MARYLAND
Health Care
Commission

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

MCDB

2025 MEDICAL CARE DATA BASE

DATA SUBMISSION MANUAL

Maryland Health Care Commission
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To be Considered by the Maryland Health Care Commission
At its November 16, 2024 Public Meeting

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

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DATA SUBMISSION MANUAL

INTRODUCTION

PURPOSE: The 2025 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 2024 manual are summarized in **Appendix A.** The MCDB is administered by the Maryland Health Care Commission (MHCC or Commission) and the manual and related documents are available on the Commission's website at: http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx.

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

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Please direct data processing and MCDB portal inquiries to:

mail to:Ryan Houseman
Onpoint Health Data
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Portland, ME 04101
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DESIGNATED REPORTING ENTITIES

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

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

The Commission will post known reporting entities on its website at https://mhcc.maryland.gov/mhcc/pages/apcd/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 2025 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.

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 2025 Q1 and the corresponding claim was paid in 2025 Q2, then the member's eligibility information must be in the Eligibility Data Report for 2025 Q1, and the claim should appear in the Professional Services Data Report for 2025 Q2. The member should only appear in the Eligibility Data Report for 2025 Q2 if the member was still eligible for benefits during 2025 Q2.

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

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

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

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

PHARMACY DATA REPORT: The **Pharmacy** Data Report should include all pharmacy services provided to applicable insureds during the reporting period, whether the services were provided by a pharmacy located in Maryland or out-of State (**COMAR 10.25.06.08**). This report should include services for claims paid in the reporting period, regardless of the date of service. In addition to prescription drugs, this report should also include medical supplies 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 2022 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:

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.

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.)

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.

2025 MCDB DATA SUBMISSION SCHEDULE:

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

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

Please note that the "***Final Data Submission Due***" date shown in the table below means that all payors must report "***clean***" data to the MCDB portal **on or before** the final data submission due date. ***Clean*** data means data that have passed all validation checks performed by the MHCC's vendor (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.

2025 Medical Care Data Base Submission Schedule				
MCDB Data Reporting	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reporting Period (Based on Paid Date)	01/01/25 – 03/31/25	04/01/25 – 06/30/25	07/01/25 – 09/30/25	10/01/25 – 12/31/25
Annual File Waiver Requests Due	01/15/2025	01/15/2025	01/15/2025	01/15/2025
Portal Submissions Begin Format Modification Requests Begin	04/01/2025	07/01/2025	10/01/2025	01/01/2026
Extension Requests Due	04/30/2025	07/31/2025	10/31/2025	01/31/2026
Format Modification Requests Due	05/15/2025	08/15/2025	11/15/2025	02/15/2026
Final Data Submissions Due	**05/31/2025**	**08/31/2025**	**11/30/2025**	**02/28/2026**

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.

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_202501_202503_45000_P_FW_20250423

- **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.

- 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 2025 SUBMISSION DATA

There will be no documentation necessary for 2025 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.

SPECIAL CONSIDERATIONS for 2025 MCDB DATA SUBMISSIONS

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

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

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

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

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

APPENDICES

- APPENDIX A – CHANGE LOG (2024-2025)
- 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

Appendix A – Change Log (2024-2025)

- **Institutional Services** –
    - Added I181 "Infant Birth Weight"

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*

Appendix E – MCDB Portal Instructions

MEDICAL CARE DATA BASE PORTAL SUBMISSIONS

In order to submit files to the MCDB Portal for the 2025 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 2025, 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 2025 data will include encryption of required fields, as outlined in Appendix G.

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 mailto: Ryan Houseman at rhouseman@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_202501_202503_45000_P_FW_20250423

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_202501_202503_45000_P_FW_20250423

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 2025 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.

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 2025 eligibility file because the file record layout guide lists 51 fields.
- Each field (bytes between two delimiters) should not be longer (shorter is fine) than what is specified in the file layout for that file type. The length of each field is in the "Length" column of the file record layout guide.

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

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

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

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 2025, Quarter 1 will NOT include any Payor unencrypted Patient identifiers, unencrypted Internal Subscriber Numbers or unencrypted Contract numbers.

Certifier Name:
Jane Doe

Certifier Signature:
Type your full name

Certifier Job Title:
Regulatory Compliance Analyst

Certifier Current Phone Number:
301-628-3000

Certifier Current Email address:
name@yourdomain.com

Date and Time
January 29, 2025 13:00

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

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. As part of implementation of Chapter 297 of the 2022 Laws of Maryland, on or before December 31, 2023, 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:

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.

Collecting non-fee-for-service data in 2025 will provide a baseline of 2024 data with sufficient runout for retrospective non-claims settlements 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 (APM) Data Collection template that will support the analyses required by Chapter 297 of the 2022 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.

Based on the experience and payor response to prior data collection efforts, MHCC has developed an updated APM Data Collection Template. The updated template addresses the core provisions outlined in Chapter 297 of the 2022 Laws of Maryland outlined above. It streamlines and simplifies data collection efforts by creating consistency among data submission worksheets and adopts a common framework for APM classification. The National Association of Health Data Organizations (NAHDO) has developed a Non-Claims Payment (NCP) Layout that categorizes APM arrangements according to the level of provider clinical and financial risk and the purpose of payment. As this framework is being explored by other states participating in APM and non-claims data collection, MHCC has adapted this framework for the purposes of data collection.

Designated as the Expanded Non-Claims Payment Framework (Expanded Framework),1 The Expanded Framework will allow MHCC to consolidate redundant fields, simplify data collection efforts, and establishes consistency across data collection worksheets. The Expanded Framework crosswalks to the Health Care Payments Learning and Action Network (HCP-LAN) classifications to support payors in accurately categorizing their payment arrangements. It organizes non-claims payments into specific categories, enabling MHCC to better understand how funds are allocated to achieve specific care delivery goals. It will also enable MHCC to use the same non-claims payment framework APM adoption and primary care non-claims data collection.

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, 2025. The Data Submission shall follow the naming convention: PayorID_FileType_PeriodStartDate_PeriodEndDate_CreateDate.

[1]Developed by the California Department of Health Care Access and Information (HCAI) and Freedman HealthCare, captures non-claims health care spending data. It is designed to capture data on non-claims health care spending, the purpose of those payments, and the level of risk assumed by providers.

Each variable in the above format must be populated as follows:

- PayorID = MHCC-assigned submitter code
- FileType = APM
- PeriodStartDate (YYYYMM format)
- PeriodEndDate (YYYYMM format)
- CreateDate (YYYYMM format)

Example: MDP020A_APM_202401_202412_20250925

If your organization does not have any APM arrangements, please request an annual waiver and/or submit questions to shankar.mesta@maryland.gov. When completing an annual waiver, provide reasons for the request.

