MARYLAND Health Care Commission

DRAFT

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

MCDB

2024 MEDICAL CARE DATA BASE

DATA SUBMISSION MANUAL

Maryland Health Care Commission
CENTER FOR ANALYSIS AND INFORMATION SYSTEMS
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MHCC.MARYLAND.GOV

To be Considered by the Maryland Health Care Commission
At its November 16, 2023 Public Meeting

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

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DATA SUBMISSION MANUAL

INTRODUCTION

PURPOSE: The 2024 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 2023 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.

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

Shankar Mesta
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Phone: (410) 764-3782
Shankar.Mesta@maryland.gov

Please direct data processing and MCDB portal inquiries to:

Gina Robertson
Onpoint Health Data
55 Washington Ave
Portland, ME 04101
Phone: (207) 623-2555
md-support@onpointhealthdata.org

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/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 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 2024 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 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 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 or SFTP. Instructions for the MCDB Portal are provided in Appendix E.

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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 or other 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
- Ambulance services
- Independent lab 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 2024 Q1 and the corresponding claim was paid in 2024 Q2, then the member's eligibility information must be in the Eligibility Data Report for 2024 Q1, and the claim should appear in the Professional Services Data Report for 2024 Q2. The member should only appear in the Eligibility Data Report for 2024 Q2 if the member was still eligible for benefits during 2024 Q2.

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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-

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.**

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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 and other services covered by pharmacy benefits.

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 HEALTHCARE (INCLUDING MEDICAL AND PHARMACY) EXPENSES REPORT: The **Non-Fee-for-Service Healthcare (Including Medical and Pharmacy) Expenses** Report **(COMAR 10.25.06.14)** will report details of non-fee-for-service payments made to providers. As part of implementation of Chapter 297 of the 2023 Laws of Maryland, on or before December 31, 2024, and annually thereafter until December 31, 2032, MHCC will report on the following information to the Senate Finance Committee and House Health and Government Operations Committee, in accordance with §2-1257 of the State Government Article:

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1. The number and type of value-based arrangements entered into;
2. Quality outcomes of the value-based arrangements;
3. The number of complaints made regarding value-based arrangement;
4. The cost-effectiveness of the value-based arrangements; and
5. The impact of two-sided incentive arrangements on the fee schedules of health care practitioners included in the target budget that are not eligible providers.

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Please see Appendix H for a description of the detailed information to be included in 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 as part of the annual Registration process with MHCC's vendor. If the certifier has not signed the certification for a particular year, the reporting entity will not be allowed to upload or submit any files for any quarter in that particular year until they have completed certification. Please note that the certification will cover subsequent resubmissions within the year.

- Each reporting entity shall provide to the MHCC and the MHCC's vendor (Onpoint 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.)

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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 Expenses
Payors	X	X	X	X	X	-	X	Testing only	X
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	
Third Party Administrators (Behavioral Health Services)	X	X	X	X	X	-	X	Testing only	
Pharmacy Benefit Managers	-	X	-	-	X	-	X	Testing only	

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

2024 MCDB DATA SUBMISSION SCHEDULE:

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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 (Onpoint 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.

2024 Medical Care Data Base Submission Schedule				
MCDB Data Reporting	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reporting Period (Based on Paid Date)	01/01/23 – 03/31/23	04/01/23 – 06/30/23	07/01/23 – 09/30/23	10/01/23 – 12/31/23
Annual File Waiver Requests Due	01/15/2024	01/15/2024	01/15/2024	01/15/2024
Portal Submissions Begin Format Modification Requests Begin	04/01/2024	07/01/2024	10/01/2024	01/01/2025
Extension Requests Due	04/30/2024	07/31/2024	10/31/2024	01/31/2025
Format Modification Requests Due	05/15/2024	08/15/2024	11/15/2024	02/15/2025
Final Data Submissions Due	**05/31/2024**	**08/31/2024**	**11/30/2024**	**02/28/2025**

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; 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.

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FORMATTING NOTES

- **PAYOR ID**
  - Each Payor ID will be assigned by the MHCC staff and will follow the below naming convention:
    - Will start with the prefix 'MD' to indicate the payor is reporting on-behalf of the Maryland APCD
    - Will include an identifier assigned by MHCC staff (for current payors this is the current Payor ID)
    - Will end with a suffix that indicates the system source code a payor is reporting if a payor is submitting a file per source system code.

