

Appendix E – MCDB Portal Instructions

MEDICAL CARE DATA BASE PORTAL SUBMISSIONS

In order to submit files to the MCDB Portal for the 2015 data submission period, each payor will need to have their primary point of contact reach out to Social & Scientific Systems, Inc. in order to request an administrative account. An administrative account will then be created for the individual designated to be the administrator in the contact email. The administrator will then receive a user name, as well as instructions with how to log-in at www.mcdbportal.com in order to submit data.

In order for data submissions to be properly processed, a payor will need to ensure that all of the following is accurate:

Tier 1 Checklist	
	All files match file width specifications.
	All files match column length specifications.
	Each field matches expected field length value.
	Record count matches the reported value during file submission.
	Delimiter selected when necessary (Portal accepts flat file, pipe (|), and comma (,) delimiters).
	File naming conventions are followed.
	Source system is reported for each file.
	If resubmitting, files being replaced from previous upload are deleted.
	If resubmitting, files not being replaced are also "readied" in order to process submission.
Tier 2 Checklist	
	All fields meet expected thresholds for validity in the Data Element Validation Report.
	Fields which do not meet the expected threshold have requested waivers.
	Review fields in the Inter-Field, Intra-Field, or Referential Integrity data reports that are flagged with warnings to ensure there are no reporting errors.

Should a payor have any problems while trying to submit files, they can submit questions to: mcdbportal@s-3.com. In the event of an issue requiring immediate assistance, contact either Adrien Ndikumwami at andikumwami@s-3.com (301-628-3262) or Alexander Bruce at abruce@s-3.com (301-628-3380).

File Naming Conventions

The following naming convention is in effect for all data reports. The indicators are separated by the _ (underscore) symbol: **PayorID_File_Version_Date**

Payor ID:	MHCC assigned payor ID number
Files:	Professional Services Data Report = ProfServ Pharmacy Data Report = Pharm Provider Directory Report = Prov Institutional Services Data Report = InstServ Eligibility Data Report = MedElig Dental Data Report = Dental
Version:	Submission order *(Note: If the submission is returned, the following sequence should be incremented by one letter in the alphabet.)*
Date:	Month/Day/Year = MMDDYY
Example:	P123_ProfServ_A_053117 P123_ProfServ_B_061517 P123_ProfServ_C_063017 P123_Pharm_A_053117 P123_Pharm_B_061517 P123_Pharm_C_063017 P123_Prov_A_053117 P123_Prov_B_061517 P123_Prov_C_063017 P123_InstServ_A_053117 P123_InstServ_B_061517 P123_InstServ_C_063017 P123_MedElig_A_053117 P123_MedElig_B_061517 P123_MedElig_C_063017 P123_Dental_A_053117 P123_Dental_B_061517 P123_Dental_C_063017

Appendix F – Frequently Asked Questions (FAQ)

Q. How do I submit data?

A. To submit data, you will need to access the MCDB Portal at www.mcdbportal.com. Contact SSS by email at mcdbportal@s-3.com to receive an administrative account. From there, you can log into the MCDB Portal and access the MCDB Portal User Guide under the tab "Documents." This will provide a comprehensive guide to the various features of the MCDB Portal. Please see Appendix E for further instructions on submission requirements.

Q. What is a source system?

A. A source system is an individual business entity or platform from which data are gathered. Source systems are required so that, in the event of errors within the data, the source of the data can be accurately identified. If you only have one source for your data, or you do not need to identify the source of your data, please report your source system as "A."

Q. Are there any other methods to submit data to the MCDB other than using the Portal?

A. No, the MCDB Portal is the only method to submit data to the MCDB.

Q. How do I know if I need to request a format modification waiver?

A. Format modification waivers need to be requested in one of two instances:

1) If a specific field is captured in a number of characters that do not correspond with the number of characters required in the File Record Layout Guide, a waiver is required for the new character length of the field that will be submitted in the file.

2) If a specific field requires a certain threshold percentage of records to be filled in order to be accepted, a waiver is required if that particular threshold cannot be met. Keep in mind that unknown values do not contribute to a field meeting the required threshold percentage.