POPULATION SPECIFICATIONS

For all worksheets payors are required to provide information on value-based arrangements *(defined by the Expanded Framework and Health Care Payment Learning and Action Network (HCP-LAN) Categories 2A-4C)* between fully-insured plans situsued in Maryland and providers with at least one Maryland location.
Note: In worksheet "A.1 Summary" payors are required to submit aggregate data for their members paid for vis fee-for-service only arrangements.

The APM Data Collection Template is focused on collection of fully-insured APM products. Some value-based payment arrangements may include members covered under self-insured plans, Medicare Advantage plans, Medicare Supplemental plans, or other plans. Data for self-insured plans, Medicare Advantage plans or other plans is not required. Payors may voluntarily include information pertaining to any member not covered by a fully-insured plan situsued in Maryland. Use the multi-choice drop down menus to identify all insurance categories included in the row.

Alternatively, some value-based arrangements may include attributed members who do not live in Maryland. Payors should exclude members attributed to arrangements who do not live in Maryland. Payors shall indicate the number of member months for Maryland residents only.

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 APM Data Submission Template Instructions below for detailed information on the completion of this data submission.

DATA SUBMISSION TEMPLATE INSTRUCTIONS

The 2025 Data Submission Template Instructions include the following sections:

- Contents
- A.1 Summary
- A.2 Financial
- B. Billing Provider Membership
- C. Notes

For the 2025 Reporting Cycle, MHCC requests that all payors include data for calendar year 2023 and 2024 APM arrangements. This allows for final calendar year 2023 data to be submitted with 18 months of run out and 2024 data with six months of run out. Payors shall report payments for the contract year regardless of the payment date. Payments made in calendar year 2024 for a 2023 contract, should not be included in 2024 data, but instead in 2023 data. For example, if a reconciliation payment for a 2023 contract is made in July 2024, it should be included in 2023 data.

CONTENTS

This worksheet is an introduction sheet that:

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

Payors are to provide their Payor ID, i.e., MHCC-assigned submitter code, the payor's name, and contact information for data submission follow-up as necessary.

A.1 SUMMARY

This worksheet collects summary information on members attributed to value-based payment arrangements (defined by the Expanded Framework and corresponding to HCP-LAN Categories). At a minimum, it should include one row of summary information for Maryland residents enrolled in fully-insured Maryland situsd plans who are attributed to HCP-LAN Categories 2A-4N, based on each Payment Category and Payment Subcategory combination and those in fee-for-service only arrangements. Note that MHCC requires submitters to provide summary data on Payment Category C and D, HCP-LAN 3 and 4, arrangements that are not linked to quality, in aggregate, on this worksheet using the Quality Indicator field.

Reporting Year (Column A) **–** The year for which data is being reported. For 2025 data collection cycle, the reporting year is 2023 or 2024.

Insurance Category Code (Column B) – 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. Please only include data from one insurance category in each row. Reporting is focused on fully-insured products, all other categories are considered voluntary for submission.

Payment Category (Column C) – This is the type of payment arrangement with a provider organization. These are distinct categories that define the type of payment arrangement. Payors must identify the payment category that is furthest along the continuum of clinical and financial risk in their contract with a provider organization. Each Payment Category must have a corresponding Payment Subcategory.

Payment Subcategory (Column D) – This is the structure of payment arrangement with a provider organization and conveys the intent of the payment. Payors must identify the payment subcategory that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization. Each Payment Subcategory must have a corresponding Payment Category.

Payment Category and Payment Subcategory Notes:

- Aggregate data on fee-for-service only and arrangements not linked to quality (HCP-LAN Categories 3N and 4N) is only collected on worksheet "A.1 Summary".

- 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 Payment Category and Payment Subcategory identified. Members attributed to multiple value-based payment arrangements with the same provider shall have all of their total medical expense and member months attributed to the Payment Category and Payment Subcategory, farthest along the continuum of provider financial risk.

- *Example Scenario:* If a member was attributed to a billing provider with an HCP-LAN Category 2B value-based payment arrangement, Payment Category B and Payment Subcategory B1, and a billing provider with an HCP-LAN Category 3A value-based payment arrangement, Payment Category C and Payment Subcategory C5, all of their spend and member months would be attributed to the billing provider in Payment Category C and Payment Subcategory C5.

Quality Indicator (Column E) **–** This field indicates when a payment arrangement is linked to quality. To indicate data on arrangements that include payments that are "linked to quality" input '1' for YES. To indicate data on arrangements that are not "linked to quality" input '0' for NO. The definition of quality follows guidance from the Alternative Payment Model (APM) Framework Refresh White Paper. Health Care Payment Learning & Action Network, https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf:

> ***"Quality:*** This term indicates that patients receive appropriate and timely care that is consistent with evidence-based guidelines and patient goals, and that results in optimal patient outcomes and patient experience. Measures of performance and impact should be meaningful, actionable, and transparent to consumers, patients, family caregivers, and other stakeholders. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process measures, outcome measures, patient-reported outcome measures, and patient experience measures that together provide an accurate and comprehensive assessment of clinical and behavioral health. Measure

scores should also be meaningfully accessed, understood, and used by patients and consumers."

A payment arrangement is "linked to quality" if any component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings or capitation payment, then the payment would be considered "linked to quality".

Pediatric APM Indicator (Column F) **-** 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.

Maryland Resident Member Months - Unduplicated (Column G) **–** The total unduplicated number of members living in Maryland, expressed in months of membership, attributed to the billing provider as part of the Payment Category and Payment Subcategory arrangement identified in Columns C and D. Payors are to attribute members to the payment category that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization.

Maryland Resident Number of Episodes - Unduplicated (Column H) **–** The total unduplicated number of episodes provided to members living in Maryland attributed to the billing provider as part of the Payment Category and Payment Subcategory arrangement identified in Columns C and D.

Total Medical Expense (Column I) – Total medical expense (not including retail pharmacy) for all members or episodes 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. ***Note:*** Fee-for-service portions of contracts categorized as HCP-LAN categories 2A, 2B, 2C, 3A, 3B, 4B and 4C, must be included in the total medical expense.

Total Non-Claims Payments (Column J) – Total non-claims payments paid under the Payment Category and Payment Subcategory combination referenced in Columns C and D in the reporting year.

A.2 FINANCIAL

This worksheet should include financial information for APM contracts, defined by the Expanded Framework and HCP-LAN category 2A-4C, and should be reported based on the Payment Category and Payment Subcategory. A new line should be created for each Payment Category and Payment Subcategory combination with a billing provider. All relevant fields should be reported, however, based on the Payment Category and Payment Subcategory combination not all fields will be reported for every line.

