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

MCDB

2022 MEDICAL CARE DATA BASE

DATA SUBMISSION MANUAL

Maryland Health Care Commission
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COMAR 10.25.06 – MARYLAND **M**EDICAL **C**ARE **D**ATA **B**ASE **(MCDB) S**UBMISSION **M**ANUAL

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DATA SUBMISSION MANUAL

INTRODUCTION

PURPOSE: The 2022 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 2021 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 https://mhcc.maryland.gov/mhcc/pages/apcd_mcdb/apcd_mcdb_data_submission.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 <u>not</u> be enforcing data collection from privately insured <u>ERISA self-funded</u> 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 2022 Data File Record Layout Guide, available on the MHCC website at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb_data_submission.aspx

Reporting entities are responsible for performing internal data quality checks in advance of submitting data to the MCDB Portal. This is to ensure a timely data submission process.

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 plans on or off the Maryland Health Benefit Exchange (MHBE), membership and allowed claims data in the MCDB <u>must</u> 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 Memoranda and rate filings.** The Individual and Small Group markets (Non-Grandfathered Health Plans only) are affected by this MCDB versus MIA

data reconciliation, and discrepancies not within -2.5% and +2.5% require explanation and may require resubmission. 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 covered regardless of whether or not the enrollee received any covered services during the reporting quarter. Based on quarterly reporting, an enrollee with three months of coverage will have three eligibility records; an enrollee with one month of coverage will only have one 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. All payors are required to submit a Demographics File to the MCDB Portal, which is used to generate the MPI. 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 <u>must</u> 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 2022 Q1 and the corresponding claim was paid in 2022 Q2, then the member's eligibility information must be in the Eligibility Data Report for 2022 Q1, and the claim should appear in the Professional Services Data Report for 2022 Q2. The member should only appear in the Eligibility Data Report for 2022 Q2 if the member was still eligible for benefits during 2022 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**, 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.

For inpatient facility (hospital and non-hospital), each line is defined by revenue code. Outpatient lines and lines for observations stays shall also have one procedure code associated with the revenue code. Inpatient lines shall have a procedure code taken from the trailer and transposed, providing the principal procedure code (if any) on claim line number 1, with all remaining procedure codes in subsequent lines, and blanks for any lines for which a procedure code cannot be attached. If no principal procedure code is available, then all procedure codes must be transposed from the claim form and attached one-by-

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one to each line, with blanks for any lines to which a procedure code cannot be attached. Appendix F provides detailed examples of the transpositions necessary to fulfill these requirements.

All diagnosis codes should be repeated on all lines of a claim, regardless of the type of facility in which the service was provided. **Note: All payors shall provide all facility claims (received on UB-04 claims forms only) for freestanding ambulatory surgical centers, and freestanding radiology centers in the institutional services report. The MHCC shall assess both the quality and completeness of data regarding services provided at these facilities and shall request additional information if necessary from data submitters to confirm the integrity of each submission.**

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. Each row that represents an individual practitioner associated with an organization shall have both the individual practitioner NPI and the associated organizational NPI value, billing tax ID, and multi-practitioner HCO indicator in the applicable fields.

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 payors with Qualified Dental Plans, information about dental plan enrollment should also be included. All payors are required to submit a Demographics File to the MCDB Portal, which is used to generate the MPI. 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 payment types include but are not limited to the following: shared savings payments, incentive or performance payments, fixed transformation payments, capitated plans, global payments, Carve-outs (Behavioral Health & Pharmacy), Managed Care (Medicaid & Commercial), Back-end-settlements, Pay for Performance, Case management fees, Rebates, contingent premiums, payments to patients/incentives, patient centered medical home payments, Provider revenue/settlements, surcharge to providers, increased fee schedules 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.

PROTECTION OF CONFIDENTIAL INFORMATION IN SUBMISSIONS:

Protection of Confidential Information Generally and in Submissions: Requirements of Code of Maryland Regulations (COMAR) 10.25.06.06.A).
Filing Data Using Encryption.
   (1) To assure that confidential records or information are protected, each reporting entity shall encrypt each of the following data elements in such a manner that each unique value for a data element produces an identical unique encrypted data element:
       (a) Patient or Enrollee Identifier; and
       (b) Internal Subscriber Contract Number.