Q. What information is needed when requesting a format modification waiver?

A. When submitting a request for a format modification waiver, include the target threshold you plan to reach for the threshold in question, if applicable, or the required field length of the data element in question. Provide an explanation for why the threshold is necessary, as well as a plan for remediation for future data submissions so that the waiver will no longer be necessary.

Q. Are the terms "patient" and "enrollee" synonymous?

A. Yes. "Patient" is the term used in claims files, while "enrollee" is used in the eligibility file.
Q. Should members without activity in the submission quarter be included in the eligibility file?

A. Yes, please include all members whether they have been active during the submission quarter or not.

Q. Should files be encrypted or compressed before being submitted?

A. No, please submit all files as text documents in a flat-file format, selecting either the pipe (|) or comma (,) delimiter on the MCDB Portal that may apply to your file.

Q. Which records should be included in each quarterly submission?

A. All claims that were paid in the current reporting quarter should be included in the claims files. No other filters should be used. Do not filter claims by coverage during the current reporting quarter or service dates within the quarterly range.

For Eligibility and CRISP files, all enrollees that were covered during the current reporting quarter should be included.

Q. Should claims which were paid in a previous quarter and later voided be reported?

A. Report all paid claims in the reporting quarter in which they were paid, regardless of whether they were voided in the future. Additionally, report adjustments to claims in the quarter in which the adjustment occurred. The original claim and all adjustment records must be submitted. In the case that a claim was paid in a previous quarter and adjusted in the current, the adjustment should be reported in the current quarter. Please indicate records that represent an adjustments to claims by using the field "Claim Line Type."

Q. Are the terms "claims paid date" and "adjudication date" synonymous?

A. No, Claim Paid Date is the date that the claim was paid. This date should agree with the paid date the Finance and Actuarial departments are using in your organization. Adjudication date is the date that a decision was made whether to approve, deny, void, or adjust a claim. If this definition does not match your system, please contact MHCC to get advice on which date to use.

Q. How do I populate a field when I have no information to provide?

A. Use a "Not-Coded/Unknown" or "N/A" code from the data submission manual to populate missing fields, such as "9" for Patient Covered by Other Insurance Indicator. Such records do not count toward meeting threshold requirements. When the manual does not specify such a code for the field, simply leave the field blank.

Q. I submitted "9 – Unknown" for all values for a field, but the Portal says I reported 0%. Why am I failing?

A. Unknown and blank values do not contribute to threshold requirements. If you are submitting all unknown values for a particular field, please request an accompanying waiver.

Q. I thought I was supposed to submit some financial fields with implied decimals?

A. The reporting of financial and units fields have been streamlined across all files, including Pharmacy. Report all financial and units fields as whole numbers without decimal places (rounded to the nearest whole number). For example, if a financial field was collected as "154.95," it would be reported as "155" because 155 is the amount rounded to the nearest whole dollar.

Q. Do I use leading zeroes when reporting Revenue Codes?

A. Leading zeroes should always be included in Revenue Codes.

Q. How do I format dates for MCDB and CRISP files?

A. CRISP files require dashes included in dates, while MCDB files do not.

- MCDB date: YYYYMMDD, "20160101"
- CRISP date, YYYY-MM-DD, "2016-01-01"

Q. How do I format phone numbers for CRISP files?

A. Include dashes in all domestic phone numbers; the only acceptable format for these numbers is ###-###-####" (without spaces). International numbers should include country code. Since this field is a warning field, it will not show a Tier 2 "red" rejection on the Details page, but may trigger a "yellow" warning. Therefore, check that the field is populated correctly after submitting by checking the Tier 2 Data Element Validation report. The column "Percent Failed Other" shows the percentage of records that contain invalid values, including phone numbers that were not supplied with the dashes.

Q. What do I do if Encrypted Enrollee ID-P changes?

A. Encrypted Enrollee ID-P must be consistently encrypted throughout the submission history. Please notify SSS and MHCC of any changes in encryption. If change is necessary, a crosswalk of old and new Patient IDPs is necessary for each enrollee.

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