Payors shall use their attribution methodology to assign members or episodes and 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.

Payors have reported that attributing Maryland and non-Maryland member months may be challenging for prospective contract-level payments, such as certain HCP-LAN Category 2A payments. Payors may attribute these member months using one of following two methods:

Method 1: Payors can use the membership associated with the contract, if available.
Method 2: Payors can use organizational claims data to identify membership attributed to the specific provider.

Payors should not cap, truncate, or risk-adjust payments. Payments should be attributed to the parent billing provider organization for individual servicing or rendering providers in APM contracts, not separately for each servicing or rendering provider.

When a contractual arrangement begins during the reporting year, payors shall report the expenditures in the appropriate Payment Category and Payment Subcategory. 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 should provide an estimate and state the basis for the estimate on Worksheet "C. Notes." Similarly, if the final episode payment amounts, bonus or savings amounts, or other payments are not reconciled by the time of data collection, estimate the amounts (if any) and state the basis for this estimate on "C. Notes."

Payors are to provide details on all existing and new contract arrangements defined by the Expanded Framework with providers during the reporting year.

Reporting Year (Column A) **–** The year for which data is being reported. For 2025 data collection cycle, the reporting year is 2023 or 2024.

Billing Provider Tax ID (Column B) **–** Employer Tax ID # of the billing provider (organization/entity) which entered into the APM arrangement with the payor.

Practitioner/Supplier ID (Column C) **–** Payor-specific identifier for the billing provider (organization/entity) which entered into the APM arrangement with the payor.

Billing Provider Organization Name (Column D) **–** The name of the billing provider (organization/entity) which entered into the APM arrangement with the payor.

Insurance Category Code (Column E) **–** 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.

Payment Category (Column F) – This is the type of payment arrangement with the provider organization. These are distinct categories that define the type of payment arrangement. Payors must identify the payment category that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization. Each Payment Category must have a corresponding Payment Subcategory.

Payment Subcategory (Column G) – This is the structure of payment arrangement with the provider organization. Payors must identify the payment category that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization. Each Payment Subcategory must have a corresponding Payment Category.

Payment Category and Payment Subcategory Notes:

- Payors do not need to submit data provider-level data on arrangements classified as fee-for-service only, which correspond to HCP-LAN Categories 1, 3N, and 4N.

- 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 Payment Category and Payment Subcategory identified. Members attributed to multiple value-based payment arrangements with the same provider shall have all of their total medical expense and member months attributed to the Payment Category and Payment Subcategory, farthest along the continuum of provider financial risk.

- *Example Scenario:* If a member was attributed to a billing provider with an HCP-LAN Category 2B value-based payment arrangement, Payment Category B and Payment Subcategory B1, and a billing provider with an HCP-LAN Category 3A value-based payment arrangement, Payment Category C and Payment Subcategory C5, all of their spend and member months would be attributed to the billing provider in Payment Category C and Payment Subcategory C5.

Pediatric Indicator (Column H) - 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.

Maryland Resident Member Months - Unduplicated (Column I) **–** The total unduplicated number of members living in Maryland, expressed in months of membership, attributed to the billing provider as part of the Payment Category and Payment Subcategory arrangement identified in Columns F and G. Payors are to attribute members to the payment category that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization.

Maryland Resident Number of Episodes - Unduplicated (Column J) **–** The total unduplicated number of episodes provided to members living in Maryland attributed to the billing provider as part of the Payment Category and Payment Subcategory arrangement identified in Columns F and G.

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 Payment Category and Payment Subcategory arrangement identified in this row. There shall be a separate row for each type of episode arrangement entered into with billing provider (entity/organization). This field is only populated when Payment Subcategory is C1, C2, C3, or C4, otherwise leave blank.

Age/Gender Factor (Column L) **–** 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.

- AgeGenderFactorExample is an additional spreadsheet on MHCC's website. It offers a framework for each payor to calculate the age/gender factors for the populations enrolled in its APM arrangements.

- 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.

Total Medical Expense (Column M) **–** Total medical expense (not including retail pharmacy) for all members or episodes 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. **Note:** Fee-for-service portions of contracts categorized by the Expanded Framework or as HCP-LAN categories 2A, 2B, 2C, 3A, 3B, 4B and 4C, must be included in the total medical expense.

Total Member Responsibility Amount (Column N) **–** Total of all member responsibility amount, which is a sum of member copay, coinsurance, and deductibles.

Total Non-Claims Payments (Column O) – Total non-claims payments paid under the Payment Category and Payment Subcategory combination referenced in Columns C and D in the reporting year.

Contract Description (Column P) **–** 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.

B. BILLING PROVIDER MEMBERSHIP

Payors shall supply provider APM membership roster information on worksheet B. Billing Provider Membership for all APM contracts defined by the Expanded Framework and HCP-LAN categories (2A, 2B, 2C, 3A, 3B, 4A, 4B and 4C) for each provider group included in worksheet A.2 Financial. The populations reported in this worksheet for each billing provider/APM combination should mirror those reported in worksheet A.2 Financial. Payments should be attributed to the parent billing provider organization for individual providers in APM contracts, not separately for each provider.

Reporting Year (Column A) **–** The year for which data is being reported. For 2025 data collection cycle, the reporting year is 2023 or 2024.

Billing Provider Tax ID (Column B) **–** Employer Tax ID # of the billing provider (organization/entity) which entered into the APM arrangement with the payor.

Practitioner/Supplier ID (Column C) **–** Payor-specific identifier for the billing provider (organization/entity) which entered into the APM arrangement with the payor.

Billing Provider Organization Name (Column D) **–** The name of the billing provider (organization/entity) which entered into the APM arrangement with the payor.

Encrypted Enrollee's Identifier (**E002)** (Column E) - Enrollee's unique identification number assigned by payor and encrypted. The unique ID for each person on this file should correspond to the same unique Enrollee ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) and is represented as the field E002 in APCD Eligibility File.

Enrollee Year and Month of Birth (**E004)** (Column F) - Date of enrollee's birth using 00 instead of day (i.e. CCYYMM00). This is represented as the field E004 in APCD Eligibility File.

Enrollee Sex (**E005)** (Column G) Sex of the enrollee. This is represented as the field E005 in APCD Eligibility File.

Payment Category (Column H) – This is the type of payment arrangement with the provider organization. These are distinct categories that define the type of payment arrangement. Payors must identify the payment category that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization. Each Payment Category must have a corresponding Payment Subcategory.