- **NAMING CONVENTION**
  - Files must be submitted using the following naming convention:

    PayorID_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_Create Date

    Each variable in the above format must be populated as follows:
    - PayorID = MHCC-assigned submitter code
    - FileType = A two-character code that indicates which file is being submitted:
      - 'ME' = Eligibility
      - 'PR' = Professional
      - 'IN' = Institutional
      - 'PC' = Pharmacy
      - 'DC' = Dental
      - 'PV' = Provider
      - 'MI' = CRISP
    - PeriodStartDate (YYYYMM format)
    - PeriodEndDate (YYYYMM format)
    - RowCount (no commas)
    - ProdFlag = A one-character code that indicates whether a file is a 'Test' file or a 'Production' file:
      - 'T' = Test
      - 'P' = Production
    - FixedWidthInd = A two-character code that indicates whether a file is reported as fixed width or with delimiters:
      - 'FW' = Fixed width
      - 'DL' = Delimiters included
    - CreateDate (YYYYMMDD)

    Example: MDP020A_ME_202401_202403_45000_P_FW_20240423

- **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) and the amount paid by other insurance.

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- If a payor is reporting data using a fixed width format, any entry less than the allowed field length for that field must be right-padded with 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 a payor is reporting data using a fixed width format, any entry less than the allowed field length for that field must be right-padded with empty positions so that the specified field length is fulfilled.
  - **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 2024 SUBMISSION DATA

There will be no documentation necessary for 2024 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_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.

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SPECIAL CONSIDERATIONS for 2024 MCDB DATA SUBMISSIONS

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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 (2023-2024)
- 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 H – ALTERNATIVE PAYMENT MODEL DATA SUBMISSION MANUAL

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Appendix A – Change Log (2023-2024)

Major Changes to 2024 Data Submission Manual:

- **New and Modified in 2024 DSM (Page numbers reference 2024 DSM)**
  - Changed length of Encrypted Enrollee's IdentifierP.
  - Changed length of Encrypted Enrollee's IdentifierU.
  - Changed length of Drug quantity.
  - Changed length of servicing practitioner ID.
  - Changed length of prescribing provider ID.
  - Changed length of prescription claim control number.
  - Added additional Diagnosis Code 11 and Diagnosis Code 12.
  - Added additional procedure modifiers Procedure Modifier III and Procedure Modifier IV.

Major Changes to 2024 File Record Layout Guide:

- **Professional Services –**
  - Changed length of P002 "Encrypted Enrollee's IdentifierP" from 12 to 25
  - Changed length of P003 "Encrypted Enrollee's IdentifierU" from 12 to 25.
  - Changed length of P038 "Servicing Practitioner ID" from 11 to 15
  - Changed length of P068 "Drug Quantity" from 6 to 7.
  - Added P073 "Diagnosis Code 11".
  - Added P074 "Diagnosis Code 12".
  - Added P075 "Modifier III".
  - Added P076 "Modifier IV".
- **Pharmacy Services –**
  - Changed length of R002 "Encrypted Enrollee's IdentifierP" from 12 to 25
  - Changed length of R003 "Encrypted Enrollee's IdentifierU" from 12 to 25
  - Changed length of R013 "Drug Quantity" from 6 to 7
  - Changed length of R019 "Prescription Claim Control Number" from 15 to 20
  - Changed length of R032 "Prescribing Provider ID" from 11 to 15.
- **Institutional Services** –
  - Changed length of I002 "Encrypted Enrollee's IdentifierP" from 12 to 25
  - Changed length of I003 "Encrypted Enrollee's IdentifierU" from 12 to 25.
- **Dental Services –**
  - Changed length of T002 "Encrypted Enrollee's IdentifierP" from 12 to 25
  - Changed length of T003 "Encrypted Enrollee's IdentifierU" from 12 to 25
  - Changed length of T022 "Servicing Practitioner ID" from 11 to 15.
- **Eligibility –**
  - Changed length of E002 "Encrypted Enrollee's IdentifierP" from 12 to 25.
  - Changed length of E003 "Encrypted Enrollee's IdentifierU" from 12 to 25.
- **Provider –**
  - Changed length of D002 "Practitioner/Supplier ID" from 11 to 12
  - Changed length of D004 "Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization" from 31 to 50.
  - Updated D006, length of "Practitioner Middle Initial" from 3 to 1 character.
- **CRISP –**

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- **Field Index –**
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  - Changed length of "Practitioner Middle Initial" to 1
  - Changed length of " Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization" to 50
  - Changed length of "Servicing Practitioner ID" to 15
  - Added "Diagnosis Code 11"
  - Added "Diagnosis Code 12"
  - Added " Modifier III"
  - Added " Modifier IV"
  - Changed length of "Drug Quantity" from 6 to 7.

