Maryland Health Care Commission

Thursday, October 15, 2015

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. UPDATE OF ACTIVITIES

3. ACTION: COMAR 10.24.17, State Health Plan for Facilities and Services: Cardiac Surgery & Percutaneous Coronary Intervention Services – Final Regulations

4. ACTION: Request for Release of MCDB Data by Berkeley Research Group (BRG)

5. ACTION: Approval for Release – Maryland Trauma Physicians Services Fund Report

6. ACTION: Approval for Release - 2015 Preauthorization Benchmark Attainment Report

7. PRESENTATION: 2015 Health Benefit Quality Report Series

8. DEMONSTRATION: *Maryland Health Care Quality Reports* Website

9. Overview of Upcoming Initiatives

10. ADJOURNMENT

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MARYLAND HEALTH CARE COMMISSION

ACTION:

COMAR 10.24.17, State Health Plan for Facilities and Services: Cardiac Surgery & Percutaneous Coronary Intervention Services – Final Regulations

(Agenda Item #3)

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Request for Release of MCDB Data by Berkeley Research Group (BRG)

(Agenda Item #4)

MCDB Data Release and IRB Review

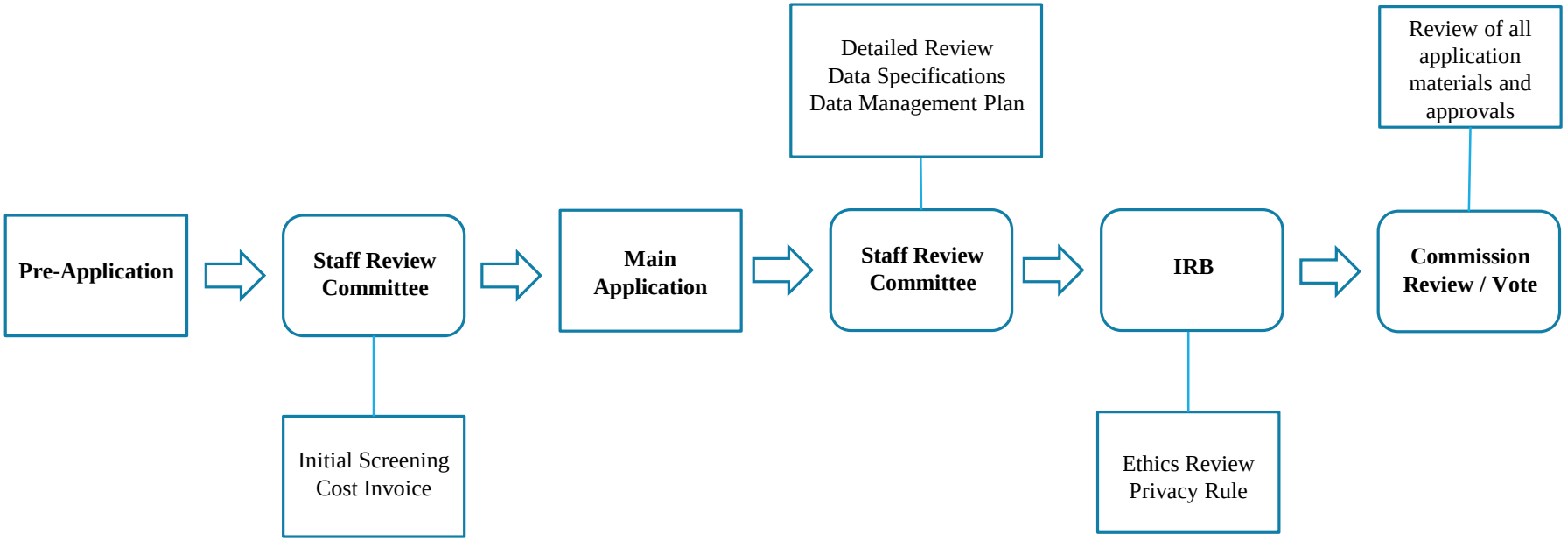
COMMISSION MEETING

OCTOBER 15, 2015

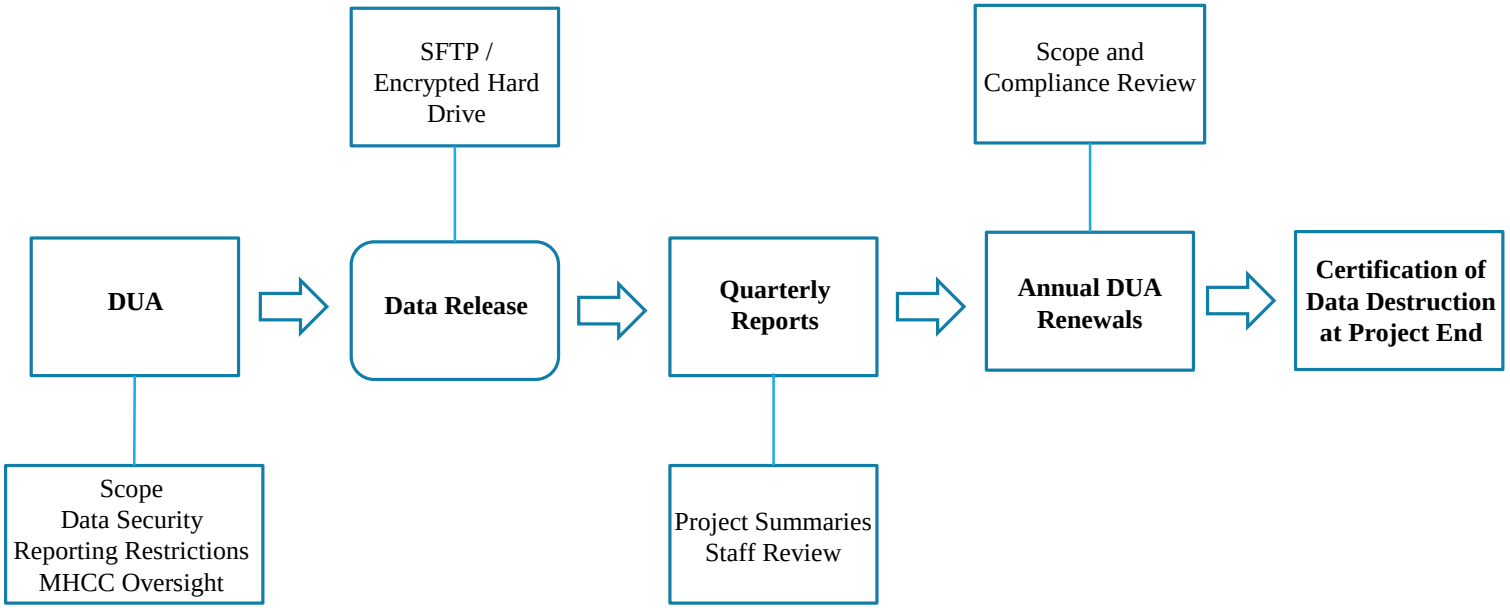
Overview

- Goal: Review and vote on application for MCDB Data by Berkley Research Group
- Refresher on Data Release Policy
- Framework for evaluation of applications
- BRG application details
- IRB Approval

Application Review Process



Data Release and Compliance



Framework for Evaluation

- Appropriate use of data
  - Is it a permitted use?
  - Is the data appropriate for the project?
- Qualified user
  - Does the applicant have expertise with this type of data?
  - Does applicant have expertise with the specified analyses/projects
- Data Security / Data Management Plan
  - Is there an appropriate plan for securing the data?
  - Is access restricted to qualified users?
  - Adherence to limitations on re-release and reporting of data

Berkley Research Group Application

- Appropriate Use
  - BRG has been contracted by Shore Health System to assist with program planning for its service area, resource allocation/service reconfiguration across the region, and population health management.
  - They plan to analyze current utilization patterns, by age cohort, by payor category (e.g. Medicaid vs. Private Insurance), by service setting, and by diagnosis/procedure as well as trend analysis to identify changes in utilization patterns and opportunities to reduce unnecessary utilization.
- Qualified User
  - BRG has extensive experience with these types of analyses and is a leading consultant for CON and state health planning activities in Maryland
  - BRG has specific expertise with health insurance claims data and has worked with and received CMS Medicare data in the past
- Data Security / Data Management Plan
  - BRG has provided appropriate documentation of its data management plan to secure MCDB Data
  - Access to MCDB data will be restricted to project staff, who will be identified to MHCC in DUA

Berkley Research Group Application

- Data request is for Commercial and Medicaid Data for CY 2014 initially, and they may request additional years in the future
- MCDB includes eligibility records and claims files (professional, institutional, and pharmacy)
  - No direct identifiers in the data, such as name, address, SSN, etc.
  - Indirect identifiers include gender, month/year of birth or age, zip code of residence, dates of service.
  - Member ID's will be masked to permit linking across MCDB files.
    - DUA will prohibit linking beyond MCDB files at the member level
    - DUA will prohibit efforts to re-identify members
  - No individual payor identification beyond broad categories of Commercial vs. Medicaid

IRB Review

- MHCC has designated Chesapeake IRB
- Chesapeake IRB has reviewed and qualified this application as exempt from IRB review based on 45 CFR 46.101(b)(4): "*Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects*"

Next Steps

- If approved by Commissioners, MHCC staff will execute a DUA with BRG and release data.
- Ongoing compliance review under DUA

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Approval for Release – Maryland Trauma Physicians Services Fund Report

(Agenda Item #5)

MARYLAND HEALTH CARE COMMISSION

Maryland Trauma Physician Services Fund

Bridget Zombro, Director of Administration

Karen Rezabek, Program Manager

October 15, 2015

PURPOSE

The Maryland Trauma Physician Services Fund:

- Reimburses trauma physicians for care rendered to patients that are uninsured;
- Offsets trauma centers' costs for physicians on-call at the centers; and
- Provides grants to trauma centers for trauma-related equipment

BUDGET

- The Fund received $11.9 million from the $5 registration fees collected by the Maryland Motor Vehicle Administration in FY 2015
- The Fund expended:
  - $4.3 million in uncompensated care
  - $6.3 million in on call and stand-by stipends
  - $66,300 to Medicaid
  - $723,000 in Administrative Expenses
- The 8% reduction in payments effective July 1, 2009 ended on July 1, 2015 (the first day of FY 2016)

Commission staff proposes that no statutory changes be made for FY 2016.