Please note, that in Section (1) (b) above, Internal Subscriber Contract number means the following:
    (i)   Subscriber ID Number (Field ID E046 in the DSM Excel File Record Layout Guide) and
    (ii)   Encrypted Contract or Group Number (Field E028 in the DSM Excel File Record Layout Guide)

==**Reporting Entity Certification of Encryption of Patient/Enrollee Identifiers, Internal Subscriber Numbers, and Contract Numbers for all MCDB submissions relevant to a reporting quarter (Note: The following Certification of Encrypted Patient/Enrollee Identifiers, Internal Subscriber Numbers, and Contract Numbers does not apply to the CRISP Demographics file. However, Encrypted Patient/Enrollee Identifiers must be present on both the CRISP Demographic file and the MCDB Eligibility File.):**== A certifier from each reporting entity organization shall certify in writing that all Encrypted Patient Identifiers (Enrollee ID-P values), Internal Subscriber Numbers, and Contract Numbers are encrypted by submitting a signed/witnessed certification form. (See Appendix G for the Certification form.)

- The certifier shall submit the signed certification form via the MCDB Portal for every reporting quarter. If the certifier has not signed the certification for a particular reporting quarter, the reporting entity will not be allowed to upload or submit any files for that particular quarter. Please note that the certification will cover subsequent resubmissions within the quarter.

- Each reporting entity shall provide to the MHCC and the MHCC's vendor (OnPointOnpoint Health Data), the name, title, and contact information of the certifier and provide any updated information if the name, title, and/or contact information of the certifier changes. (See Appendix G for reporting form.)

- The certifier shall have an active account on the MCDB Portal. Appendix E includes more information regarding how to obtain MCDB Portal accounts.

- The MCDB Portal will display the certification form found at Appendix G for the certifier to review and electronically sign with their information.

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.

2022 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 in each report that clears all validation steps by the date of the deadline or approved extension, the 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.

It is the responsibility of all reporting entities to perform data quality checks on their data before reporting to the MCDB Portal.

Please note that the "***Final Data Submission Due***" date shown in the table below means that all payors must report "***clean***" data to the MCDB portal **on or before** the final data submission due date. ***Clean*** data means data that have passed all validation checks performed by the MHCC's vendor (OnPointOnpoint Health Data). All data submissions that have **not** passed all validation checks by the final data submission due date or approved extension date are considered **late**. Penalties (COMAR 10.25.12) due to late data submissions as described above will apply.
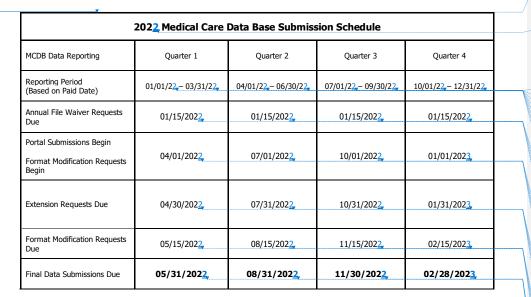
2022 Medical Care Data Base Submission Schedule				
MCDB Data Reporting	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reporting Period (Based on Paid Date)	01/01/22 – 03/31/22	04/01/22 – 06/30/22	07/01/22 – 09/30/22	10/01/22 – 12/31/22
Annual File Waiver Requests Due	01/15/2022	01/15/2022	01/15/2022	01/15/2022
Portal Submissions Begin Format Modification Requests Begin	04/01/2022	07/01/2022	10/01/2022	01/01/2023
Extension Requests Due	04/30/2022	07/31/2022	10/31/2022	01/31/2023
Format Modification Requests Due	05/15/2022	08/15/2022	11/15/2022	02/15/2023
Final Data Submissions Due	**05/31/2022**	**08/31/2022**	**11/30/2022**	**02/28/2023**

ANNUAL FILE WAIVER, FORMAT MODIFICATION, and EXTENSION REQUESTS

Reporting entities 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 E. 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.