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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 then 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 as part of the annual Registration process within 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 (Onpoint 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 (Onpoint 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 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.

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	*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.*
Patient Co-payment	*Fixed amount that the patient must pay for covered services during every visit/service after deductible amount is paid.*	*Fixed amount that the patient must pay for covered services during every visit/service after deductible amount is paid.*
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*

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Appendix E – MCDB Portal Instructions

MEDICAL CARE DATA BASE PORTAL SUBMISSIONS

In order to submit files to the MCDB Portal for the 2024 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 and to complete the payor registration process. As part of registering to submit data to the MCDB Portal for 2024, payors will provide to the MHCC and the MHCC's vendor (Onpoint Health Data) regarding the current contacts at the organization, the type of data each payor will submit, and other organizational information about the payor. The payor will also certify as part of the registration process that their 2024 data will include encryption of required fields, as outlined in Appendix G.

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Once registration is complete, 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.

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 fixed-width files match file width specifications.
	All fixed-width files match column length specifications.
	Field lengths do not exceed maximum values per File Record Layout Guide (FLRG).
	Record count matches the reported value in the file name.
	Delimiter selected when necessary (Portal accepts flat file, pipe (|), and comma (,) delimiters).
	File naming conventions are followed.
	Source system is reported for each file.
Tier 2 Checklist	
	All fields meet or exceed 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 Validation 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 Gina Robertson at grobertson@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_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_CreateDate

Example: MDP020A_ME_202401_202403_45000_P_FW_20240423

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Payor ID: The MHCC assigned payor ID number

Files:

ME = Eligibility
PR = Professional
IN = Institutional
PC = Pharmacy
DC = Dental
PV = Provider
MI = CRISP

Period Start Date: Submission reporting period start date *(YYYYMM)*

Period End Date: Submission reporting period end date *(YYYYMM)*

Row Count: Number of rows in file (no commas)

Prod Flag: T = Test
P = Production

Fixed Width Ind: FW = Fixed width
DL = Delimiters included

Create Date: Date that file was generated *(YYYYMMDD)*

Example: MDP020A_ME_202401_202403_45000_P_FW_20240423

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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 "Documents" menu item. 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. Yes, submitters can either submit through the MCDB Portal or via SFTP. Contact md-support@onpointhealthdata.org for more information on submitting via SFTP.

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

A. Format modification waivers need to be requested 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. 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.

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.

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), the file will fail in formatting. When a file is submitted in fixed format, the following properties of the columns and rows are checked in Tier 1:

- 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 2024 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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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 2024 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.

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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.

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	A68	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
Claim header		
Procedure Code 1	Procedure Code 2	Procedure Code 3
8E0WXY8	B020ZZZ	

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

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 2024, Quarter 1 will NOT include any Payor unencrypted Patient identifiers, unencrypted Internal Subscriber Numbers or unencrypted Contract numbers.

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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, 2024 13:00

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

Certify

Appendix H – Alternative Payment Model Data Submission Manual

INTRODUCTION

The Maryland Health Care Commission (MHCC) is responsible for working with stakeholders to collaborate on a method of data collection to meet the requirements of COMAR 10.25.06.14, to develop a non-fee-for-service expenses report and incorporate the information and instructions for collection into the Commission's annual update to the MCDB Submission Manual.

Collecting non-fee-for-service data now will provide a baseline to monitor cost, utilization, and quality trends as the share of non-fee-for-service payment models grows in the Maryland commercial health care market.
This data submission manual describes the format and contents necessary to complete the Alternative Payment Model Data Collection template that will support the analyses required by Chapter 297 of the 2023 Laws of Maryland. The Data Submission Template is available at the MHCC website and will be prepared in accordance with the instructions in this manual.

Note that the Data Submission categorizes alternative payment model (APM) contracts according to the framework developed by the Health Care Payments Learning and Action Network (HCP-LAN). Established in 2015, HCP-LAN is an active group of public and private health care leaders dedicated to mobilizing payors, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduces the barriers to APM participation, and promote shared accountability. Since its inception, healthcare stakeholders have relied on the HCP-LAN to align them around core APM design components. Please submit completed Alternative Payment Models Data Submission to the Chief, Cost and Quality at the MHCC Center for Analysis and Information Systems at shankar.mesta@maryland.gov no later than September 30, 2024. If your organization does not have any APM arrangements, please request a waiver and/or submit questions to shankar.mesta@maryland.gov.