Payment Subcategory (Column I) – This is the structure of payment arrangement with the provider organization. Payors must identify the payment category that is furthest along the continuum of clinical and financial risk in their contracts with a provider organization. Each Payment Subcategory must have a corresponding Payment Category.

Payment Category and Payment Subcategory Notes:

- Payors do not need to submit data on arrangements classified as fee-for-service only, HCP-LAN Category 1, 3N, and 4N. Do not submit membership data on arrangements in Worksheet A.1 Summary where the quality indicator is 0, not linked to quality.

- 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 Payment Category and Payment Subcategory 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, and Payment Category and Payment Subcategory, farthest along the continuum.

- **Example Scenario 1:** If a member was attributed to a billing provider with an HCP-LAN Category 2B value-based payment arrangement, Payment Category B and Payment Subcategory B1, and a billing provider with an HCP-LAN Category 3A value-based payment arrangement, Payment Category C and Payment Subcategory C5, the member and all of their spend and member months would be attributed to the billing provider with the HCP-LAN Category 3A arrangement, Payment Category C and Payment Subcategory C5.

- **Example Scenario 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 be attributed to the Payment Category and Subcategory farthest along the continuum.

- **Example Scenario 3:** If a member is attributed to a billing provider under an Expanded Framework Payment Subcategories C1, C2, C3, or C4 episode-based payment arrangements and attributed to the same or a different billing provider under any other Expanded Framework Payment Subcategory or

HCP-LAN Category payment arrangement (2A, 2B, 2C, 3A, 3B, 4B and 4C), the member would be attributed to both arrangements and have two lines in Worksheet B.

For each quality measure listed below MHCC will calculate quality scores using payor-submitted data in the APCD. Technical specifications shall align with those provided by the National Committee for Quality Assurance and 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.

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.

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

3. 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.

4. **Eye Exam for Patients With Diabetes (EED) -** Assesses the percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.

5. **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.

6. **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.

C. NOTES

Payors are to 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.

OVERVIEW OF THE EXPANDED NON-CLAIMS PAYMENTS FRAMEWORK AND HCP-LAN FRAMEWORK

Freedman HealthCare (FHC) collaborated with the California Department of Health Care Access and Information (HCAI) to develop the Expanded Non-Claims Payment (NCP) Framework. This framework is designed to capture non-claims healthcare spending, the purpose of these payments, and the level of risk assumed by providers.

The framework incorporates and refines elements from two existing models: the Health Care Payment Learning and Action Network (HCP-LAN) and the Milbank Memorial Fund-Bailit (Milbank) models.

Key features include:

- Cross-references the HCP-LAN Framework to assess provider risk levels and reduce data collection burden.

- Categorizes and subcategorizes healthcare spending in clear and current terms aligned with actual payor-provider contracts and payments.
- Assists policymakers and stakeholders in evaluating the value of non-claims payments and their alignment with healthcare priorities.

Expanded Non-Claims Payments Framework and HCP-LAN Framework Crosswalk

Payors should use these definitions when classifying their provider contract and payment arrangement.

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
A	**Population Health and Infrastructure Payments**	**Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.**	
A1	Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A
A2	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A
A3	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A
A4	Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	2A
A5	EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables	2A

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
		practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	
B	**Performance Payments**	**Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.**	
B1	Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B
B2	Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C
C	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category may be considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality." Payments in this category may also not be "linked to quality".**	
C1	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via	3A

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
		capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	
C2	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
C3	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A
C4	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid	3A

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
		predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as "Risk for total cost of care with shared savings."	3B
D	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category may be considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality." Payments in this category may also not be "linked to quality".**	
D1	Primary care capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to	4A

Payment Category and Subcategory	Non-claims-based Payment Categories and Subcategories	Definition	Corresponding HCP-LAN Category
		primary care services performed by primary care teams.	
D2	Professional capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A
D3	Facility capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A
D4	Behavioral health capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A
D5	Global capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B
D6	Payments to integrated, comprehensive payment and delivery systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C
E	**Other Non-Claims Payments**	**Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).**	

EXAMPLE DATA QUALITY MEMO

MARYLAND Health Care Commission

The following information is provided as an example of the information that MHCC summarizes and shares with each payor regarding their APM file submission. This is provided here to give payors context for data quality issues MHCC reviews to support their submission of accurate, actionable data.

Date	
Payor Name	
Submission Date	
Resubmission Date	

1. Summary of Fully-Insured Data

Payment Subcategory	Maryland Resident Member Months	Total Medical Expense	Average Per Member Per Month
A1 - Care management/care coordination/population health/medication reconciliation			
B1 - Retrospective/prospective incentive payments: pay-for-reporting			
C5 - Risk for total cost of care (e.g., ACO) with shared savings			
C6 - Risk for total cost of care (e.g., ACO) with risk of recoupments			
D1 - Primary care capitation			
D2 - Professional capitation			
D3 - Facility capitation			
D4 - Behavioral health capitation			
D5 - Global capitation			
D6 - Payment to integrated, comprehensive payment and delivery systems			
Category	**Maryland Resident # of Episodes**	**Total Medical Expense**	**Average Cost Per Episode**
C1 - Procedure-related, episode-based payments with shared savings			
C2 - Procedure-related, episode-based payments with risk of recoupments			
C3 - Condition-related, episode-based payments with shared savings			
C4 - Condition-related, episode-based payments with risk of recoupments			

2. Confirmation of Fully-Insured Data

Description	Values
# of Unique Providers	
# of Contracts	
Total Membership in APMs	
Members Matched to MCDB by Payment Subcategory	
Total Non-Claims payments as a % of Total Medical Expenditure	

3. Data Submission Questions on Fully-Insured Data

1. Example Questions for MHCC
    a. The following Age/Gender factors are outside of the expected range:
        i. X.XX -X.XX
    b. The shared savings PMPM is very low. Please provide additional information.
    c. There is total medical expense data when there is 0 member months. Please provide additional information.
    d. The contract information provided on X does not align with the categorization. Please provide additional information.

EXAMPLE QUALITY ASSURANCE METHODOLOGY

DESCRIPTION

MHCC will be using the methodology below to QA Alternative Payment Model data submissions. The steps below identify how MHCC will produce each payors' QA memo and can be used by payors to review their data prior to submission.

PRELIMINARY CHECKS

1. Confirm the carrier information on Contents worksheet is populated and correct.
2. Confirm whether there are multiple insurance categories reported throughout the worksheets.
    a. Summary statistics are calculated based on data submitted for the fully-insured population.