- **Questions?**

- **Contact us:**

  - **Bridget Zombro, Director of Administration, Bridget.Zombro@maryland.gov**

  - **Karen Rezabek, Program Manager, Karen.Rezabek@maryland.gov**

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Approval for Release - 2015 Preauthorization Benchmark Attainment Report

(Agenda Item #6)

Electronic Preauthorization

Benchmark Attainment

A Legislative Report

October 15, 2015

The MARYLAND
HEALTH CARE COMMISSION

Overview of Preauthorization

- Preauthorization of medication and health services are required by State-regulated payors (payors) and pharmacy benefit managers (PBMs) to ensure that services are medically necessary, diagnosis based, cost effective, and safe for patients

- Historically, preauthorization has been a time consuming manual process, relying heavily on paper forms, faxes, and phone calls

- Electronic preauthorization aims to create an efficient means to submit, process, and track preauthorization requests using online portals or national transaction standards (ePA standards)

Maryland Law

- Maryland was one of the first states to enact legislation for the implementation of electronic preauthorization in 2012, requiring payors and PBMs to implement processes in a series of three benchmarks

- Amendments enacted in 2014 added a fourth benchmark requiring an electronic process to override a step therapy or fail-first protocol for pharmaceutical preauthorization

- Report to the Governor and General Assembly annually by December 31st through 2016

STEP THERAPY LEGISLATION
A Brief Look Back

Step Therapy Legislative History

- 2013 Legislative Session - HB 1015/SB 746 Health Insurance- Step Therapy or Fail-First Protocol introduced
  - Limited step therapy or fail-first protocols for prescription drugs or devices to the lesser of: (1) the period required to determine clinical effectiveness, or (2) 30 days
  - Carriers must allow prescriber access to an override process if
    - The prescription drug or device preferred by the carrier has been ineffective in treating the patient, or
    - Based on sound clinical, medical, and scientific evidence, the known relevant physical or mental characteristics of the patient, and the known characteristics of the treatment regimen, the prescription drug or device preferred by the carrier is likely either to be ineffective or adversely affect the compliance with the treatment regimen or has caused or is likely to cause an adverse reaction or other harm to the patient
- Legislation failed, and MHCC was asked to convene stakeholders to study the issue of step therapy

Step Therapy Report Recommendations

1. **Standardize step therapy grandfathering exemptions to permit patients already successfully managed by a drug or service to continue with that treatment without having to restart step therapy protocols**

    - **All payors use a one year look back period; currently, look back periods vary from 130 days to 365 days with exceptions based on the treating physician's documentation**

2. **Require all payors to incorporate step therapy approval and override processes in their automated preauthorization applications beginning in July 2015**

3. **Require all payors, including PBMs, to submit claim information to MHCC**

Implementation of Recommendations

- Chapter 317 of 2014
  - Recommendation 1- Standardize Grandfathering Exemptions
    - A step therapy or fail-first protocol may not be imposed if …a prescriber provides supporting medical information to the carrier or PBM that a prescription drug covered by the carrier or PBM (1) was ordered for the insured or enrollee within the past 180 days and (2) based on the professional judgment of the prescriber, was effective in treating the insured or enrollee
  - Recommendation 2 - Automated Override Process
    - Requires each payor, by July 1, 2015, to incorporate an override process into the preauthorization portal
- COMAR 10.25.06
  - Recommendation 3 - Require all payors to submit claim information to MHCC
    - Regulation amended in 2014 to require PBMs to submit claim information (HMO and Life & Health Insurers had been submitting data since 2000)

Electronic Preauthorization IMPLEMENTATION RESULTS

Key Findings

- All payors and PBMs are in compliance with the requirements
  - All have met the first three benchmark requirements of the law; and those required to implement the fourth benchmark did so by July 1, 2015
- Increased growth in utilization of electronic preauthorization
  - Electronic preauthorization for medical services experienced significant growth (nearly 52 percent) between 2012 and 2014
  - Pharmaceutical requests experienced much smaller growth (2 percent)
    - ePA standards are being implemented by EHR vendors; the use of online portals for pharmaceutical preauthorization requests are not expected to increase significantly in the future

Usability

- Health care professionals generally prefer submitting online preauthorization requests rather than telephone requests; however, challenges still exist
  - Uploading support documentation deters use by some professionals
    - About half of payors and PMBs support uploading documentation for pharmaceuticals but only one payor supports this for medical services
  - One in four professionals experience some difficulty incorporating the online preauthorization process into their workflow
  - Nearly all payors and PBMs enable out-of-network professionals to access their online portal by registering; completion of registration time varies from minutes to weeks

Promotion of Online Preauthorization Systems

- Payors rely on various communication techniques to promote the use of online preauthorization systems
  - Web-based communication is used more by payors than telephonic or paper-based forms of awareness building
  - The majority of payors, nearly 80 percent, offer online training programs
  - On-site training is used less than web-based training; however, on-site training is identified as effective in building awareness

Conclusions

- The State benchmarks have been impactful in increasing implementation and utilization of electronic preauthorization for medical services

- The increased availability of ePA standards within EHR systems is expected to accelerate the use of electronic preauthorization for pharmaceutical services

- To expand use by medical providers, payors should address usability challenges and modify education/training efforts

Next Steps – 2016

- Continue to collaborate with payors and MedChi, The State Medical Society to identify strategies to:
  - Increase awareness and utilization of payors' online portals
  - Address known health care professional challenges to using online portals and continue to assess challenges more broadly
- As required by law, report on payors' and PBMs' progress in implementing electronic preauthorization processes

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

Appendix

Preauthorization Benchmarks

1) Provide by October 1, 2012 online access to a listing of all medical services and pharmaceuticals that require preauthorization and the key criteria for making a preauthorization determination

2) Establish by March 1, 2013 an online system to receive preauthorization requests electronically and assign a unique identification number to each request for tracking purposes

3) Ensure by July 1, 2013 all electronic preauthorization requests for medical services and pharmaceuticals are rendered a determination within established timeframes

4) Establish by July 1, 2015 an electronic process to override a step therapy or fail-first protocol

Implementation of Benchmark 4

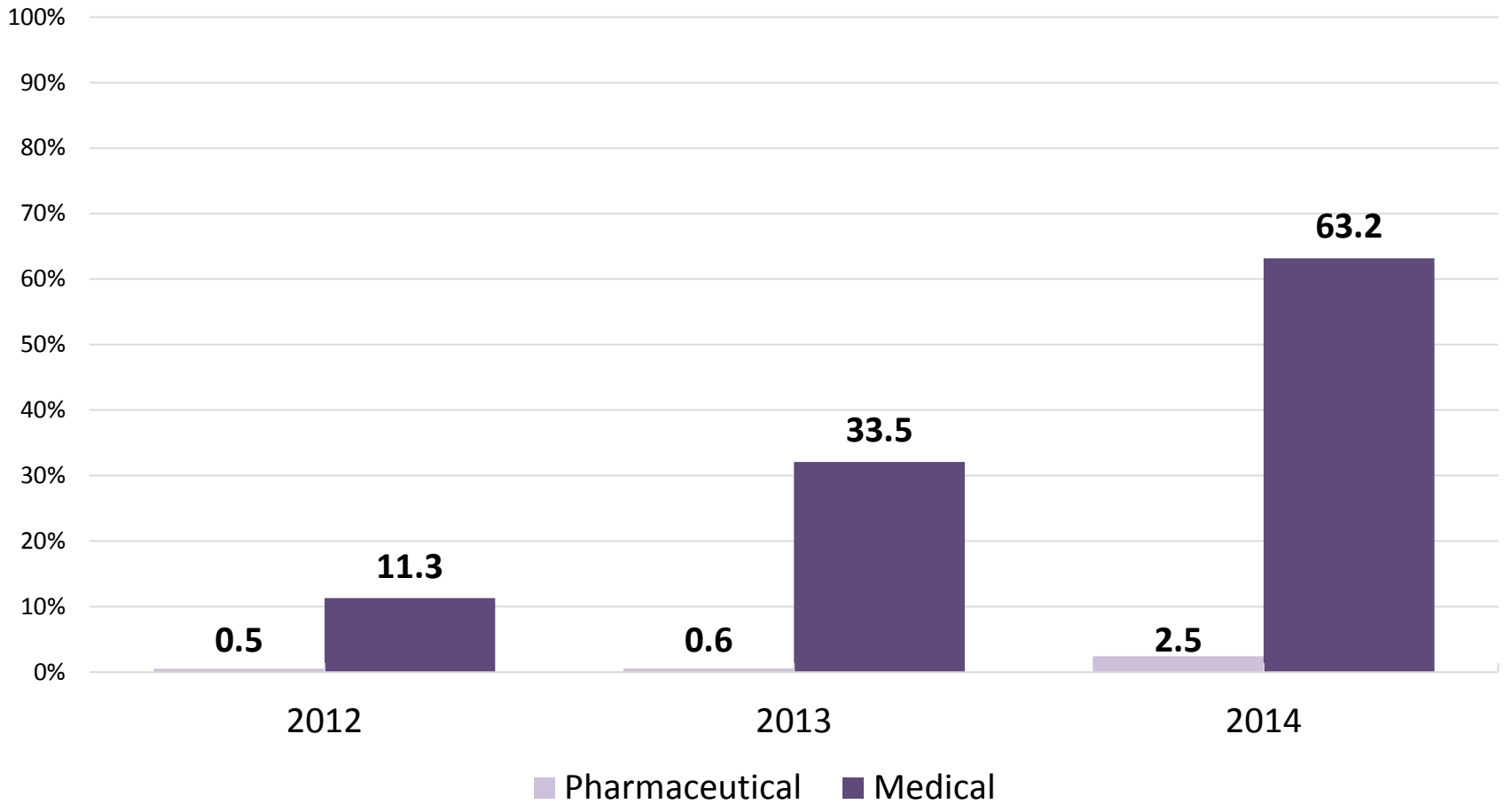
Electronic Override for Step Therapy and Fail-First Protocols		
Payor/PBM	**Implemented Benchmark**	**Date Completed/ Expected Date of Completion**
Aetna/Coventry	Yes	June 1, 2015
CareFirst	Yes	July 1, 2015
Catamaran	Yes	July 1, 2014
Cigna Pharmacy Management	Yes	July 1, 2013
CVS Caremark	Yes	June 1, 2012
Express Scripts	No	November 1, 2015
UnitedHealthcare OptumRX	Yes	July 1, 2015

ePA Standard

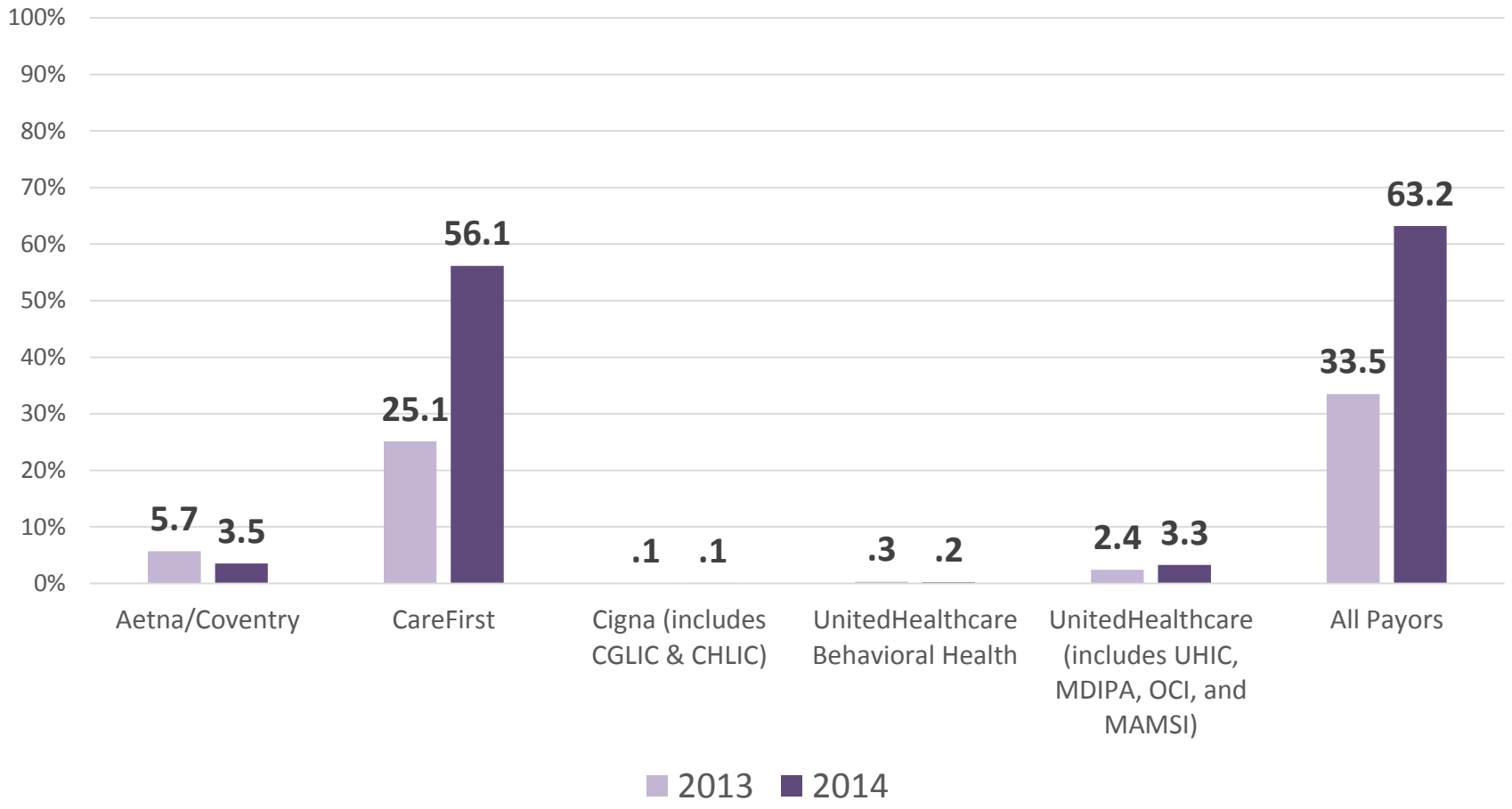
- The ePA standard is part of the approved, published NCPDP SCRIPT Standard for e-prescribing, which was named in the Medicare Modernization Act and a requirement of Meaningful Use