POPULATION SPECIFICATIONS

For all worksheets except "Worksheet D. Summary," payors are required to provide information only on value-based arrangements *(defined as Health Care Payment Learning and Action Network (HCP-LAN) Categories 2A-4C)* between fully-insured plans situsted in Maryland and providers with at least one Maryland location. "Worksheet D. Summary," requires summary data for individuals attributed to a value-based payment arrangement (defined as HCP-LAN Categories 2A-4C) and not attributed to one of these arrangements.

MHCC appreciates that some value-based payment arrangements may include members covered under self-insured plans, Medicare Advantage plans, Medicare Supplemental plans, or other plans. Payors may include or exclude information pertaining to any member not covered by a fully-insured plan situsted in Maryland. Use the multi-choice drop down menus to identify all insurance categories included in the row.

MHCC also appreciates that some value-based arrangements may include attributed members who do not live in Maryland. Payors may include or exclude members attributed to these arrangements who do not live in Maryland. Payors shall indicate the number of member months for Maryland residents and Maryland non-residents in the appropriate column.

MHCC recognizes that some payors only have information on subscriber state of residence not member state of residence. In these instances, payors shall assign the member to the subscriber state of residence.
Please refer to the Data Submission Template Instructions below for detailed information on the completion of the Data Submission.

DATA SUBMISSION TEMPLATE INSTRUCTION

The 2024 Data Submission Template Instructions include the following sections:

- Contents
- A.1 Financial
- A.2 Financial – Episodes
- B.1 Quality
- C. Contract Information

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- D. Summary
- E. Notes

For the 2024 Reporting Cycle, MHCC requests that all payors include data for calendar year 2023.

CONTENTS

This worksheet is an introduction sheet that:

- Captures general payor information
- Provides a table of contents
- Links to the Data Specification Manual

A1. FINANCIAL

- This worksheet collects financial information associated with certain APM contracts, defined as HCP-LAN Category 2A, 2B, 2C, 3A, 3B, 4B and 4C. Note: Financial information related to HCP-LAN Category 1 and Category 4A are not collected on this worksheet.
- Payors shall use their attribution methodology to assign members and their healthcare expenditures (excluding retail pharmacy) to the billing provider, regardless of whether the billing provider provided the service or received the payment. The billing provider is the entity which entered into the APM arrangement with the payor. Do not cap, truncate or risk-adjust payments.
- When a contractual arrangement begins during the reporting year, payors shall report the expenditures in the appropriate HCP-LAN Category. For example, if the payor enters into a shared savings contract effective August 1, 2023 (and the reporting period is CY 2023), the payor shall report the associated member months and total dollars (including FFS payments and bonus/savings incentives) paid for that population of members from August 1, 2023 – December 31, 2023.
- Given the timing of the data request, some payors may not have access to complete or final data. If complete or final information for the calendar year is not complete, payors shall provide an estimate and state the basis for the estimate on Worksheet E. Notes. Similarly, if the bonus or savings amounts are not reconciled by the time of data collection, payors shall estimate the bonus or savings payment amount (if any) and state the basis for this estimate on E. Notes.
- **Reporting Year** (Column A) **–** The year for which data is being reported. For this data collection cycle, the reporting year is 2023.
- **Billing Provider (Organization/Entity) Tax ID** (Column B) **–** Employer Tax ID # of the billing provider (organization/entity) which entered into the APM arrangement with the payor.
- **Billing Provider (Organization/Entity) Name** (Column C) **–** The name of the billing provider (organization/entity) which entered into the APM arrangement with the payor.
- **National Provider Identifier (NPI) Number of the Billing Provider (Organization/Entity)** (Column D – *Optional*)**-** The National Provider ID (NPI) of the billing provider (organization/entity) which entered into the APM arrangement with the payor.
- **Practitioner/Supplier ID** (Column E – *Optional*) **–** Payor-specific identifier for the billing provider (organization/entity) which entered into the APM arrangement with the payor.
- **Pediatric Indicator** (Column F) - Indicates if the Billing Provider is an organization/entity in which at least 75% of its patients are children up to the age of 18. The pediatric indicator should be used to separately report pediatric practices, not the subset of pediatric patients within a non-pediatric practice. To indicate pediatric patients are included input '1' for YES. To indicate no pediatric patients are included input '0' for No.
- **Insurance Category Code or Categories** (Column G) **–** A number that indicates the insurance category or insurance categories that are being reported: 1 Commercial Fully-Insured; 2 Commercial Self-Insured; 3 Medicare Advantage; 4 Medicare Supplemental; 5 Other. Please use the multi-choice drop-down menu to identify all insurance categories included in the row.
- **Maryland Resident Member Months** (Column H) **–** The number of members living in Maryland, expressed in months of membership, attributed to the billing provider as part of the HCP-LAN category arrangement identified in Column K.
- **Maryland Non-Resident Member Months** (Column I) **–** The number of members not living in Maryland, expressed in months of membership, attributed to the billing provider as part of the HCP-LAN category arrangement identified in Column K.
- **Note:** Some value-based payment arrangements, such as those classified as HCP-LAN Category 2A, may not have a defined population of attributed members. Insert a zero in Column H and Column I for these arrangements.
- **Age/Gender Factor** (Column J) **–** A factor based on the age, gender and contract type of the population used by payors during their underwriting processes. It is the ratio of the census adjusted population over the unadjusted population based on payor census factors.
- **Age Gender Factor Specifications**
- Payors should use their unique census factors for gender by age group and the populations in these groups to calculate the adjusted populations attributed to the different types of APM arrangements. These factors