C. NOTES

1. Review all notes with a focus on "Comment on whether data provided includes data for residents outside of Maryland". Non-MD resident Member Months (MM) should be entered and associated Total Medical Expense should be included in Worksheet A.1 and A.2.

A.1 SUMMARY

1. Check all data elements for completeness and reasonableness.
2. Review the following totals:
    a. Sum of Maryland resident MM
    b. Sum of Non-Maryland resident MM
    c. Sum of Total Medical Expense
3. Review whether MM within each arrangement type are reasonable.
4. Calculate Per Member, Per Month (PMPM) payments by dividing column J by the sum of column F and G.
    a. Is the PMPM reasonable?
5. Calculate Average Cost Per Episode by dividing column J by the sum of column H and I.
    a. By type of episode (e.g., orthopedics, cancer care, etc.)
    b. Is the Average Cost Per Episode reasonable?
6. Calculate non-claims as a percent of total medical expenses for fully-insured by using the sum of column K divided by the sum of columns J, including the Total Medical Expense (Column J) for fee-for-service only arrangements.
    a. Are they reasonable?

A.2 FINANCIAL

1. Check all data elements for completeness and reasonableness.

2. Review contract information descriptions for alignment with assigned Expanded Framework Payment Subcategories.
3. Calculate Per Member, Per Month (PMPM) payments by dividing column O by the sum of column I and J.
    b. Is the PMPM reasonable?
4. Calculate Average Cost Per Episode by dividing column O by the sum of column K and L.
    a. By type of episode (e.g., orthopedics, cancer care, etc.)
    b. Is the Average Cost Per Episode reasonable?
5. Review the following totals:
    a. Count of billing providers
    b. Sum of Maryland resident MM
    c. Sum of Non-Maryland resident MM
    d. Sum of Total Medical Expense
6. Review whether MM within each arrangement type are reasonable.
7. Review whether Age/Gender Factors are reasonable.
    a. Results are expected to be greater than 0.5 and less than 2. However, results can exceed 2.0 for ages 65 and older.
8. Confirm consistent number of unique providers and contracts across worksheets A.2 and B.1 by Payment Subcategory.

B.1 BILLING PROVIDER MEMBERSHIP

1. Confirm all billing providers have associated data in worksheet A.2.
2. Confirm Payment Categories and Payment Subcategories match across A.1 and A.2 worksheets.
3. Review the following:
    a. Total number of enrollees
    b. Average number of enrollees per arrangement
4. Confirm consistent number of contracts:
    a. Match with worksheet A.2.
5. Review Encrypted Enrollee's Identifier, Enrollee Year and Month of Birth, and Enrollee Sex data to match with membership data in the MCDB.
    a. Review rate of matching members in APM file to MCDB.
    b. Confirm that the same member does not appear in multiple Payment Subcategories unless for episode-based arrangements (Subcategories C1, C2, C3, and C4).

Appendix I – Alternative Payment Model Frequently Asked Questions (FAQ)

Updated as of 11/21/2024

This Frequently Asked Questions document (FAQ) was developed to provide detail and clarify information in Appendix H – Alternative Payment Model (APM) Data Submission Manual of the Medical Care Data Base Data Submission Manual (MCDB DSM). Please refer to the APM Data Submission Manual or reach out to Shankar Mesta, shankar.mesta@maryland.gov for additional information.

GENERAL INFORMATION

What is the objective of the Maryland Alternative Payment Model (APM) File?

The Maryland Health Care Commission (MHCC) is seeking APM data to meet requirements of COMAR 10.25.06.14, to develop a non-fee-for-service expenses report. 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.

Who needs to submit the APM File?

MHCC seeks to collect data on medical claims administered through the medical benefit for the APM File. 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 of the MCDB DSM.

What if a payor has no alternative model payments to report during the requested timeframe? For example, what if a provider only receives payments under a fee-for-service with no link to APM model?

If your organization does not have any medical benefit APM arrangements, please request a waiver and/or submit questions to shankar.mesta@maryland.gov.

What is the difference between the population required to be submitted in the APM File vs. the claims submissions?

The populations required to be submitted differs between the claims files (submitted quarterly) and the APM File (submitted annually). The quarterly claims submissions to the MCDB are transactions submitted at the member level, whereas the annual APM File requires submission of contract level payments to provider organizations for a set of attributes members. Data for self-insured plans, Medicare Advantage plans or other plans **is not required**. Please see the table below for information on Maryland situsd plans that are required and optional for each submission. R denotes required and O denotes optional.

Residency	Fully-Insured Plans	Self-Insured Plans	Medicare Advantage, and Medicare Supplemental Plans
Maryland	**R** MCDB **R** APM	**R** MCDB **O** APM	**R** MCDB **O** APM
Non-Maryland	**R** MCDB **O** APM	**R** MCDB **O** APM	**R** MCDB **O** APM

Why would a data submitter choose to provide optional information in the APM File?

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 this information pertaining to members not covered by a fully-insured plan situsedin Maryland. Use the multi-choice drop down menus to identify the insurance category included in the row. MHCC also appreciates that some value-based arrangements may include attributed members who do not live in Maryland. Payors should exclude members attributed to arrangements who do not live in Maryland. Payors shall indicate the number of member months for Maryland residents only. Please indicate in the "C. Notes" worksheet whether data provided includes data for residents outside of Maryland.

What is the timeframe ("performance period") of the payments included in the APM File?

For the 2025 Reporting Cycle, MHCC requests that all payors include data for calendar year 2023 and 2024 APM arrangements. This allows for final calendar year 2023 data to be submitted with 18 months of run out to establish an accurate baseline and 2024 data with six months of run out. Please report any contractual arrangement that spans any part of the year. For example, if the payor enters into a shared savings contract effective August 1, 2022 (and the reporting period is CY 2022), 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, 2022 – December 31, 2022.

Should allowed or incurred and paid payments be reported?

All payments for all worksheets in the APM file should be made on an allowed basis.

What is the submission schedule?

The performance period is CY 2023 (January 1st, 2023 – December 31st 2023) and CY 2024 (January 1st, 2024 – December 31st, 2024). Please submit the APM file 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, 2025.

SUMMARY DATA

How should payors summarize data on provider organizations in worksheet "A.1 Summary"?

Please submit one aggregate row for each Payment Category and Payment Subcategory that the payor has with any entity/provider. If there are pediatric arrangements for an Payment Category and Payment Subcategory, please submit a separate row aggregating the data for the pediatric arrangements. **Include a single row on fee-for-service only arrangements.**

FINANCIAL DATA

What payments must be included in the APM File?