- Information on the ePA standard is available at: http://www.ncpdp.org/NCPDP/media/pdf/NCPDP_SCRIPT_ePA_Standard.pdf

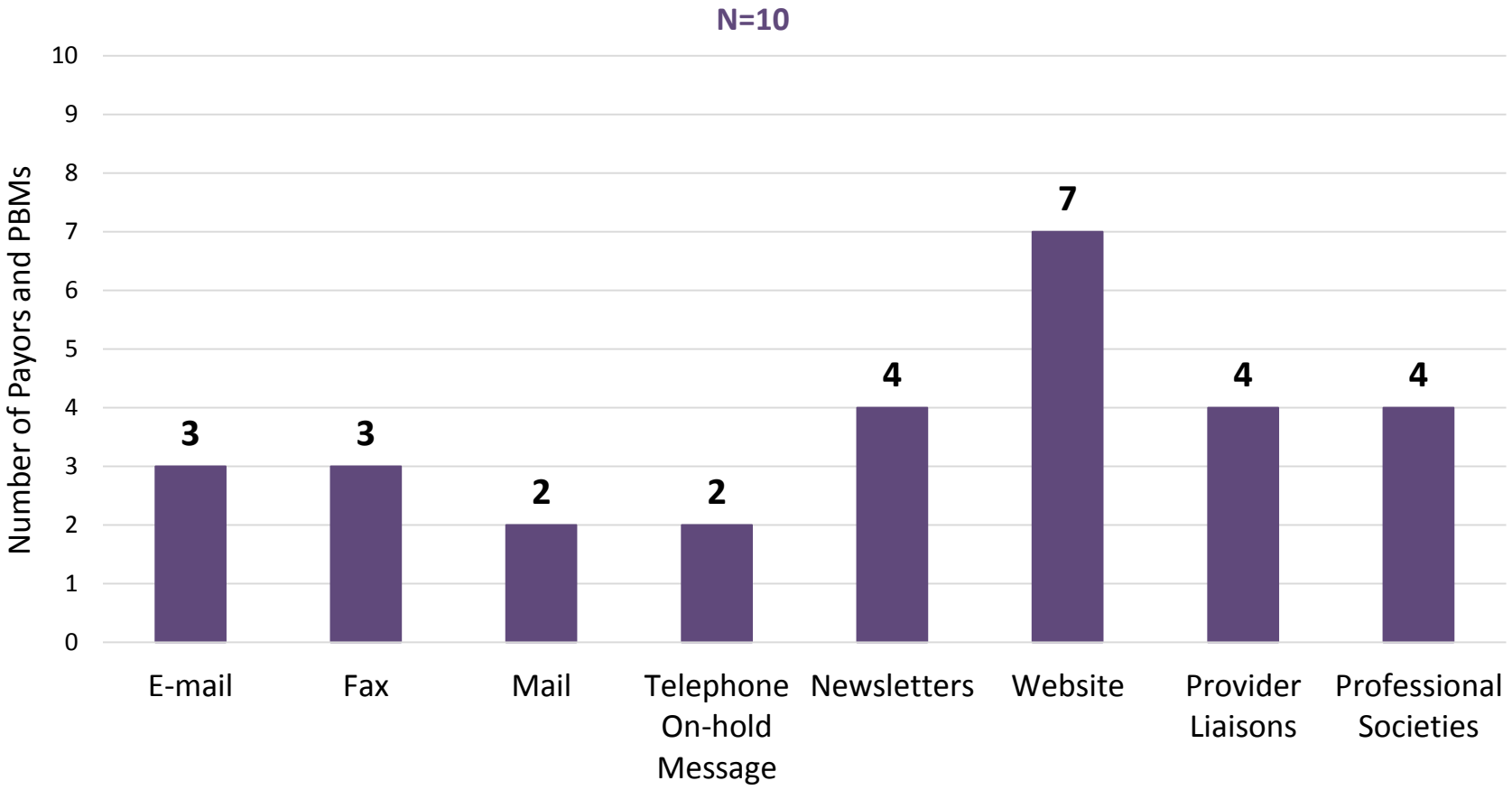
Electronic Preauthorization Requests



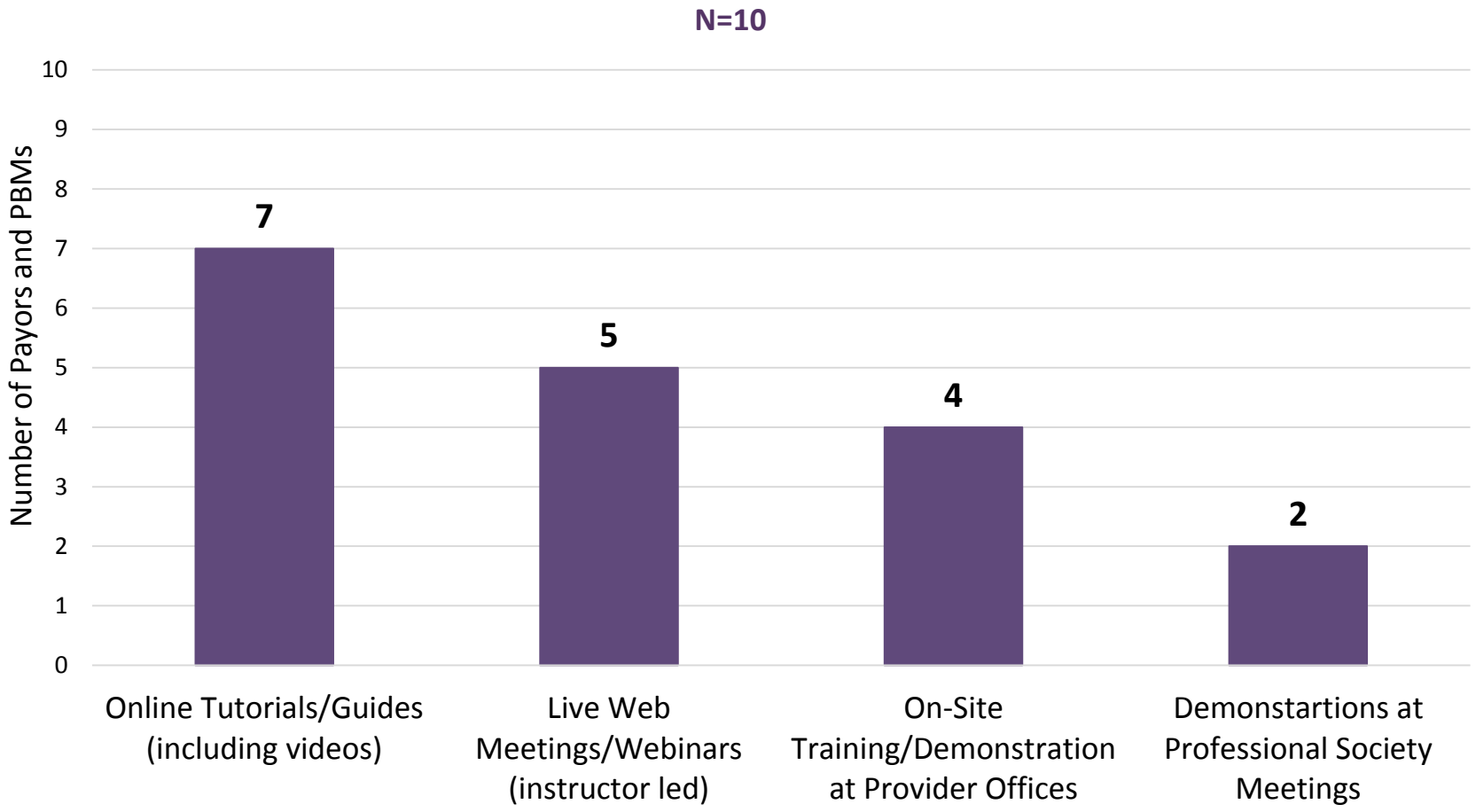
Estimated Share of Electronic Preauthorization Among all Preauthorization Requests - Medical Services



Communication Techniques Utilized by Payors and PBMs



Training Methods Utilized by Payors and PBMs



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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

2015 Health Benefit Quality Report Series

(Agenda Item #7)

2015 Quality Report Series:

Exchange Edition

Comprehensive Edition

Consumer Edition

Comparing Performance Trends of Maryland's Commercial Health Benefit Plans
www.marylandqmdc.org

Presentation to the Commission
October 15, 2015

Background

- **2015 Quality Report Series (final year in production)**
  - **Streamlined Consumer Edition: CAHPS® results**
  - **Detailed Comprehensive Edition: CAHPS® plus RELICC™, HEDIS®, BHA, QP, and additional helpful information (Maryland and National benchmark comparisons; Performance dashboards; Statewide health care initiatives; Information for State employees/retirees)**
  - **Summary Exchange Edition: QHP 5-Star Ratings (HBP performance data used as a proxy for QHP performance)**
- **2015 Health Benefit Plan Website (2nd year expansion)**
  - **Launched in 2014 with content from a single-year of CAHPS® results**
  - **Updated with content from 3-years of CAHPS® and HEDIS® results**
  - **Maryland benchmark comparisons**
  - **Pending additional updates throughout CY2015 to include results from RELICC™, BHA, QP, and additional helpful information (Performance dashboards; Statewide health care initiatives; Information for State employees/retirees)**