Reporting entities are reminded to submit format modification requests only for those data elements that have an assigned threshold value. It is important that Reporting entities 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. Reporting entities 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 <u>no data to report</u> with **ZEROS**— except the financial fields for capitated/global contract services (see below) and the amount paid by other insurance.
  - If an entry is less than the allowed field length for that field. 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 <u>no data to report</u>.
  - **DO NOT** use filler values to indicate blank fields, such as "U", "*", "UNKNOWN", or "N/A", etc.

Other qualitative data needed by the 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 2022 SUBMISSION DATA

There will be no documentation necessary for 2022 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

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The record layout and data element specifications are available for download at
http://mhcc.maryland.gov/mhcc/pages/apcd_mcdb/apcd_mcdb_data_submission.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 the 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 2022 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 (2021-2022)

- 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 G – REPORTING ENTITY CERTIFICATION OF SUBMISSION OF ENCRYPTED PATIENT/ENROLLEE IDENTIFIERS, INTERNAL SUBSCRIBER NUMBERS AND CONTRACT NUMBERS

Appendix A – Change Log (2021-2022)

Major Changes to 2022 Data Submission Manual:

- **New and Modified in 2022 DSM (Page numbers reference 2022 DSM)**
  - Updated email addresses of contact person(s) from OnPoint Health Data.

Major Changes to 2022 File Record Layout Guide:

- **Professional Services –**
  - No changes
- **Pharmacy Services –**
  - No changes
- **Institutional Services –**
  - No changes
- **Dental Services –**
  - No changes
- **Eligibility –**
  - No changes
- **Provider –**
  - No changes
- **Field Index –**
  - No changes

Appendix B – Glossary of Reporting Entity Definitions

Reporting entity – A payor or a third party administrator that is designated by the Commission to provide reports to be collected and compiled into the Medical Care Data Base.

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) a third party administrator registered under Insurance Article, Title 8, Subtitle 3, Annotated Code of Maryland.

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

Two Party Coverage – This policy type includes Individual plus other adult or Individual plus partner. Note that other adult or partner is someone who is not subscribers spouse or children.

Appendix C – Patient, Plan, and Payor Identifiers

In the MCDB there 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 the 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) The Payor Encrypted Patient Identifier, which is the payor's internal identifier for the member; (b) the Universally Unique Identifier (UUID), which is generated by the payor using an encryption algorithm provided by the MHCC; and (c) the Master Patient Index (MPI), which is created by the State Designated Health Information Exchange (HIE) on behalf of the MHCC based on data provided by payors to the MCDB Portal.

Beginning in 2018, the Universally Unique Identifier (UUID) will no longer be required to be reported by payors. The payor encrypted ID is still 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 demographic data to the MCDB Portal, which the HIE will use to generate the MPI and provide a cross-walk of the payor-encrypted ID and MPI to the MHCC. Additional details regarding the MPI is provided below.

Encrypted Enrollee ID-P values are alphanumeric values of at least 3 characters that uniquely identify an enrollee consistently throughout the submission history, that do not contain as whole or in-part, any values that can lead to an individual's identification absent the other information in the record. These values must always be consistently encrypted throughout the submission history. Similar requirements apply for the internal subscriber number and contract number values. Beginning in year 2019, an individual designated by the reporting entity organization shall submit, along with each required MCDB data report, a signed, certification form certifying that all Payor Encrypted Patient Identifiers (Enrollee ID-P values), internal subscriber numbers, and contract numbers have been encrypted prior to submission of each MCDB data report to the MCDB Portal. (This certification form can be found at Appendix G.) Each reporting entity shall provide written up-to-date information on the designated representative's name, title, and contact information to the MHCC and the MHCC's vendor (OnPointOnpoint Health Data). Additionally, each certifier shall have an active account on the MCDB Portal. Appendix E includes more information regarding how to obtain MCDB Portal accounts.

Payors must notify the MHCC's vendor (OnPointOnpoint Health Data) and the MHCC of any changes in the encrypted enrollee ID-P scheme and explain why the identifiers must change. The MHCC and OnPointOnpoint Health Data will discuss options with payor representatives for ensuring that the encrypted enrollee identifier-P values are consistent within the MCDB for unique individuals across time.