Worksheets "A.1 Summary" and "A.2 Financial" collect financial information associated with APM contracts, defined by the Expanded Non-Claims Payment Framework and HCP-LAN Category 2A, 2B, 2C, 3A, 3B, 4A, 4B and 4C. Note: Financial information related to fee-for-service only or HCP-LAN Category 1 and APMs not linked to quality, HCP-LAN Category 3N and 4N, are collected only on A.1 Summary.

Are fee-for-service payments included anywhere in this data submission?

Worksheet "A.1 Summary" should also include one row of summary information for Maryland residents enrolled in fully-insured Maryland situsued plans who are not attributed to one of the Expanded Framework or HCP-LAN categories above and thus are paid for via a fee-for-service arrangement with no link to quality or value.

Should payors separate out pharmacy services delivered under a medical benefit?

No, payors are not required to separate out pharmacy services covered under a medical benefit. Payments made to providers under a standalone pharmacy benefits contract should not be included in the APM file. Pharmacy Benefit Managers should not submit an APM File.

What if a given payment model includes multiple different components?

Reporting shall occur in the Payment Category and Payment Subcategory furthest along the continuum of financial and clinical risk for the provider organization.

- If a billing provider is participating in multiple value-based payment arrangements, payors should submit a separate row for each value-based payment arrangement. 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 of financial and provider risk.
- **Example:** If a member was attributed to a billing provider with an HCP-LAN Category 2B value-based payment arrangement, Payment Category B and Payment Subcategory B1, and a billing provider with an HCP-LAN Category 3A value-based payment arrangement, Payment Category C and Payment Subcategory C5, the member and all of their spend and member months would be attributed to the billing provider with the HCP-LAN Category 3A arrangement, Payment Category C and Payment Subcategory C5.

How should a payor differentiate contract-level payments between Maryland and Maryland non-residents?

Payors should report the total contract-level payment, such as a foundational payment for infrastructure and operation (HCP-LAN Category 2A, Payment Category A and Payment Subcategory A4), in the appropriate field and report the total member months for Maryland residents only.

How should a payor report when a payor receives money from the contracted entity?

When a payor receives money from the contracted entity in the form of a recoupment, as opposed to paying money out, the payor should report the net payments made to the contracted entity in the appropriate Payment Category and Payment Subcategory. For example, a recoupment payment a contracted entity makes to the payor under a shared risk payment model.

When would payors report a zero-dollar figure?

All dollars associated with an APM contract should be reported to the Payment Category and Payment Subcategory furthest along the continuum of financial and provider risk. Each row of data should have an assigned Payment Category and Payment Subcategory and dollars associated with that contract, therefore zero-dollar figures should not be reported.

Should payors report payments to Billing Providers or providers within a provider organization when the provider-level data is available?

Payors must report each row of data with the Billing Provider Tax ID and Billing Provider Name. MHCC requests that the Practitioner/Supplier ID is also included. Payments to individual providers part of an APM contract with a parent Billing Provider Organization should not be reported separately.

How should payors report "Total Member Responsibility Amount" for episode-based APMs?

Payors should report the member responsibility for each episode-based APM based on the TME for that episode. If a payor is not able to determine the member responsibility for that episode, the payor should then report the total member responsibility for the reporting year. For example, if a member attributed to an episode-based APM had $1,000 in member responsibility in 2024, the entire $1,000 amount will be reported for that year.

How can payors ensure that fee-for-service payments that have a link to an APM are accurately reflected in the data?

Payors should report the fee-for-service payments associated with an APM contract in the Payment Category and Payment Subcategory furthest along the continuum of financial and provider risk coinciding with the APM payment in the contract.

How should payors report APM arrangements that do not have a link to quality and value (HCP-LAN Categories 3N and 4N)?

For the 2025 data collection cycle, MHCC is collecting provider organization level data on APM arrangements with a link to quality and value. Payors must submit data on arrangements classified as HCP-LAN Category 3N and 4N, which do not have a link to quality and value, in aggregate at the payer level on worksheet "A.1 Summary". If the payor is uncertain on the classification, please reach out to MHCC to discuss.

When should payors report an Age/Gender Factor? How should this be calculated?

Payors should report the Age/Gender Factor for each row for an APM contract reported in Worksheet "A.2 Financial." Payors should follow the guidance below and contact their pricing teams for additional information on development of the age/gender factor.

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.

AgeGenderFactorExample is an additional spreadsheet linked on the MHCC Website. It offers a framework for each payor to calculate the age/gender factors for the populations enrolled in its APM arrangements.

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.

MEMBERSHIP DATA

Which data elements should be consistent between a claims file submission and the APM file submission?

Payors should report an Encrypted Enrollee's Identifier (E002 in APCD Eligibility File), Enrollee Year and Month of Birth (E004 in APCD Eligibility File), and Enrollee Sex (E005 in APCD Eligibility File) in worksheet "B. Billing Provider

Membership" for each provider group/APM contract combination reported in Worksheet "A.2 Financial". These data elements will be used by MHCC to determine performance on a set of select quality measures as defined in the APM Data Submission Manual.

- Note: If a member is in more than one APM arrangement, the member's information should only be submitted for the arrangement in the Payment Category and Subcategory combination that is furthest along the continuum of financial and provider risk. A member may be included twice in the B. Billing Provider Membership if they are also in an episode-based arrangement denoted by Expanded Framework Payment Subcategories C1-C4.

- **Example:** Individual with a primary care physician participating in an accountable care organization that has a shared savings contract with the payor and is also attributed to an episode-based cancer care treatment shared savings program with another provider. Their total spend would be attributed to the shared savings provider in the Payment Category and Payment Subcategory furthest along the continuum of financial and provider risk in worksheet "A.2 Financial" and the spend associated with their cancer care treatment would be attributed to the episode-based Payment Subcategory with the other provider and be reported in the "A.2 Financial" worksheet. The member would be included twice in "B. Billing Provider Membership" worksheet.

How should member months be reported in the APM File?

Member months should always be reported for APM contracts, defined by Expanded Framework Payment Category and Payment Subcategory in the worksheet "A.1 Summary" and "A.2 Financial". Maryland Resident Member Months and Maryland Resident Number of Episodes should be submitted with the associated APM contract for all episode-based payment arrangements categorized as Payment Subcategories C1-C4.

Total Unduplicated Member Months should be reported for all Payment Categories and Payment Subcategories, including fee-for-service only contracts, category 1, for all contracts in the "A.1 Summary" worksheet.

Which contracts should be included?

Information on existing and new contract arrangements during the performance period defined in the Expanded Framework and as HCP-LAN Category 2A, 2B, 2C, 3A, 3B, 4A, 4B and 4C should be included.