HBPs Reporting in Maryland

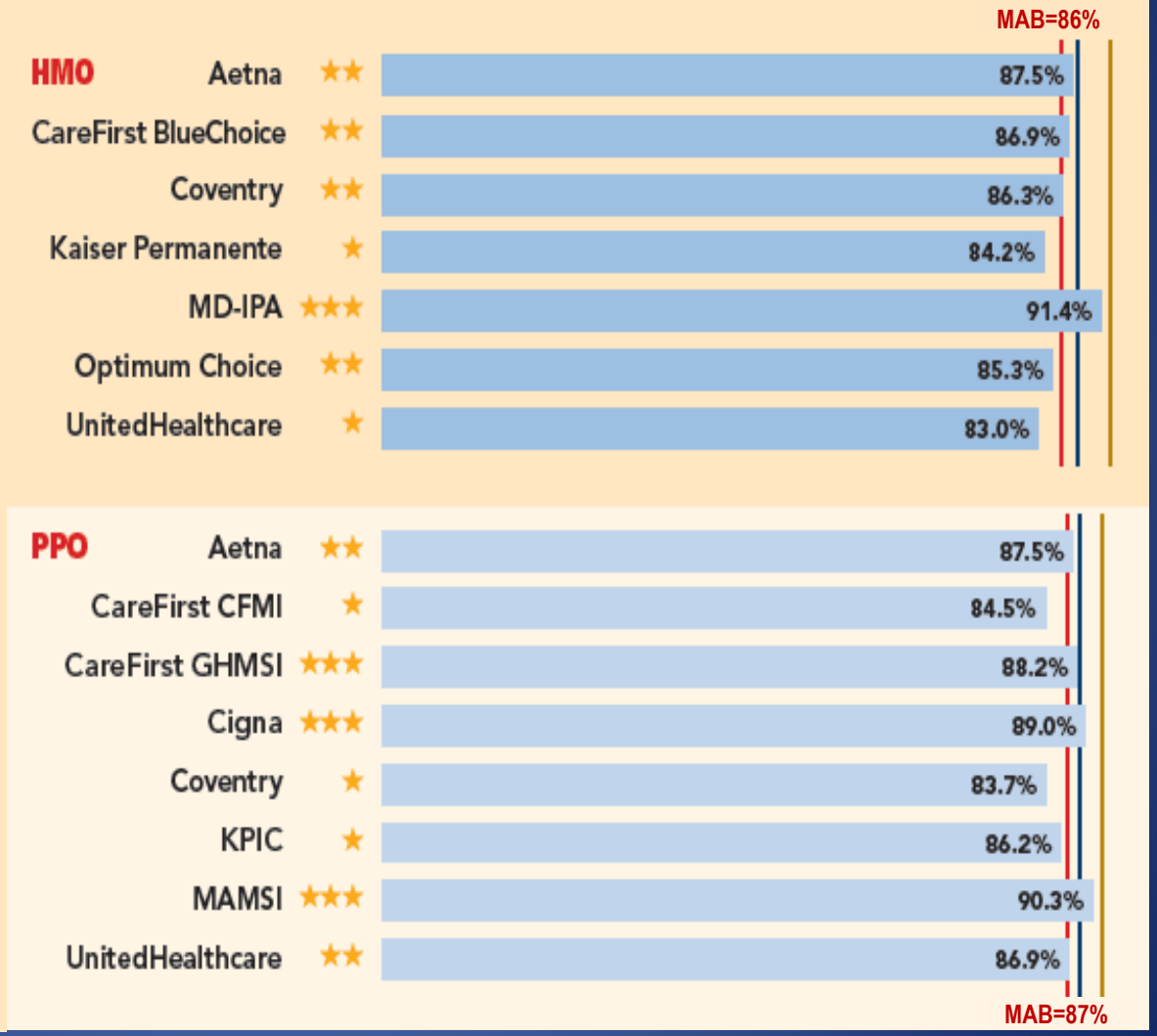
Report Level Name (Category)	Health Benefit Plan Name	Product Type
Aetna (HMO)	Aetna Health, Inc. (Pennsylvania) - Maryland	HMO/POS
Aetna (PPO)	Aetna Life Insurance Company (MD/DC)	PPO/EPO
CareFirst BlueChoice (HMO)	CareFirst BlueChoice, Inc	HMO/POS
CareFirst CFMI (PPO)	CareFirst of Maryland, Inc	PPO/EPO
CareFirst GHMSI (PPO)	Group Hospitalization and Medical Services, Inc	PPO
Cigna (PPO)	Cigna Health and Life Insurance Co/ Connecticut General Life Insurance Co	POS/PPO
Coventry (HMO)	Coventry Health Care of Delaware, Inc	HMO/POS
Coventry (PPO)	Coventry Health and Life Insurance Co	PPO
Kaiser Permanente (HMO)	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc	HMO/POS
KPIC (PPO)	Kaiser Permanente Insurance Co	POS
MD-IPA (HMO)	UHC-Maryland Individual Practice Association, Inc	HMO/POS
Optimum Choice (HMO)	UHC-Optimum Choice, Inc	HMO/POS
UnitedHealthcare (HMO)	UnitedHealthcare of the Mid-Atlantic, Inc	HMO
MAMSI (PPO)	UHC-MAMSI Life and Health Insurance Co	PPO
UnitedHealthcare (PPO)	UnitedHealthcare Insurance Company (Maryland)	PPO/POS/EPO

Member Experience Comparisons

GETTING NEEDED CARE

Percentage of survey participants who responded with "Usually" or "Always" for the following questions:

- **In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?**
- **…did you get an appointment to see a specialist as soon as you needed?**



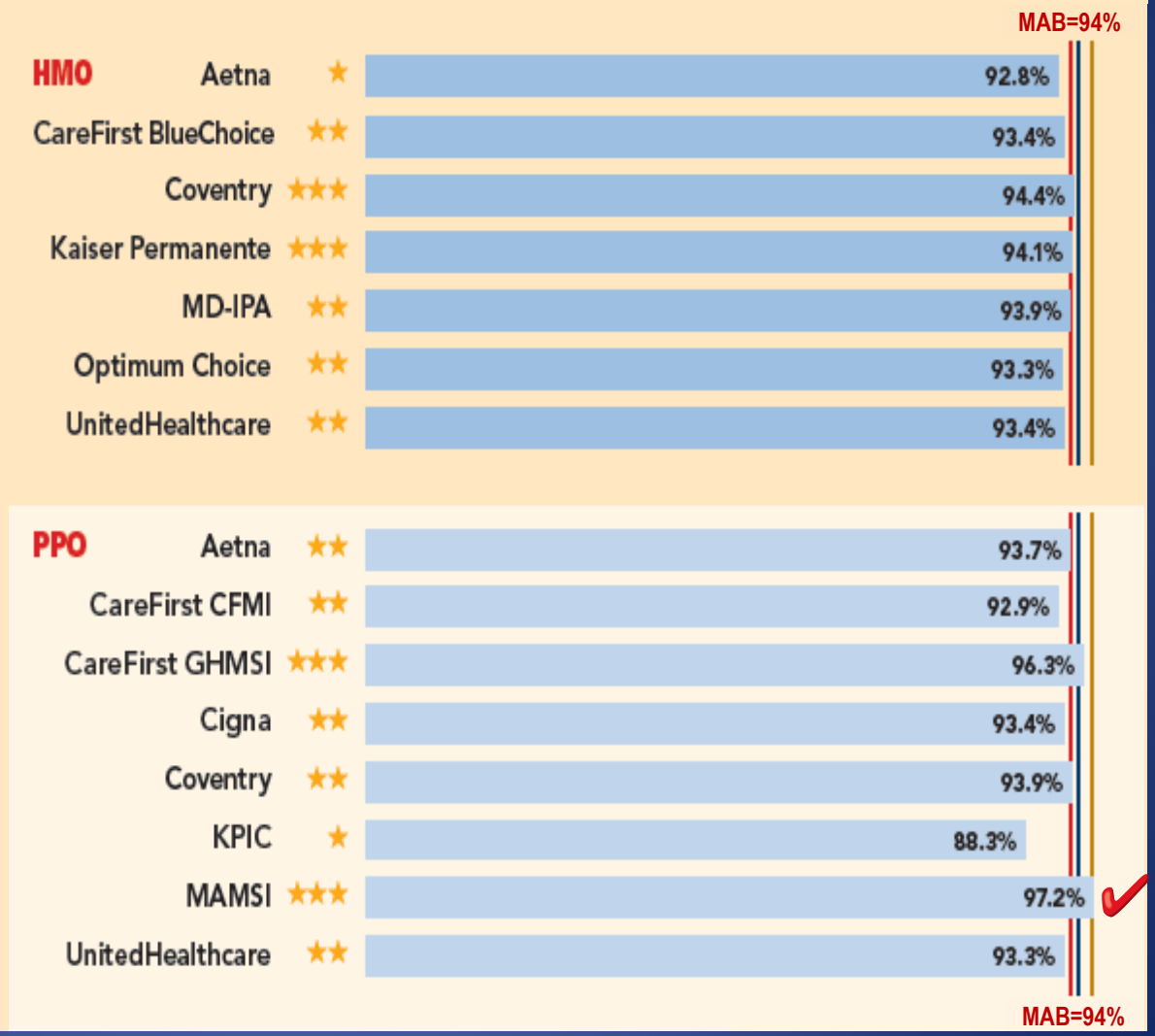
Data Source: CAHPS® Submission or Health Benefit Plan Records

Member Experience Comparisons

HOW WELL DOCTORS COMMUNICATE

Percentage of survey participants who responded with "Usually" or "Always" for the following questions:

- **In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?**
- **…listen carefully to you?**
- **…show respect for what you had to say?**
- **…spend enough time with you?**



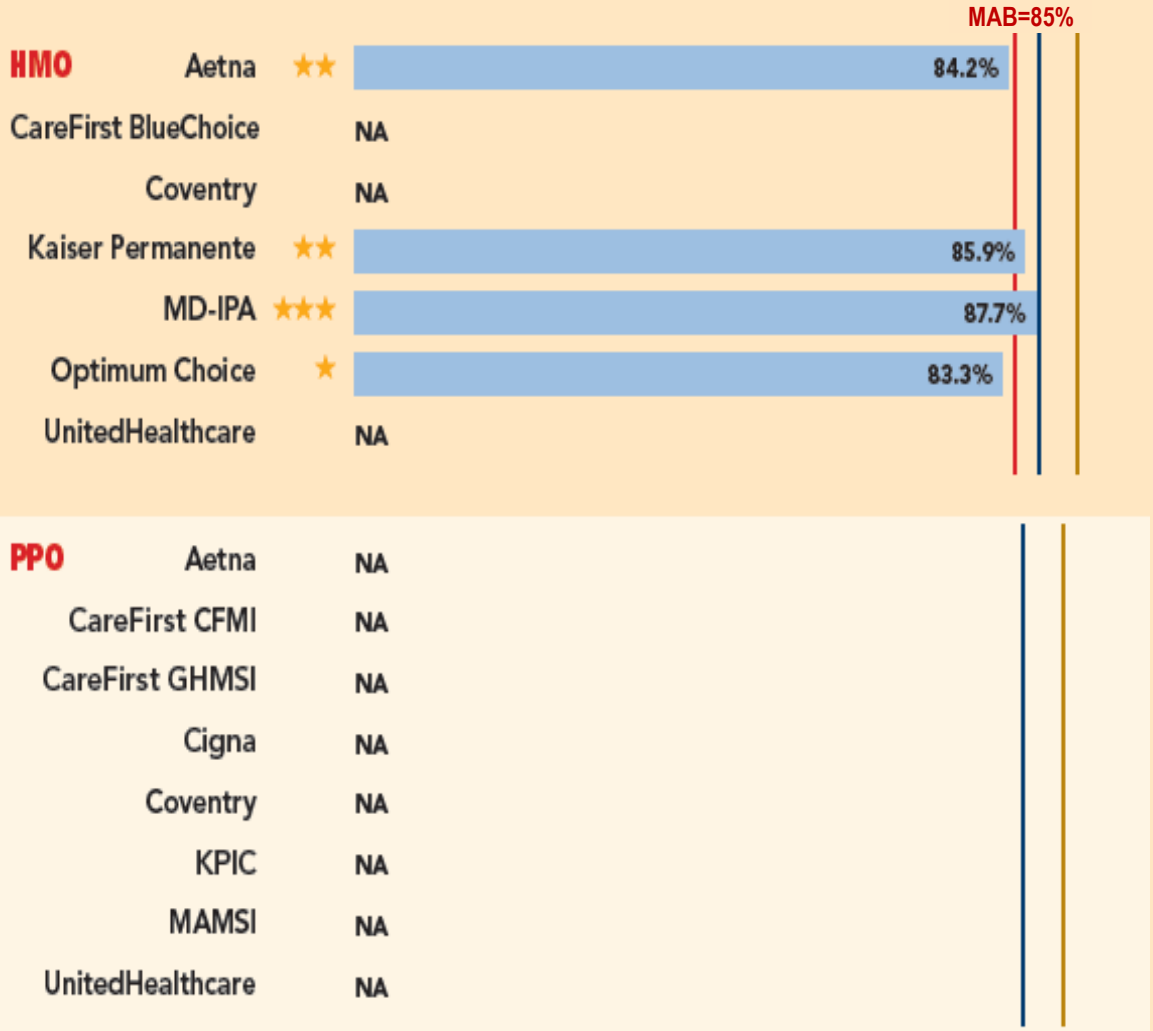
Data Source: CAHPS® Submission or Health Benefit Plan Records