MASTER PATIENT INDEX (MPI) – CRISP Hashed Unique Identifier

The MCDB previously used a software algorithm to generate Universally Unique ID's (UUIDs) for each person across payors; however, this algorithm was limited by its over-reliance on Social Security Number. This was 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 through the MCDB Portal, who will generate the MPI.

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 if data are available by line-item. Report all financial fields at the most granular level that is available in the data warehouse for that particular field and source system. For a particular field, if financial information is not available at the line-level and only at the claim-level, report the total value in the first line of the claim and the value 0 in subsequent lines for that particular field. Appendix F contains a detailed example.

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 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).

If line-level financial information is not available for a particular financial field, but claim-level information is, then the first claim line should have the total value for the claim inserted into that field, while all subsequent lines must have the value 0. Appendix F contains an example of claim lines submitted in this case.

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 insurance for each prescription. **From year 2016 onward, 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.*	*Reported maximum contractually allowed (discounted amount). This amount approximately equals to the sum of payor reimbursement amount (excludes patient liable amount) and patient liability. The allowed amount should be a reported field, not calculated. Please leave blank if not reported.*
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.*
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.*
Plan Prescription Drug Rebate Amount	*N/A*	*Amount passed along to the client.*
Member Prescription Drug Rebate Amount	*N/A*	*Amount passed along directly to the member.*
Network Administrative and Access Fees	*Liable amount paid by an insurer for the administration of its members claims and access to out of area provider networks*	*Liable amount paid by an insurer for the administration of its members claims and access to out of area provider networks*

Appendix E – MCDB Portal Instructions

MEDICAL CARE DATA BASE PORTAL SUBMISSIONS

In order to submit files to the MCDB Portal for the 2022 data submission period, each payor will need to have their primary point of contact reach out to Onpoint Health Data to request an administrative account. Payors must provide updates to the MHCC and the MHCC's vendor (OnPointOnpoint Health Data) regarding the current contacts at the organization, including information regarding individuals who are no longer representing the organization.

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 cdm.onpointhealthdata.org. Payor administrators are responsible for assigning additional "user accounts" through the Portal's Administration screen. In brief, "user accounts" have permission to upload files and request waivers. Administrators have the same basic permissions as "user accounts" and also the permission to add and deactivate users and to submit all uploaded files for full processing.

Beginning in 2019, a certifier from each payor organization must certify that the Enrollee ID-P values are encrypted by signing a letter. It is the responsibility of every payor to appoint such an individual within their organization and provide up-to-date information on the individual's name, title, and contact information to the MHCC and the MHCC's vendor (OnPointOnpoint Health Data). Additionally, this individual must have an active account on the MCDB Portal.

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	
	Field lengths do not exceed maximum values per File Record Layout Guide (FLRG).
	Record count matches the reported value during file submission.
	Delimiter selected when necessary (Portal accepts pipe (|), and comma (,) delimiters).
	File naming conventions are followed.
	Source system is reported for each file.
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: md-support@onpointhealthdata.org. In the event of an issue requiring immediate assistance, contact Data, Wes Davie, at wdavie@onpointhealthdata.org or by calling 207-623-2555.

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: The 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
                          CRISP Demographics Report=CRISP

Version: Submission order *(Note: If the submission is returned, the following sequence should be incremented by one letter in the alphabet.)*

Date: File created date
                          Month/Day/Year = MMDDYY

Example: P123_ProfServ_A_053119
                          P123_ProfServ_B_061519
                          P123_ProfServ_C_063019

                          P123_Pharm_A_053119
                          P123_Pharm_B_061519
                          P123_Pharm_C_063019

                          P123_Prov_A_053119
                          P123_Prov_B_061519
                          P123_Prov_C_063019

                          P123_InstServ_A_053119
                          P123_InstServ_B_061519
                          P123_InstServ_C_063019

                          P123_MedElig_A_053119
                          P123_MedElig_B_061519
                          P123_MedElig_C_063019

                          P123_Dental_A_053119
                          P123_Dental_B_061519
                          P123_Dental_C_063019

                          P123_CRISP_A_053119
                          P123_CRISP_B_061519
                          P123_CRISP_C_063019

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 cdm.onpointhealthdata.org. Contact Onpoint Health Data by email at md-support@onpointhealthdata.org 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 (fields P052, R029, I143, T035, E043, D017, C031) 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. Ensure that the values in the encrypted enrollee ID-P, internal subscriber number, and contract number fields are indeed encrypted and cannot be used to identify an individual person absent the other information in the data row.