EXAMPLE WORKSHEETS

What should the APM File look like when submitted?

See examples below

Below is an example of a 20252025 APM File submission for worksheet "A.1 Summary". Actual APM file submission would be far longer.

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This worksheet should include summary information on members attributed to value-based payment arrangements (defined by the Expanded Non-Claims Payment Framework and corresponding to HCP-LAN Categories 2A, 2B, 2C, 3A, 3B, 4A, 4B, 4C). It should also include one row of summary information for Maryland residents enrolled in fully-insured Maryland situsted plans who are attributed to one of the categories above.

Reporting Year	Insurance Category Code	Payment Category	Payment Subcategory	Quality Indicator	Pediatric APM Indicator	Maryland Resident Member Months - Unduplicated	Maryland Non-Resident Member Months - Unduplicated	Maryland Resident Number of Episodes - Unduplicated	Maryland Non-Resident Number of Episodes - Unduplicated	Total Medical Expense	Total Non-Claims Payments
2023	1	C	C1	1	0	0	0	6,000	0	$ 146,000,000	$ 3,000,000
2023	1	C	C2	1	0	0	0	1,000	0	$ 210,000,000	$ 3,000,000
2023	1	B	B2	1	0	64,000	0	0	0	$ 21,000,000	$ 6,000,000
2023	1	D	D2	1	0	47,000	0	0	0	$ 18,000,000	$ 3,100,000

Below is an example of a 20252025 APM File submission for worksheet "A.2 Financial". Actual APM file submission would be far longer.

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This worksheet should include financial information for APM contracts, defined as HCP-LAN category 2A-4C, and should be reported based on the Payment Category and Payment Subcategory. A new line should be created for each Payment Category and Payment Subcategory combination and a single row should be added for members who are enrolled in FFS only contracts. All relevant fields should be reported, however, based on the Payment Category and Payment Subcategory combination not all fields will be reported for every line.

Reporting Year	Billing Provider Tax ID	Practitioner/Supplier ID	Billing Provider Organization Name	Insurance Category Code	Payment Category	Payment Subcategory	Quality Indicator	Pediatric APM Indicator	Maryland Resident Member Months - Unduplicated	Maryland Non-Resident Member Months - Unduplicated	Maryland Resident Number of Episodes - Unduplicated	Maryland Non-Resident Number of Episodes - Unduplicated	Episode Type	Age/Gender Factor	Total Medical Expense	Total Member Responsibility Amount	Total Non-Claims Payments	Contract Description
2023	521111111	ABCDEF	Good Doctor Primary Care, LLC	1	C	C6	1	0	123,000	0	0	0	N/A	1.135	$ 60,000,000	$ 6,000,000	$ 10,000,000	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as "Risk for total cost of care with shared savings." Payments in this subcategory are "linked to quality".
2023	521111112	ABCDEG	Quality Care Providers, LLC	1	C	C5	1	0	18,000	0	0	0	N/A	1.185	$ 10,000,000	$ 1,000,000	$ -	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements. Payments in this subcategory may be "linked to quality".
2023	521111113	ABCDEH	Integrated Network, LLC	1	C	C2	1	0	0	0	22	43	PREGN	1.088	$ 1,300,000	$ 130,000	$ -	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. Payments in this subcategory may be "linked to quality".

Below is an example of a 2025 APM File submission for worksheet "B. Billing Provider Membership". Actual APM File submission would be far longer.

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This worksheet should only include information on value-based arrangements (defined by the Expanded Non-Claims Payment Framework Category and Subcategory and corresponding to HCP-LAN Categories 2A, 2B, 2C, 3A, 3B, 4A, 4B, 4C).

Reporting Year	Billing Provider Tax ID	Practitioner/Supplier ID	Billing Provider Organization Name	Encrypted Enrollee's Identifier (E002)	Enrollee Year and Month of Birth (E004)	Enrollee Sex (E005)	Payment Category	Payment Subcategory
2023	521111111	ABCDEF	Good Doctor Primary Care, LLC.	UEE241ZZZ	19640120	F	C	C1
2023	521111112	ABCDEG	Quality Care Providers, LLC.	6Z183T2P7	19711201	F	C	C1
2024	521111113	ABCDEH	Integrated Network, LLC.	56Y20S056	19861228	M	D	D1
2024	521111111	ABCDEF	Good Doctor Primary Care, LLC.	NNEHJAZTL	20071005	F	D	D1

Appendix J – Primary Care Data Submission Manual

This manual provides comprehensive instructions for submitting non-claims spending data related to primary care at the payer level. The Maryland Health Care Commission (MHCC) is conducting this data collection as part of its statutory mandate under COMAR 10.25.06.14 and in alignment with Chapter 297 of the 2022 Laws of Maryland.

The purpose of this separate data submission template and manual for primary care non-claims data is to support the broader reporting requirements for non-claims spending. This submission will provide will inform MHCC's annual reports to the Senate Finance Committee and House Health and Government Operations Committee through 2032.

Please submit completed Primary Care 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, 2025. The Data Submission shall follow the naming convention: PayorID_FileType_PeriodStartDate_PeriodEndDate_CreateDate.

Each variable in the above format must be populated as follows:

- PayorID = MHCC-assigned submitter code
- FileType = PC
- PeriodStartDate (YYYYMM format)
- PeriodEndDate (YYYYMM format)
- CreateDate (YYYYMM format)

Example: MDP020A_PC_202401_202412_20250925

If your organization does not have any Alternative Payment Model (APM) arrangements with primary care non-claims payments, please request an annual waiver and/or submit questions to shankar.mesta@maryland.gov. When completing an annual waiver, provide reasons for the request.

POPULATION SPECIFICATIONS

The Primary Care Data Collection Template is focused on collection of fully-insured APM products from Maryland residents. Some value-based payment arrangements may include members covered under self-insured plans, Medicare Advantage plans, Medicare Supplemental plans, or other plans. Data for self-insured plans, Medicare Advantage plans or other plans is not required. Payors may voluntarily include information pertaining to any member not covered by a fully-insured plan situsedin Maryland. Use the multi-choice drop down menus to identify all insurance categories included in the row.

Alternatively, some value-based arrangements may include attributed members who do not live in Maryland. Payors should exclude members attributed to these arrangements who do not live in Maryland.

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.

PRIMARY CARE DATA SUBMISSION TEMPLATE INSTRUCTIONS

The 2025 Primary Care Data Submission Template Instructions include the following sections:

- Contents
- A. Primary Care
- B. Notes

For the 2025 Reporting Cycle, MHCC requests that all payors include data for calendar year 2023 and 2024 Primary Care APM arrangements. This allows for final calendar year 2023 data to be submitted with 18 months of run out and 2024 data with six months of run out. Payors shall report payments for the contract year regardless of the payment date. Payments made in calendar year 2024 for a 2023 contract, should not be included in 2024 data, but instead in 2023 data. For example, if a reconciliation payment for a 2023 contract is made in July 2024, it should be included in 2023 data.