Member Experience Comparisons

CUSTOMER SERVICE

Percentage of survey participants who responded with "Usually" or "Always" for the following questions:

- **In the last 12 months, how often did your health plan's customer service staff give you the information or help you needed?**
- **…treat you with courtesy and respect?**

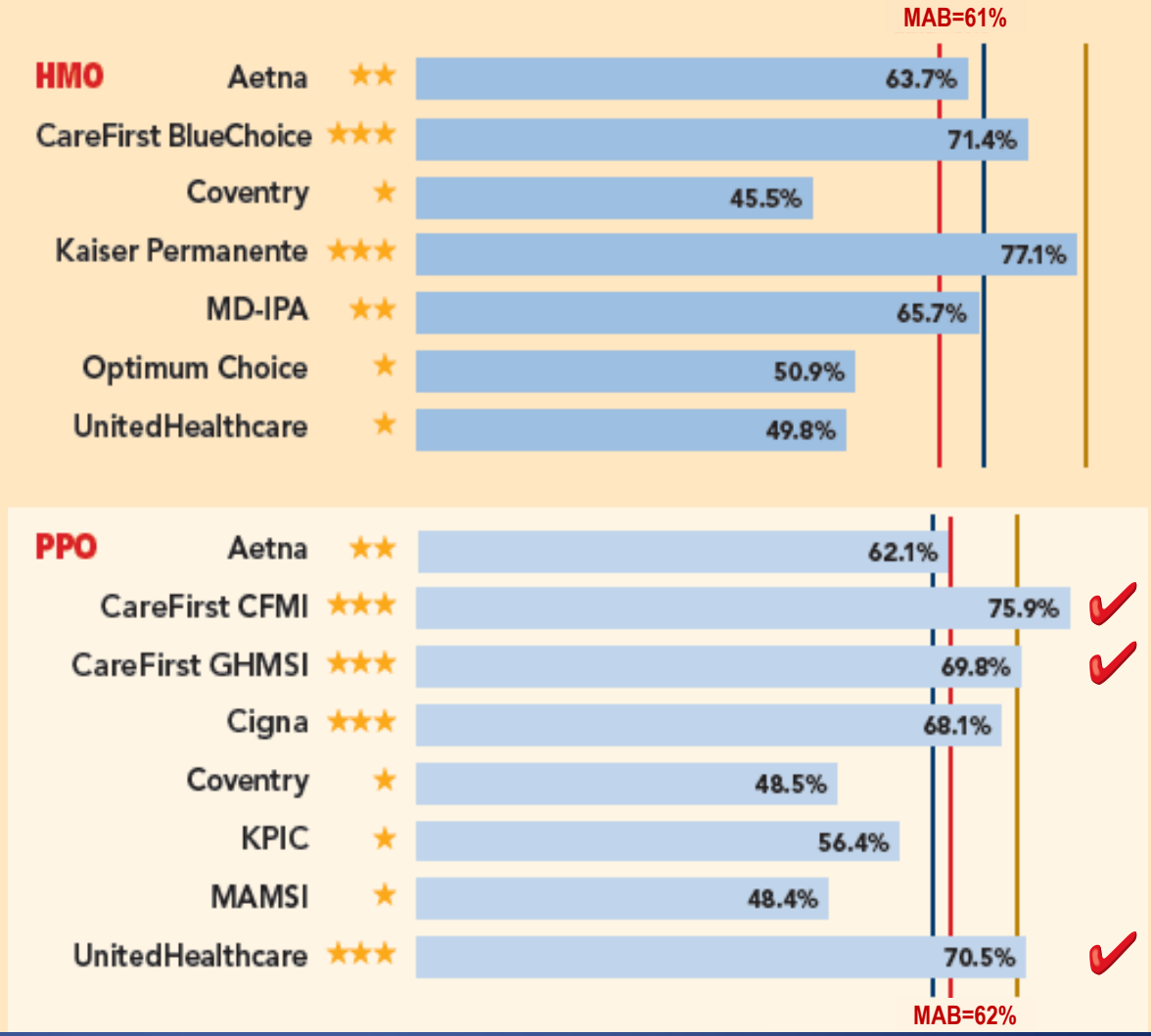


Data Source: CAHPS® Submission or Health Benefit Plan Records

Member Experience Comparisons

GOOD OVERALL RATING OF HEALTH BENEFIT PLAN

Percentage of survey participants who rated their health benefit plan an 8, 9 or 10 on a scale from 0 to 10.



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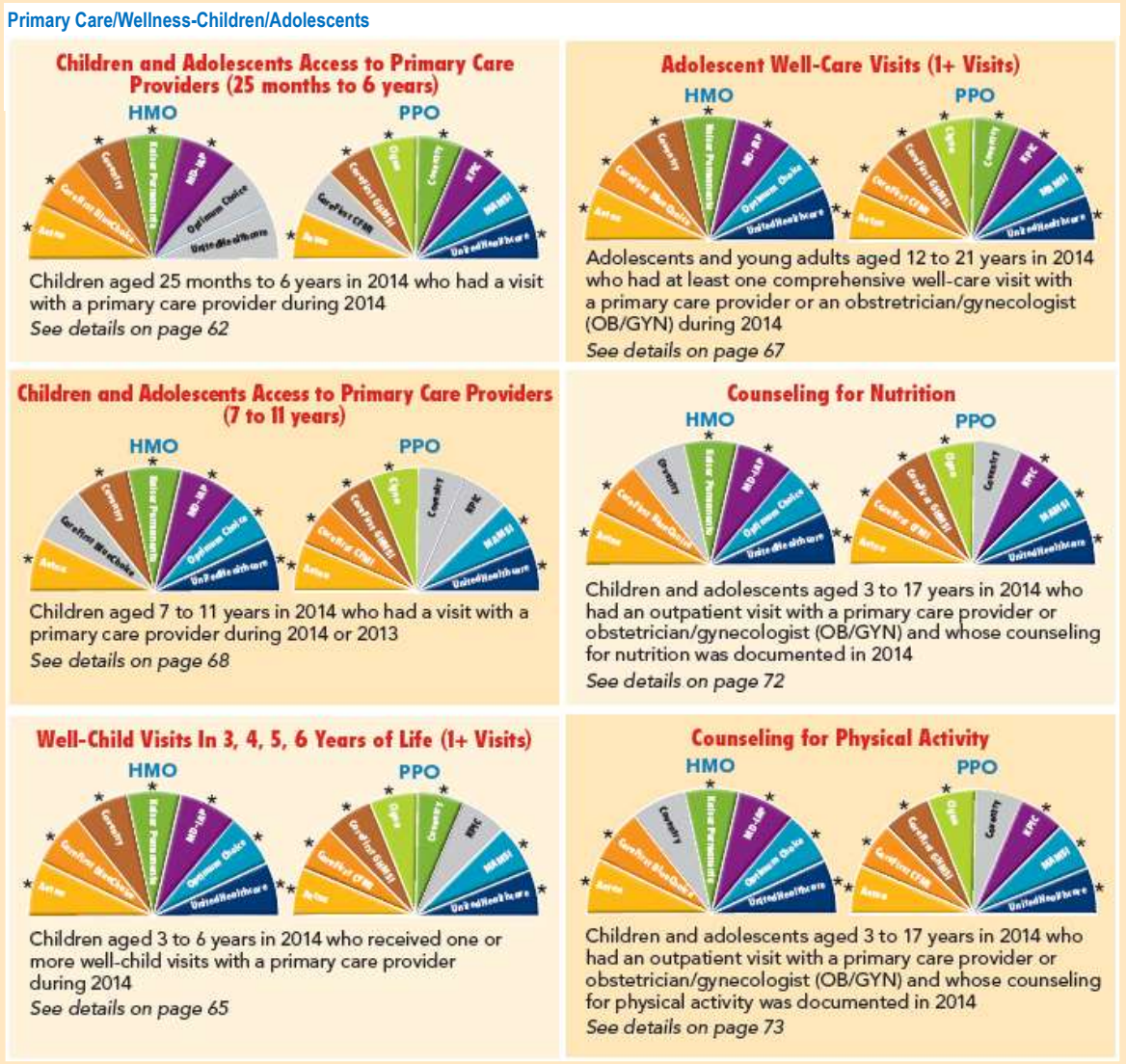
Clinical Comparisons

Excellent Performance Areas

Out of 5 categories of clinical performance measures and indicators, Maryland health benefit plans demonstrate excellent performance, at or better than the national average benchmark, on several measures within 4 categories:

- **Primary Care and Wellness for Children and Adolescents**
- **Child Respiratory Conditions**
- **Women's Health**
- **Behavioral Health**



Clinical Comparisons

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- **Child Respiratory Conditions**
- **Women's Health**
- **Behavioral Health**

Excellent Performance Areas

Child Respiratory Conditions | Women's Health | Behavioral Health

Appropriate Testing for Children With Pharyngitis

Children and adolescents aged 2 to 18 years in 2014 who received a group-A streptococces (strep) test before being diagnosed with pharyngitis and then being given an appropriate prescription for an antibiotic during 2014

See details on page 77

Chlamydia Screening

Women aged 16 to 24 years in 2014 who were identified as sexually active and who had a least one test for chlamydia during 2014

See details on page 92

Appropriate Treatment for Children With Upper Respiratory Infection

Infants, children, and adolescents aged 3 months to 18 years in 2014 who were given a diagnosis of upper respiratory infection, and were appropriately not given an antibiotic prescription within 3 days of their visit

See details on page 78

Antidepressant Medication Management (Effective Acute Phase)

Adults aged 18 years and over in 2014 with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 12 weeks

See details on page 129

Antidepressant Medication Management (Effective Continuation Phase)

Adults aged 18 years and over in 2014 with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication for at least 6 months