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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 (fields P016, R020, I014, T015) 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 (fields P061, R033, I168, T076) 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 the 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 (field I144).

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 (fields P002, R002, I002, T002, E002, C003) must be consistently encrypted throughout the submission history. Please notify Onpoint Health Data and the MHCC of any changes in encryption and explain why the identifiers must change. The MHCC and Onpoint Health Data will discuss options with payor representatives for ensuring that the encrypted enrollee identifier-P values are consistent within the MCDB for unique individuals across time.

Q. In the Eligibility file, when the coverage is not from an ACA-compliant plan, how should the cost-sharing reduction indicator be populated (field E051)? How should the metal level plan indicator be populated (field E050)?

A. Please leave these two fields empty when the coverage is not from an ACA-compliant plan. The validation for these fields is relevant only to the coverage types that are ACA compliant (coverage types B and C for the MHBE plans, and coverage types 3 and 8 for non-MHBE ACA compliant plans).

Q. When submitting a fixed format file, how is the length of each row and field validated in Tier 1? How does the validation differ for validation for a delimited format file?

A. Regardless of the file format submitted, whenever a single field is longer than what is specified in the file record layout guide (in any row), a length waiver is required for that field.

When a file is submitted in delimited format, the following properties of the columns and rows are checked in Tier 1:
- The number of fields in every row should be exactly what is specified for the file type. For each row, this is calculated by adding 1 to the count of the number of delimiters found in that row. For example, there should be 50 delimiters (= 51 fields) found for every row in the 2022 eligibility file because the file record layout guide lists 51 fields.
- Each field (bytes between two delimiters) should not be longer (shorter is fine) than what is specified in the file layout for that file type. The length of each field is in the "Length" column of the file record layout guide.

Q. How should financial fields be populated on the line-level institutional file, if only claim-level financial information is available for a particular field?

A. Report all financial fields at the most granular level that is available in the data warehouse. If financial information is not available at the line-level but is available at the claim-level, report the claim-level value in the first line of the claim and the value 0 in subsequent lines.

Below is an example of how a reporting entity must submit data where the data warehouse contains only claim-level information regarding a billed charge, but line-level information for other fields. This service was submitted for claim adjudication to only one payor, and thus the field "amount paid by other insurance" is submitted blank.

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For every row, the length of the entire row should be exactly the value of the ending position of the last column indicated in the file record layout guide (e.g. the entry in the column "End" of the very last field for that file type). For example, in the 20212022 eligibility file, there should not be any row with more or less than 257 characters-or-spaces (bytes). The length of the row must be exactly 257 bytes.

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Claim line number	Billed Charge	Allowed Amount	Reimbursement Amount	Patient Copayment	Patient Deductible	Other Patient Obligations	Amount Paid by Other Insurance
1	5000	800	600	25	0	5	
2	0	500	450	25	0	5	
3	0	300	200	25	0	5	
4	0	250	50	25	0	5	

Q. How must payors provide procedure codes for inpatient, outpatient, and observation services in the Institutional Services file?

A. In the Principal Procedure Code 1 (Field I085), at least 85% of outpatient services and observations stays must have valid HCPCS or CPT codes, and at least 85% of inpatient services must have valid ICD-10-PCS codes for services beginning on or after October 1, 2015 or ICD-9-CM for services before October 1, 2015. For the inpatient, outpatient, and observation cases, each row in the submitted file represents one revenue code and associated financial information for that revenue code. The procedure code (Field I085) is populated according to whether the service was inpatient, outpatient, or an observation. The result is that every row should have both a revenue code and a procedure code in the outpatient and observation case.

Because inpatient claims have procedure codes that do not directly relate one-to-one with revenue codes, inpatient rows contain a procedure code whose form position is equal to that of the line number in the submitted MCDB row.

Below is an example of the data transformation from a typical claim form to the required MCDB layout for the outpatient and inpatient cases. The lines that indicate observation should follow the outpatient example.