CONTENTS

This worksheet is an introduction sheet that:

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

Payors are to provide their Payor ID, i.e., MHCC-assigned submitter code, the payor's name, and contact information for data submission follow-up as necessary.

A. PRIMARY CARE

This worksheet should include non-claims spending data and the portion of those payments that are primary care aggregated at the payer level. Payors should use the appropriate methodology for each Payment Category of the Expanded Framework. For this worksheet only, payors only need to submit the Payment Category and are not required to identify a Payment Subcategory.

Reporting Year (Column A) **–** The year for which data is being reported. For 2025 data collection cycle, the reporting year is 2023 or 2024.

Insurance Category Code (Column B) **–** 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.

Payment Category (Column C) – This is the type of non-claims payment made to provider organizations. These are distinct categories that define the type of payment.

Maryland Resident Member Months (Column D) **–** The total number of member months associated with the Payment Category identified in Column C and the Total Amount Paid/Allowed in Column E.

Total Amount Paid/Allowed (Column E) - Total of all payments made across billing providers during the Reporting Year for the non-claims payment category. For non-fee-for-service payments, this is the amount paid to the provider by the Payor. Note: This field does not include any fee-for-service payments and only reflects actual non-claims payments.

Total Amount Primary Care (Column F) - Total of all payments associated with the Payment Category in Column C made across billing providers for primary care services during the Reporting Year. Note this field is a subset of the Total Amount Paid/Allowed in Column E.

The following table provides guidance to payors on how to apportion non-claims payments to primary care :

Payment Category	Description/Valid Values	Apportioning Non-Claims Payments to Total Primary Care Amount Field
A	Population health and practice infrastructure payments	• Include payments to primary care provider organizations or multi-specialty providers for primary care programs such as care management, care coordination, population health, health promotion, behavioral health or social care integration. • Multispecialty Organizations: Limit the portion of practice transformation and IT infrastructure payments that "count" as primary care to 1% of total medical expense. • Primary Care Provider Organizations: Attribute all practice transformation and IT infrastructure payments to primary care.
B	Performance payments	• Include performance payments to primary care provider organizations. • Include performance payments to multi-specialty provider organizations only for patients attributed to primary care providers.

Payment Category	Description/Valid Values	Apportioning Non-Claims Payments to Total Primary Care Amount Field
C	Payments with shared savings and recoupments	• Report "Total Amount Paid/Allowed," do not report "Total Amount Primary Care" for this Payment Category. • MHCC will develop a methodology in consultation with payors to be applied to this Payment Category for future reporting. The methodology will take into account the volume of payments submitted in the "Total Amount Paid/Allowed" field during this reporting cycle.
D	Capitation and full risk payments	• Report "Total Amount Paid/Allowed," do not report "Total Amount Primary Care" for this Payment Category. • MHCC will develop a methodology in consultation with payors to be applied to this Payment Category for future reporting. The methodology will take into account the volume of payments submitted in the "Total Amount Paid/Allowed" field during this reporting cycle.
E	Other non-claims payments	• Report "Total Amount Paid/Allowed," do not report "Total Amount Primary Care" for this Payment Category. • MHCC will develop a methodology in consultation with payors to be applied to this Payment Category for future reporting. The methodology will take into account the volume of payments submitted in the "Total Amount Paid/Allowed" field during this reporting cycle.
X	Fee for service	• Do not submit data for this Payment Category. MHCC will use the MCDB to determine primary care claims spending.

B. NOTES

Payors are to 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 submitted data.

Frequently Asked Questions (FAQ) - PRIMARY CARE DATA

How will MHCC collect primary care claims payments?

In Reporting Year 2025, MHCC is only seeking to collect data on actual non-claims payments at the payer level. MHCC will run a primary care claims definition based on primary care provider, place of service, and service on the Medical Care Data Base (MCDB) to study the claims portion of primary care spending.

Which categories of the Expanded Non-Claims Payment Framework will count towards primary care non-claims?

In Reporting Year 2025, MHCC is only allocation portions of population health and practice infrastructure payments and performance payments to primary care. MHCC will work with payors to determine the right methodology to allocate payments with shared savings and recoupments, capitation and full risk payments, and other non-claims payments to primary care based on the volume of payments in these non-claims categories as submitted in 2025.

How does the payment data submitted in the Primary Care Worksheet differ from payment data in the rest of the APM File?

The primary care worksheet collects actual non-claims payments by payment category. It does not include payment subcategory detail. The payments are the actual non-claims payments in the category rather than all of a members' total medical expense as reported on other worksheets in the APM File.

EXAMPLE PRIMARY CARE DATA QUALITY MEMO

The following information is provided as an example of the information that MHCC summarizes and shares with each payor regarding their Primary Care Data file submission. This is provided here to give payors context for data quality issues MHCC reviews to support their submission of accurate, actionable data.

Date	
Payor Name	
Submission Date	
Resubmission Date	

1. Summary of Fully-Insured Data

Payment Category	Maryland Resident Member Months	Total Amount Paid/Allowed	Total Amount Primary Care
A - Population health and practice infrastructure payments			
B - Performance payments			
C - Payments with shared savings and recoupments			
D - Capitation and full risk payments			
E - Other non-claims payments			
X - Fee-for-service			

2. Data Submission Questions on Primary Care Data

1. Example Questions for MHCC
    a. The information provided on X does not align with the categorization. Please provide additional information.

EXAMPLE QUALITY ASSURANCE METHODOLOGY

DESCRIPTION

MHCC will be using the methodology below to QA Primary Care submissions. The steps below identify how MHCC will produce each payors' Primary Care QA memo and can be used by payors to review their data prior to submission.

PRELIMINARY CHECKS

1. Confirm the carrier information on Contents worksheet is populated and correct.
2. Confirm whether there are multiple insurance categories reported throughout the worksheets.
    a. Summary statistics are calculated based on data submitted for the fully-insured population.

A. PRIMARY CARE

1. Check all data elements for completeness and reasonableness.
2. Sum all non-claims payments reported and check against sum of total non-claims payments in Data Collection Template, A.1 Summary.
3. Review reasonableness of "Total Amount Primary Care" field
    a. Are primary care amounts a subset of "Total Amount Paid/Allowed"?
    b. Calculate PMPM payments by dividing column F by column D.

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