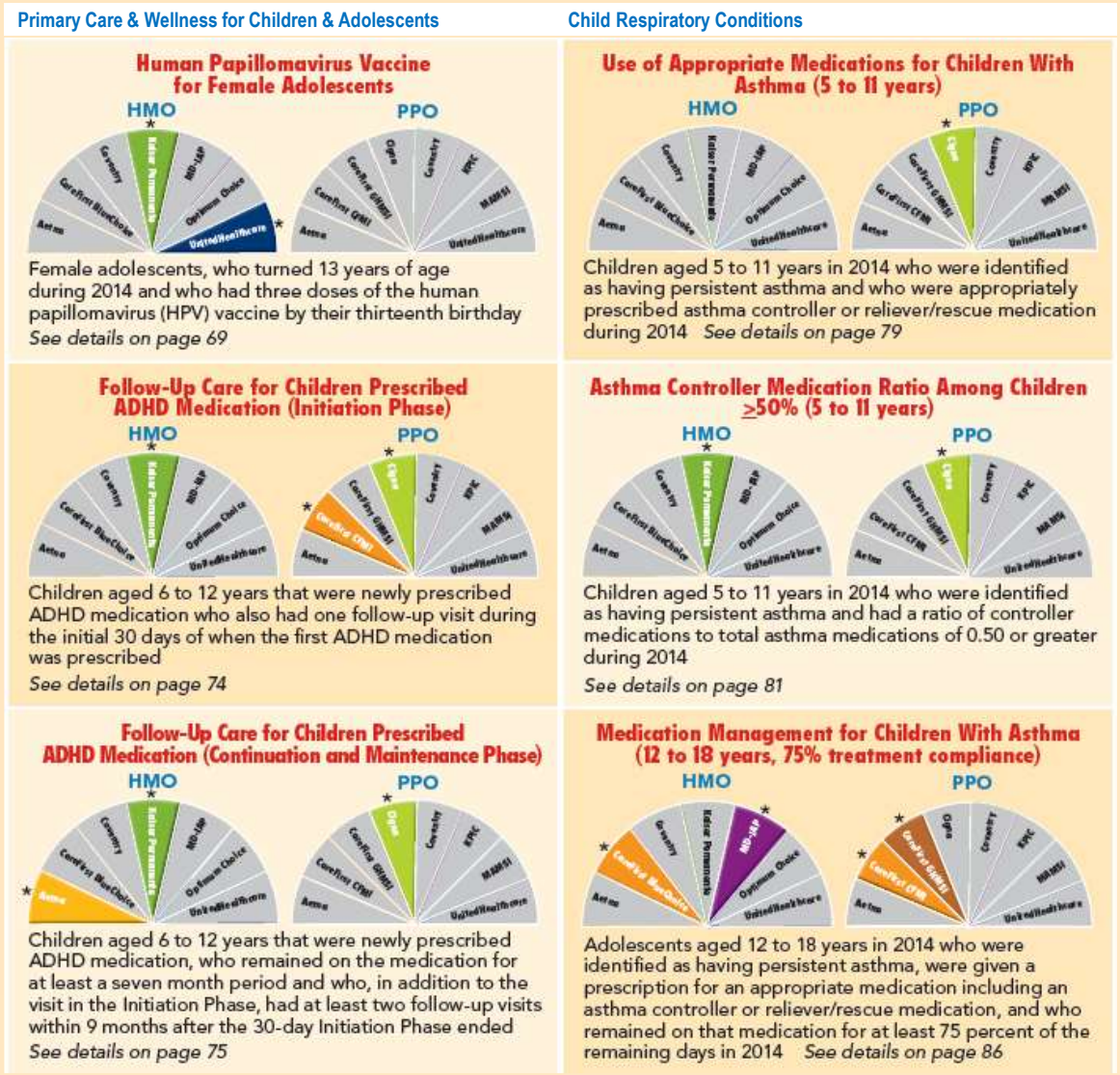
See details on page 130

Clinical Comparisons

Out of 5 categories of clinical performance measures and indicators, Maryland health benefit plans demonstrate poor performance, where few plans perform at or better than the national average benchmark, on several measures within 4 categories:

- **Primary Care and Wellness for Children and Adolescents**
- **Child Respiratory Conditions**
- **Primary Care for Adults**
- **Behavioral Health**

Areas That Need Improvement

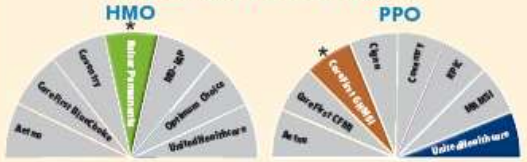


Clinical Comparisons

Areas That Need Improvement

Primary Care for Adults–Respiratory Conditions

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis



Adults aged 18 to 64 years in 2014 with a diagnosis of acute bronchitis who were appropriately not given an antibiotic prescription unless needed

See details on page 100

Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation (Bronchodilator)

Adults aged 40 years and over in 2014 who had an acute inpatient discharge or emergency department encounter for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation on or between January 1st and November 30th, 2014, and who were given a prescription for a bronchodilator within 30 days of the COPD event

See details on page 103

Primary Care for Adults–Cardiovascular Conditions & Diabetes

Comprehensive Diabetes Care (HbA1c Testing)

Adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had an HbA1c test during 2014

See details on page 115

Comprehensive Diabetes Care (Good BP Control <140/90 mm Hg)

Adults aged 18 to 75 years in 2014 with diabetes (type 1 and type 2) who had their blood pressure assessed and demonstrated good blood pressure control <140/90 mm Hg, during 2014

See details on page 121

Primary Care for Adults–Musculoskeletal Disease&Medication Mgmt

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

Adults aged 18 years and over in 2014 who were diagnosed with rheumatoid arthritis (RA) and who were given a prescription for at least one Disease Modifying anti-Rheumatic Drug (DMARD) in 2014. DMARDs are medications proven effective in slowing or preventing joint damage as opposed to just relieving pain and inflammation.

See details on page 123

Annual Monitoring for Patients on Persistent Medications (Digoxin)

Adults aged 18 years and over in 2014 who received at least 180 treatment days of ambulatory medication therapy with digoxin during 2014 and had at least one therapeutic monitoring event for the digoxin agent in 2014

See details on page 126

Behavioral Health

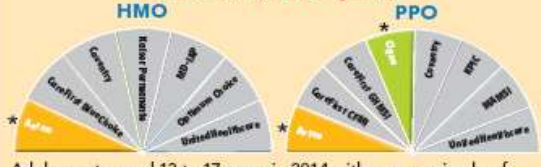
Initiation of Alcohol and Other Drug Dependence Treatment (13 to 17 years)

Adolescents aged 13 to 17 years in 2014 with a new episode of Alcohol and Other Drug (AOD) dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis *See details on page 133*

Initiation of Alcohol and Other Drug Dependence Treatment (18+ years)

Adults aged 18 years and over in 2014 with a new episode of Alcohol and Other Drug (AOD) dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis *See details on page 134*

Engagement of Alcohol and Other Drug Dependence Treatment (13 to 17 years)



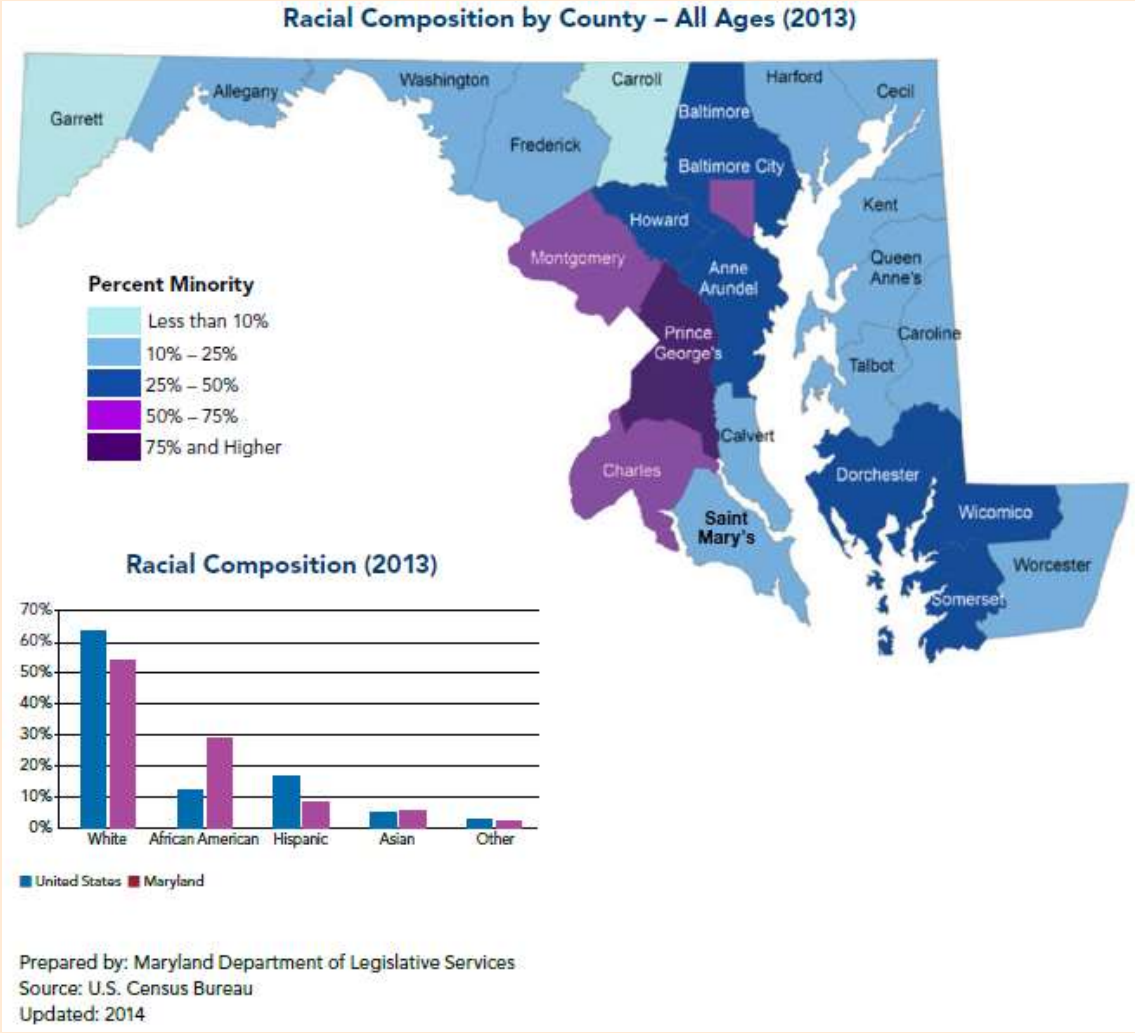
Adolescents aged 13 to 17 years in 2014 with a new episode of Alcohol and Other Drug (AOD) dependence, whose treatment was initiated through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis and who had two or more additional services within 30 days of the initiation visit *See details on page 135*

Understanding Disparities

Background to Maryland Demographics

Racial Composition:

- **4 of Maryland's jurisdictions have a majority minority population**
- **Racial minorities comprise 46.7% of the State's population compared to 37.4% nationally**
- **African Americans are the largest racial minority in Maryland comprising 29.2% of the State's population; whereas Hispanics account for 9.0%, followed by Asians at 6.0%**