Outpatient: (minimal changes)

Claim form entries

Line Number	Revenue Code	Procedure code	Allowed Amount
1	0402	A4215	400.05
2	0214	A4649	100.99
3	0481	A6228	50.75

MCDB fields

Line Number	Revenue Code	Procedure code	Allowed Amount
1	0402	A4215	400
2	0214	A4649	101
3	0481	A6228	51

Inpatient: (transposition of procedure codes is required):

Claim form entries

Line Number	Revenue Code	Allowed Amount
1	0402	400.05
2	0214	100.99
3	0481	50.75

MCDB fields

Line Number	Revenue Code	Procedure Code	Allowed Amount
1	0402	8E0WXY8	400
2	0214	B020ZZZ	101
3	0481		51

Claim header

Procedure Code 1	Procedure Code 2	Procedure Code 3
8E0WXY8	B020ZZZ	

Q. In the "Protection of Confidential Information", under Code of Maryland Regulations (COMAR 10.25.06.06), what are the Field Names and Field IDs of payor encrypted fields in the Eligibility and Claim files that shall be certified as encrypted by the certifier from each reporting entity organization?

A. Under Code of Maryland Regulations (COMAR)10.25.06.06, the table below shows the Field Names and Field IDs of payor encrypted fields in the Eligibility and Claims files that shall be certified as encrypted by the certifier from each reporting entity. The CRISP demographic file is exempted from this attestation as unencrypted identifiers are needed for CRISP organization to create the Master Patient Index for the MHCC. However, the "Encrypted Enrollee's IdentifierP" that is in the CRISP demographic file must match the "Encrypted Enrollee's IdentifierP" in the Eligibility file.

Eligibility file	Field ID
Encrypted Enrollee's IdentifierP	E002
Encrypted Enrollee's IdentifierU	E003
Encrypted Contract or Group Number	E028
Subscriber ID Number	E046

Professional Services file	Field ID
Encrypted Enrollee's IdentifierP	P002
Encrypted Enrollee's IdentifierU	P003

Institutional Services file	Field ID
Encrypted Enrollee's IdentifierP	I002
Encrypted Enrollee's IdentifierU	I003

Dental Services file	Field ID
Encrypted Enrollee's IdentifierP	T002
Encrypted Enrollee's IdentifierU	T003
Encrypted Contract or Group Number	T036

Pharmacy Services file	Field ID
Encrypted Enrollee's IdentifierP	R002
Encrypted Enrollee's IdentifierU	R003

Appendix G – Reporting Entity Certification of Submission of Encrypted Patient/Enrollee Identifiers, Internal Subscriber Numbers, and Contract Numbers

Payor Certification of Encrypted Patient Identifiers, Encrypted Internal Subscriber Numbers, and Encrypted Contract Numbers

The undersigned hereby certifies that all Medical Care Database (MCDB) data files provided to the Maryland Health Care Commission (MHCC) and the MHCC's Vendor Onpoint Health Data (Onpoint) via the MCDB Portal for 2022, Quarter 1 will NOT include any Payor unencrypted Patient identifiers, unencrypted Internal Subscriber Numbers or unencrypted Contract numbers.

Certifier Name:

Jane Doe

Certifier Signature:

Type your full name

Certifier Job Title:

Regulatory Compliance Analyst

Certifier Current Phone Number:

301-628-3000

Certifier Current Email address:

name@yourdomain.com

Date and Time

January 29, 2022 13:00

I certify under penalties of perjury that the contents of this certification are true to the best of my knowledge, information, and belief.

Certif

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Payor Certification of Encrypted Subscriber Numbers, and Encrypt

The undersigned hereby certifies that all M Health Care Commission (MHCC) and the N MCDB Portal for 2020, Quarter 1 will NOT i Internal Subscriber Numbers, or unencrypt

Certifier Name:

Jane Doe

Certifier Signature:

Type your full name

Certifier Job Title:

Regulatory Compliance Analyst

Certifier Current Phone Number:

301-628-3000

Certifier Current E-mail Address:

name@yourdomain.com

Date and Time:

January 29, 2020 13:00

☐ I certify under penalties of perjury that t knowledge, information, and belief.

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