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may vary depending on the number of tiers included in the calculation. Tiers include: self, self and child, self and spouse, and self and family.

- Note: Census factors for self and spouse are the same as those as self and family and therefore can be used as a three-tier calculation as needed.

- **HCP-LAN Payment Category** (Column K) – Use the drop-down menu to identify the appropriate APM HCP-LAN category (2A, 2B, 2C, 3A, 3B, 4B and 4C) for the member months identified in Column H and Column I. Payors shall attribute members on a hierarchical basis. Reporting shall occur in the category furthest along the continuum of clinical and financial risk for the provider organization.
- **Example 1:** If a member was attributed to a billing provider with an HCP-LAN Category 2B value-based payment arrangement and a billing provider with an HCP-LAN Category 3A value-based payment arrangement, the member and all of their spend and member months would be attributed to the billing provider with the HCP-LAN Category 3A arrangement.
- **Example 2:** If a billing provider is participating in multiple value-based payment arrangements, the billing provider would a have distinct row for each arrangement with the appropriate HCP-LAN Category identified. Members attributed to multiple value-based payment arrangements with the same provider shall have all of their spend and member months attributed to the HCP-LAN Category farthest along the continuum.
- **Note:** Financial information related to HCP-LAN Category 1 and Category 4A are not collected on this worksheet.
- **Total Medical Expense for Member Months Reported in Column H and Column I** (Column L) **–** Total medical expense (not including retail pharmacy) for all members attributed to the billing provider in the value-based payment arrangement, regardless of the type of payment (e.g., fee-for-service, value-based) and regardless of whether the payment was made to the billing provider identified in the row or another billing provider. Payments shall not be capped, truncated or risk-adjusted.

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A2. FINANCIAL – EPISODES

- This worksheet collects financial information associated with certain APM contracts, defined as HCP-LAN Category 4A. For the purposes of this reporting, payors should designate all episode-based payment arrangements as HCP-LAN Category 4A including those for a specific procedure, such as those designed to look similar to The Episode Quality Improvement Program (EQIP).
- Payors shall use their attribution methodology to assign episodes and all healthcare expenditures related to the episode to the billing provider. The billing provider shall be the entity which entered into the APM arrangement with the payor.
- When a contractual arrangement begins during the reporting year, the payor is expected to report the expenditures in the appropriate LAN Category. For example, if the payor enters into an episode-based payment arrangement effective August 1, 2023 (and the reporting period is CY 2023), the payor shall report the associated episodes and dollars paid for those episodes from August 1, 2023 – December 31, 2023.
- Given the timing of the data request, some payors may not have access to complete or final data. If complete or final information for the calendar year is not complete, provide an estimate and state the basis for the estimate on Worksheet D. Notes. Similarly, if the final episode payment amounts are not reconciled by the time of data collection, estimate the amounts (if any) and state the basis for this estimate on D. Notes.
- For **columns A-G**, please refer to the definitions in section A1. Financial.
- **Maryland Resident Number of Episodes** (Column H) **–** The number of episodes provided to members living in Maryland attributed to the billing provider as part of the HCP-LAN Category 4A arrangement identified in Column L.
- **Non-Maryland Resident Number of Episodes** (Column I) **–** The number of episodes provided to members not living in Maryland attributed to the billing provider as part of the HCP-LAN Category 4A arrangement identified in Column L.
- **Age/Gender Factor** (Column J) **–** A factor based on the age, gender and contract type of the population used by payors during their underwriting processes. It is the ratio of the census adjusted population over the unadjusted population based on payor census factors.
- **Age Gender Factor Specifications**
- Payors should use their unique census factors for gender by age group and the populations in these groups to calculate the adjusted populations attributed to the different types of APM arrangements. These factors may vary depending on the number of tiers included in the calculation. Tiers include: self, self and child, self and spouse, and self and family.
- Note: Census factors for self and spouse are the same as those as for self and family and therefore can be used as a three tierthreetier -tier calculation as needed.
- **Episode Type** (Column K) – The type of episodes (e.g., maternity, joint replacement) provided to members attributed to the billing provider as part of the HCP-LAN Category 4A arrangement identified in A2.