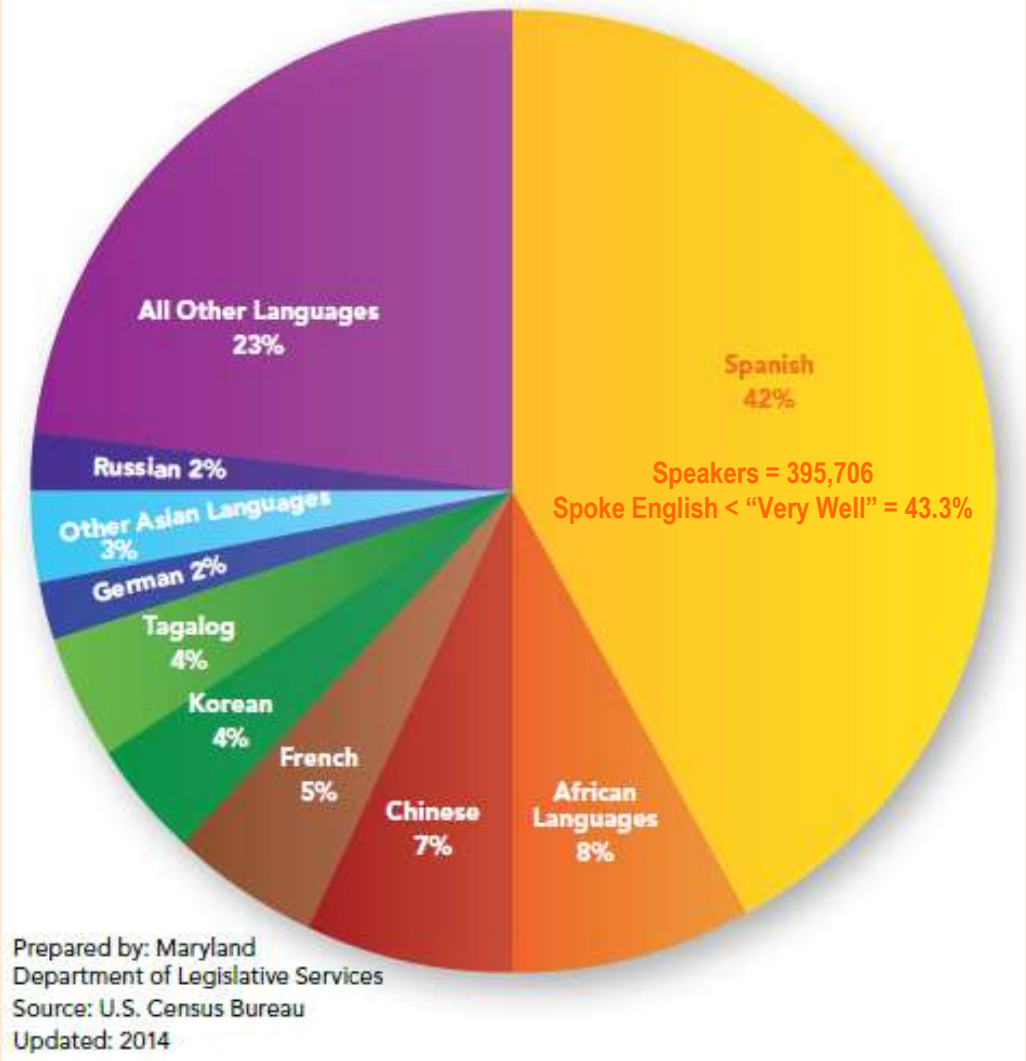


Understanding Disparities

Background to Maryland Demographics

Languages Spoken at Home, other than English:

- **Maryland remains one of the most diverse states with people from approximately 160 different countries speaking over 100 languages**
- **Nationally, Maryland has the 10th highest percentage of residents who are foreign-born**
- **14.2% of Maryland residents are foreign-born compared to 13.1% at the national level**

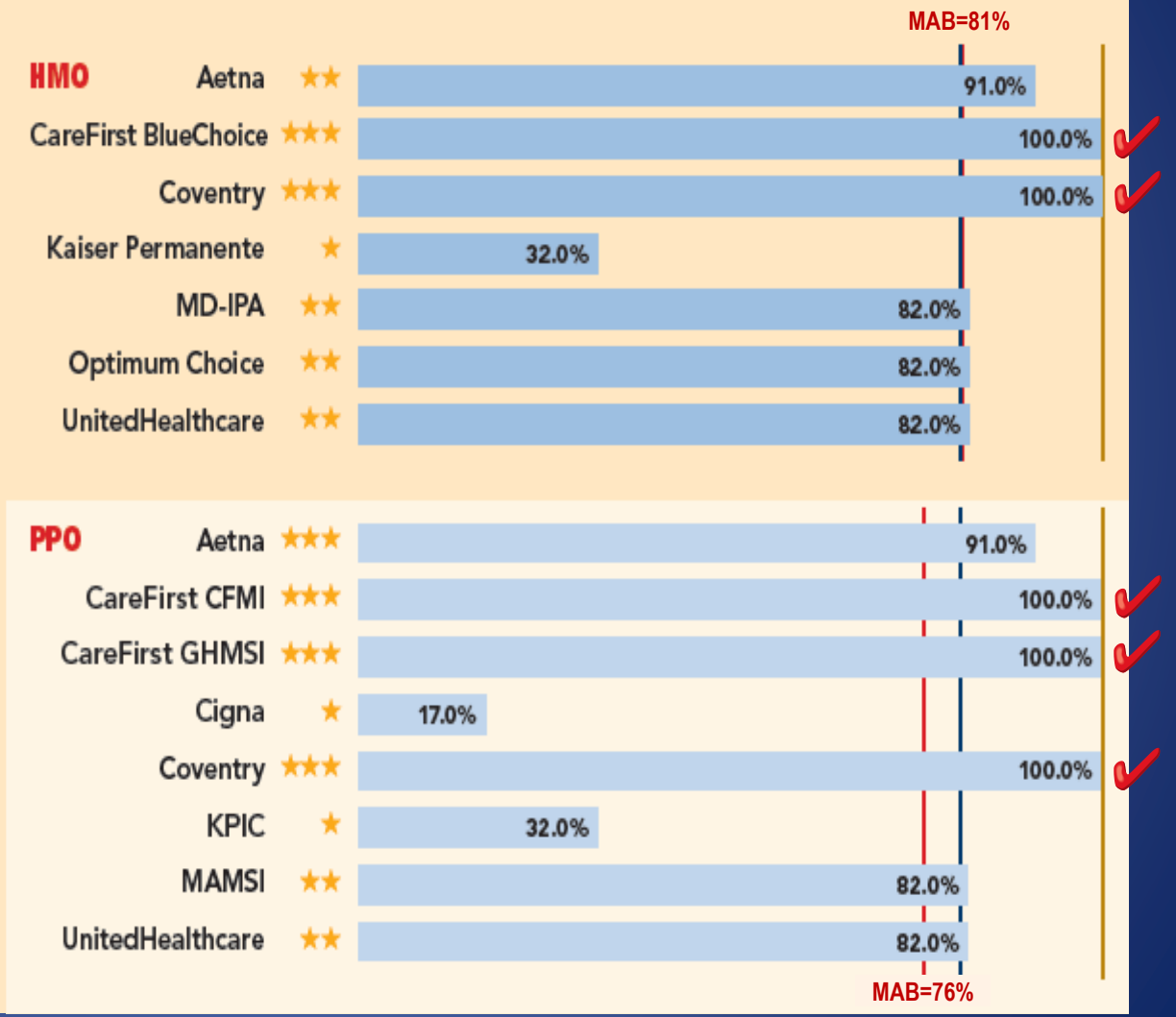


Carrier Disparities Initiatives

Member Information Sources

Percentage of meaningful member information sources and other informational characteristics being proactively captured by the health benefit plan and used to identify RELICC™ data elements of plan members:

- **Race/ethnicity**
- **Languages spoken other than English**
- **Interpreter need**
- **Cultural characteristics**



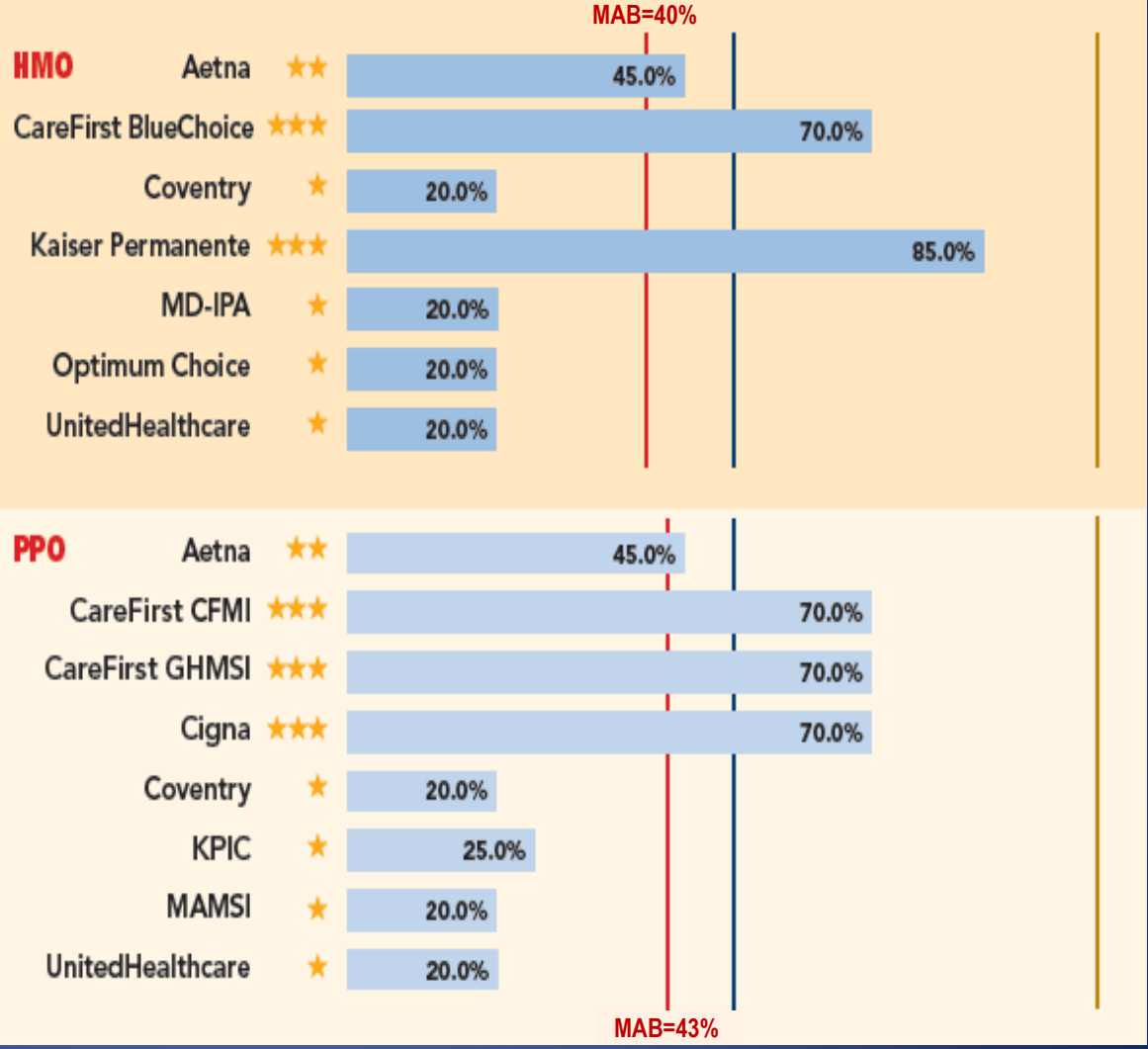
Carrier Disparities Initiatives

Information on Physicians, Physician Office Staff & Plan Personnel

Percentage of network physicians, provider office staff and plan personnel for which the plan has identified RELICC™ data elements of plan members:

- **Race/ethnicity**
- **Languages spoken other than English**

NOTE:
Each data element is weighted differently, thus a plan performance rate of 47% does not necessarily indicate the plan has 47% of the RELICC™ data



Carrier Disparities Initiatives

Other RELICC™ Measures

- Using the Data
- Supporting the needs of members with limited English proficiency
- Assuring that culturally competent health care is delivered
- Evaluating and measuring the impact of language assistance
- Information available through the online provider directory
- Interactive selection features for members selecting a physician online
- Health Assessment (HA) programming

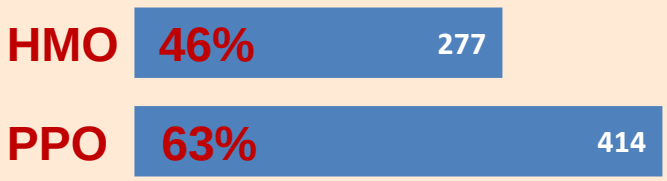
Overall Performance

FREQUENCY - PERFORMANCE AT OR BETTER THAN NATIONAL AVERAGE

Quality measures/indicators:

- **9 RELICC™**
- **79 HEDIS®**
- **13 CAHPS®**
- **98 measures have a national average benchmark to be compared against**

NOTE: BHA and QP measures are informational only and have no comparison benchmarks



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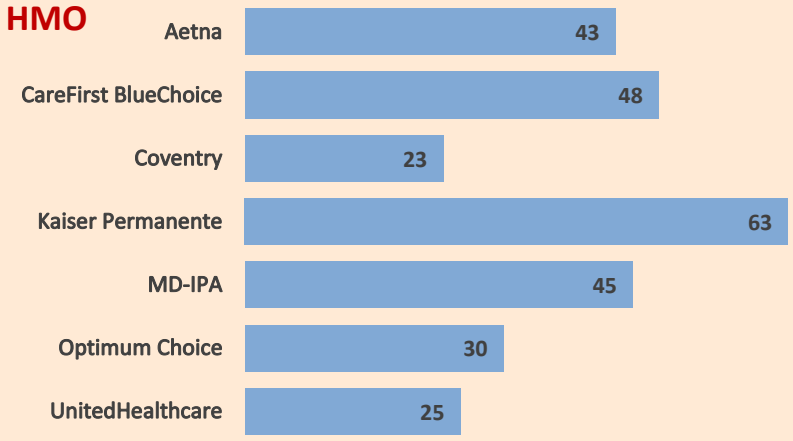

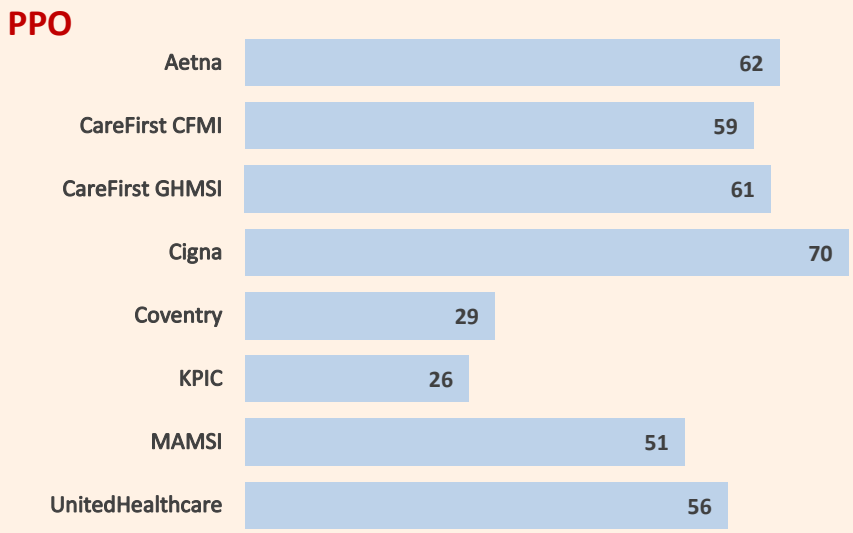

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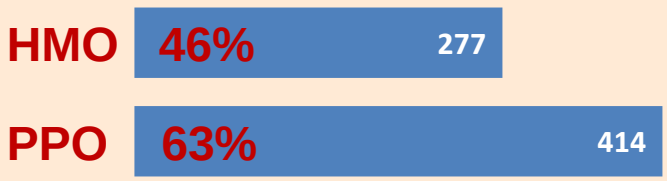

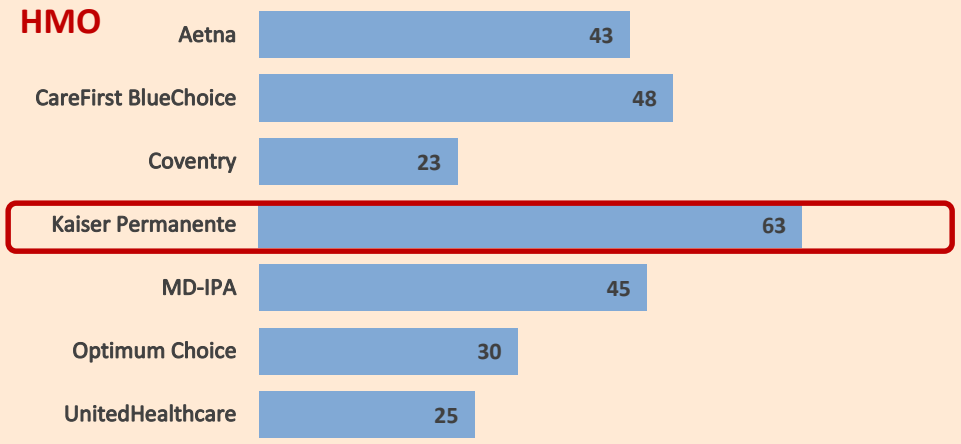

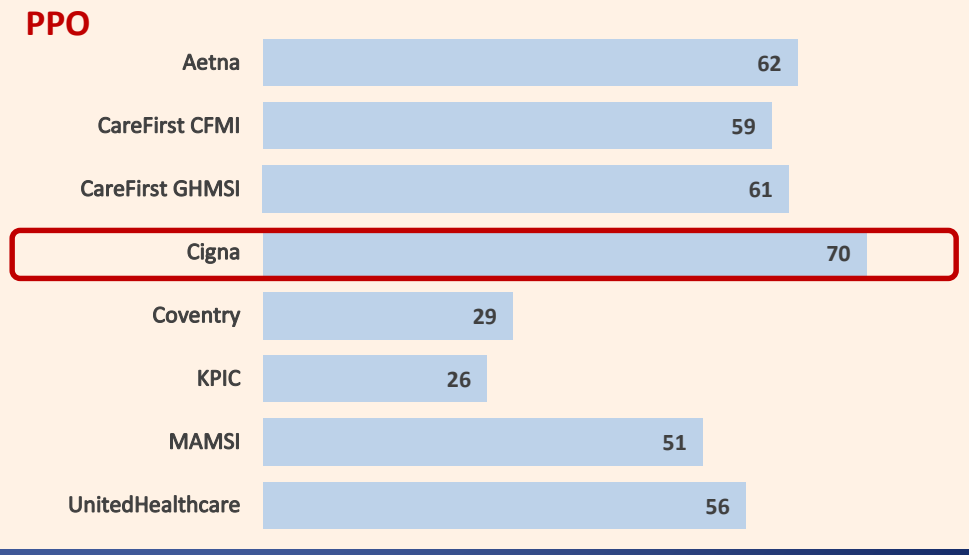

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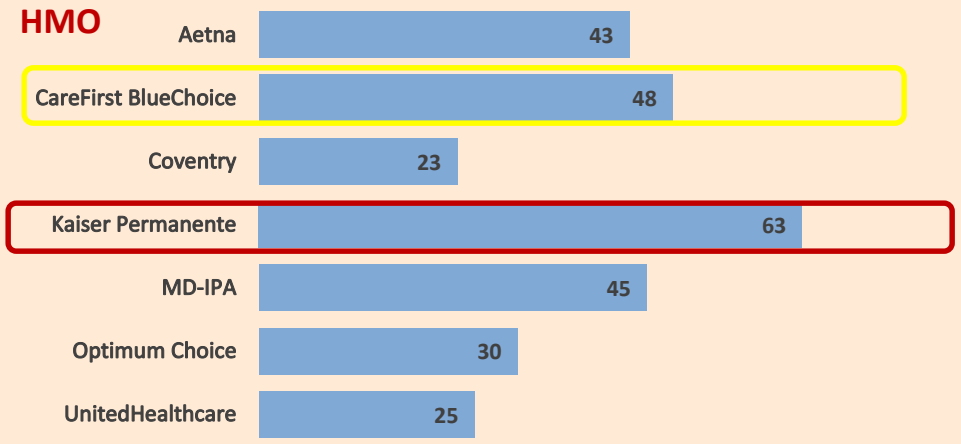

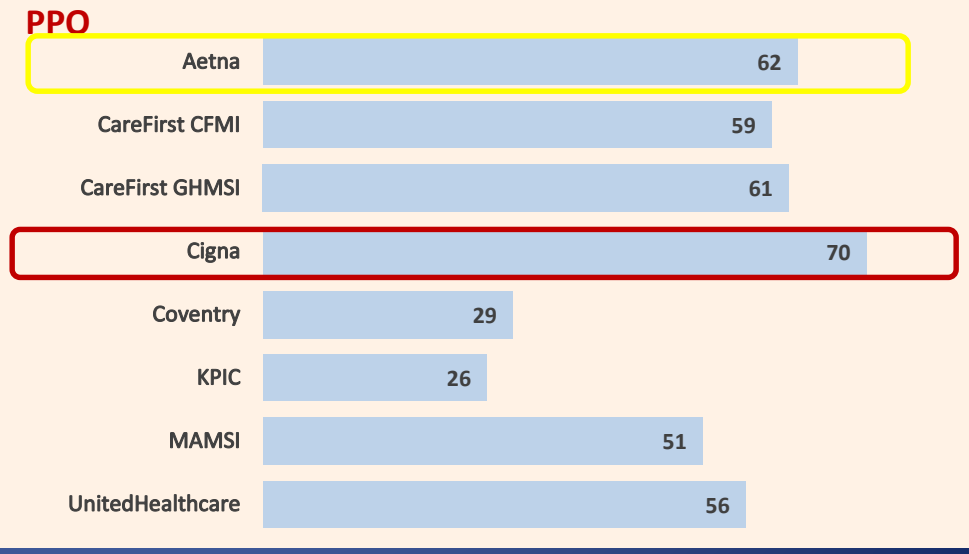

Next Steps

- **Exchange Edition**
  - **Maryland Health Connection Quality Report 2015 due for public release by MHBE prior to Open Enrollment**
- **Promote Improved Consumer Awareness**
  - **Information Booth: Disparities Conference, BBJ Expo, etc .**
  - **Electronic Mailings: Maryland Chamber of Commerce, Maryland Retailers Association, etc .**
- **Annual Quality Reporting Cycle**
  - **MHBE Collaboration (HBPs and QHPs)**
  - **Carrier/Consumer/Employer/Benefits Manager Feedback**
  - **Finalize 2016 QPRR – Audit – Attestation – Validation –**
  - **Public release of 2016 performance results via web only**

Thank You.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. APPROVAL OF MINUTES

2. UPDATE OF ACTIVITIES

3. ACTION: COMAR 10.24.17, State Health Plan for Facilities and Services: Cardiac Surgery & Percutaneous Coronary Intervention Services – Final Regulations

4. ACTION: Request for Release of MCDB Data by Berkeley Research Group (BRG)

5. ACTION: Approval for Release – Maryland Trauma Physicians Services Fund Report

6. ACTION: Approval for Release - 2015 Preauthorization Benchmark Attainment Report

7. PRESENTATION: 2015 Health Benefit Quality Report Series

8. **DEMONSTRATION: *Maryland Health Care Quality Reports* Website**

9. Overview of Upcoming Initiatives

10. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

DEMONSTRATION:

Maryland Health Care Quality Reports Website

(Agenda Item #8)

MARYLAND HEALTH CARE COMMISSION

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9. **Overview of Upcoming Initiatives**

10. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #9)


ENJOY THE REST OF
YOUR DAY