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Column J. There shall be a separate row for each type of episode arrangement entered into with billing provider (entity/organization).

- **HCP-LAN Payment Category** (Column L) – Use the drop-down menu to identify APM HCP-LAN Category 4A for the episodes identified in Column G and Column H. This worksheet only applies to Category 4A value-based payment arrangements.
- **Total Medical Expense for Member Months Reported in Column H and Column I** (Column M) **–** Total medical expense (not including retail pharmacy) for all members attributed to the billing provider in the value-based payment arrangement, regardless of the type of payment (e.g., fee-for-service, value-based) and regardless of whether the payment was made to the billing provider identified in the row or another billing provider. Payments shall not be capped, truncated or risk-adjusted.

HCP-LAN Category Hierarchy and Descriptions

HCP-LAN Category 1- Fee for Service – Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments nor provider reporting of quality data nor provider performance on cost and quality metrics. Additionally, diagnosis-related groups (DRGs) not linked to quality and value are classified as Category 1.

HCP-Lan Category 2A- Fee for Service Linked to Quality & Value – Foundational Payments for Infrastructure & Operations: Payments placed into Category 2A involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A.

HCP-Lan Category 2B- Fee for Service Linked to Quality & Value – Pay for Reporting: Payments placed into Category 2B provide positive or negative incentives to report quality data to the health plan and/or to the public. Participation in a pay-for-reporting program gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan's reporting system. Because pay-for-reporting does not link payment to quality performance, participation in Category 2B payment models should be time limited and will typically evolve into subsequent categories**.**

HCP-Lan Category 2C- Fee for Service Linked to Quality & Value – Pay for Performance: Payments are placed into Category 2C if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well; thus, providing a significant linkage between payment and quality. For example, providers may receive higher or lower updates to their FFS baseline, or they may receive a percent reduction or increase on all claims paid, depending on whether they meet quality goals. In some instances, these programs have an extensive set of performance measures that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in hospital-acquired infections. Payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets but may account for performance on a more limited set of utilization measures. Note that a contract with pay-for-performance that affects the future fee-for-service base payment would be categorized in Category 2C.

HCP-Lan Category 3A- APMs Built on Fee-for-Service Architecture – APMs with Shared Savings: In Category 3A, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. However, providers do not compensate payors for a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of-network, etc., all of the dollars associated with the attributed members can be included.

HCP-Lan Category 3B- APMs Built on Fee-for-Service Architecture– APMs with Shared Savings and Downside Risk: In Category 3B, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. Additionally, payors recoup from providers a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of-network, etc., all of the dollars associated with the attributed members can be included.

HCP-Lan Category 4A- Population-Based Payment – Condition-Specific Population-Based Payment: Category 4A includes bundled payments for the comprehensive treatment of specific condition. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering, for example, only chemotherapy payments. Additionally, prospective payments are classified in Category 4A if they are prospective and population-based, and also cover all care delivered by particular types of clinicians (e.g., primary care or orthopedics). For the purposes of this reporting, payors should designate all episode-based payment arrangements as HCP-LAN Category 4A including those for a specific procedure, such as those designed to look similar to the The Episode Quality Improvement Program (EQIP).

HCP-Lan Category 4B- Population-Based Payment – Comprehensive Population-Based Payment: Payments in Category 4B are prospective and population-based and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements in which payors and providers are organizationally distinct.

HCP-Lan Category 4C- Population-Based Payment (Column Q) **– Integrated Finance & Delivery System**: Payments in Category 4C also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of payors that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products. Additionally, it is important to note that when integrated lines of business comprise a portion of a company's portfolio, only the integrated payments count toward Category 4C.

B1. QUALITY

Payors may choose to either provide quality information on worksheet B1. Quality or flag members attributed to APM contracts defined as HCP-LAN categories (2A, 2B, 2C, 3A, 3B, 4B and 4C) in the Eligibility File the payor submits to the MD APCD and submit a roster of patients attributed to each provider group included in worksheet A1. Financial.

This worksheet collects data on the quality of care provided to members attributed to certain APM contracts, defined as HCP-LAN category 2A, 2B, 2C, 3A, 3B, 4B and 4C. Note: Quality information related to members with expenses classified as HCP-LAN Category 1 and Category 4A is not collected on this worksheet.

For each quality measure listed below, provide numerators and denominators using specifications from the National Committee for Quality Assurance. Technical specifications shall align with those used to support MHCC's data collection through its Quality and Performance Reporting Requirements. This data is currently provided by payors participating in Maryland's Health Benefit Plan Quality and Performance Evaluation System.
For **columns A-K** please refer to the definitions in section A1. Financial.

1. **Acute Hospital Utilization (AHU)–** Assesses hospital inpatient and observation stay utilization among adult commercial and Medicare health plan members. Health plans report observed rates of hospital use and expected rates of hospital use that take the member's health history into account. The observed rate and expected rate are used to calculate a calibrated observed-to-expected ratio that assesses where plans had more, the same, or fewer readmissions than expected while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the hospitalization rate across all health plans to produce a risk-standardized rate which allows for national comparison.

   Numerator (Column L) **–** Actual (observed) rates of hospital use.
   Denominator (Column M) **–** Expected rates of hospital use.

2. **Emergency Department Utilization (EDU)–** Assesses emergency department (ED) utilization among commercial (18 and older) and Medicare (18 and older) health plan members. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population. The observed and expected rates are used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less emergency department visits than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the emergency department visit rate across all health plans to produce a risk-standardized rate which allows for national comparison.

   Numerator (Column N) **-** Actual (observed) rates of ED use.
   Denominator (Column O) **-** Expected rates of ED use.

3. **Follow-up After Emergency Department Visit for Mental Illness (FUM)-** Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days.

   Numerator (Column P) **-** Number of Patients with diagnosis who received follow-up within 7 or 30 days after ED visit.
   Denominator (Column Q) **-** Number of Patients with diagnosis who had ED visit.

4. **Breast Cancer Screening (BCS)– Optional -** Assesses women 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.

   Numerator (Column R**– Optional**) **-** Number of women 50-74 who had at least one mammogram in past two years.
   Denominator (Column S**– Optional**) **-** Number of women 50-74 attributed to practice over the past two years.

5. **Comprehensive Diabetes Care (CDC)–** Assesses adults 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:
   - Hemoglobin A1c (HbA1c) testing.
   - HbA1c poor control (>9.0%).
   - Eye exam (retinal) performed.
   - Medical attention for nephropathy*
   - BP control (<140/90 mm Hg).

*This indicator is only reported for the Medicare product line.

Numerator (Column T) **-** Number of patients with diabetes who received the care and results outlined above.
Denominator (Column U) **-** Number of patients 18-75 with diabetes

6. **Risk of Continued Opioid Use (COU)–** Assesses potentially high-risk opioid analgesic prescribing practices. The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:
   - The percentage of members with at least 15 days of prescription opioids in a 30-day period.
   - The percentage of members with at least 31 days of prescription opioids in a 62-day period.

   Numerator 1 (Column V) **-** Number of members 18+ who had a new episode of opioid use that received at least 15 days of prescription opioids in a 30-day period.
   Numerator 2 (Column W) **–** Number of members 18+ who had a new episode of opioid use that received at least 31 days of prescription opioids in a 62-day period.
   Denominator (Column X) **-** Number of members 18+ with new episode of opioid use

7. **Composite Care Scores- Coordination of Care (CAHPS)** (Column Y**– Optional**)**:** Composite Care Scores are a part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey which asks consumers and patients to report on their experiences with health care services in different settings. The surveys are a product of the Agency for HealthCare Research and Quality's CAHPS program, which is a public-private initiative to develop and maintain standardized surveys of patients' experiences with ambulatory and facility-level care. Composite measures combine results for closely related items that have been grouped together.

   Composite measures combine two or more related survey items; rating measures, which reflect respondents' ratings on a scale of 0 to 10; and single-item measures.
   The CAHPS Analysis Program (also known as the CAHPS macro) calculates composite scores for the unit of comparison (e.g., health plan, physician practice) by summing the responses of the items in that composite measure. The macro calculates a mean of each item for all those who responded to that item and then calculates the mean of the individual item means.

   Getting Care Quickly – The Getting Care Quickly composite measures members' perception of how quickly they received care when it was sought in the last 6/12 months (Medicaid/Commercial). Members were asked how often they were able to:
   a. Receive needed care right away.
   b. Get an appointment for health care at a doctor's office or clinic as soon as they thought care was needed.

   Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Usually" or "Always."

   Getting Needed Care – The Getting Needed Care composite measures members' perception of how easy it was to get care from their doctor and from specialists in the last 6/12 months (Medicaid/Commercial). Members were asked how often they were able to:
   c. See a specialist when they needed on.
   d. Obtain the care, tests or treatment they believed were necessary.

   Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Usually" or "Always."

   How Well Doctors Communicate – The How Well Doctors Communicate composite measures members' perception of the quality of communication with their personal doctor in the last 6/12 months (Medicaid/Commercial). Members were asked how often their doctor:
   e. Explained things in a way that was easy to understand.
   f. Listened carefully to them.
   g. Showed respect for what they had to say.
   h. Spend enough time with them.
   i. Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Usually" or "Always."

C. CONTRACT INFORMATION

Please provide details on all existing and new contract arrangements defined as HCP-LAN Category 2A to HCP-LAN Category 4C with providers during the reporting year.

For **columns A-D** please refer to the definitions in section A1. Financial
Contract Type Name (Column E) **–** Name of arrangement. Name of contracting organization not required.
Contract Description (Column F) **–** Description of the alternative payment model contract. Please provide three to five sentences describing the nature of the contract including a summary of services provided, provider reimbursement method, and any other important details related to the purpose and structure of the contract.
Total Non-Claims Payments (Column G) – Total non-claims payments paid under the contract referenced in Column D in the reporting year.
Involves Both Claims and Non-Claims (Column H) **–** Use one of the following letters to indicate what type of payments are included:

- C = claims only
- N = non-claims only
- B = both claims and non-claims

Services Covered (Column I) **–** Use one of the following letters to indicate the type of services included:

- N = non-medical activities only
- S = specific set of medical services
- M = comprehensive medical services

Involves Measurement of Quality (Column J) **–** Use one of the following letters to indicate whether the payment arrangement involves any quality measurements:

- Y = Yes
- N = No

Involves measurement of spending targets (Column K) **–** Use one of the following letters to indicate whether the payment arrangement involves any spending targets measurements:

- Y = Yes
- N = No

Payments are prospective or retrospective (Column L) **–** Use one of the following pairs of letters to indicate whether the payments are prospective or retrospective, or if this measure is not applicable to the payment arrangement:

- PR = Prospective with retrospective reconciliation
- PN = Prospective without retrospective reconciliation
- RT = Retrospective

Payment is population based (Column M) **–** Use one of the following letters to indicate whether the payment is based on a population.

- Y = Yes
- N = No

Risk to Provider (Column N) **–** Use one of the following letters or pair of letters to indicate the type of risk/s the payment arrangement subjects providers to:

- U = Upside only
- D = Downside only
- B = Both upside and downside
- N/A = Not applicable

HCP-LAN Payment Category (Column O) **–** Payor classification of contract into HCP-LAN category.
Comments (Column P) **–**Additional comment on the associated contract arrangement.

D. SUMMARY

Population Note: This is the only worksheet that shall contain any information on members with only fee-for-service spending. Please include one row with information for any member not attributed to a value-based payment arrangement defined as HCP-LAN Category 2A-4C.

Reporting Year (Column A) **–** The year for which data is being reported.

Pediatric APM Indicator (Column B) **-** Indicates if the APM arrangement has at least 75% of its patients who are children up to the age of 18. The pediatric indicator should be used to separately report pediatric APM arrangements, not the subset of pediatric patients within a non-pediatric arrangement. To indicate pediatric patients are included input '1' for YES. To indicate no pediatric patients are included input '0' for No.

Insurance Category Code (Column C) **–** A number that indicates the insurance category that is being reported.

Total Unduplicated Member Months (Column D) – Total, unduplicated member months associated with the HCP-LAN category identified in Column F.

Total Number of Episodes (Column E) – Total number of episodes associated with an episode-based APM arrangement.

HCP-LAN Payment Category (Column F) **–** Payors shall identify the HCP-LAN category associated with the category furthest along the continuum of clinical and financial risk in their contracts with a provider organization.

Total Medical Expense (Column G) **–** Total payments associated with the HCP-LAN category by the payor for the specific insurance category code and product type across all contracts with providers.

Total Non-Claims Payments (Column H) – Total non-claims payments paid under the HCP-LAN Category referenced in Column E in the reporting year.

E. NOTES

Please provide notes to the questions asked in this worksheet and indicated in prior worksheets. In addition, please provide any additional information that may be necessary to understand payor APM contracts in Maryland.

MARYLAND Health Care Commission

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