Maryland Health Care Commission

Thursday, July 20, 2017

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **PRESENTATION**: Maryland's All Payer Model (HSCRC)

4. **ACTION**: Certificate of Need
   - Riva Road Surgical Center, L.L.C. (Docket No. 17-02-2392)
   - Visiting Nurse Association of Maryland, L.L.C. d/b/a VNA of Maryland (Docket No. 17-R1-2393)

5. **PRESENTATION**: Surescripts Overview – A Maryland Registered HIE

6. **PRESENTATION**: Spending and Use among Maryland's Privately Fully Insured

7. **OVERVIEW OF UPCOMING EVENTS**

8. **ADJOURNMENT**

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Maryland's All Payer Model (HSCRC)

(Agenda Item #3)

HSCRC Update on Maryland's Health Care Transformation

July 2017

HSCRC
Health Services Cost Review Commission

Goals of Today's Discussion

- Maryland's Current All-Payer Model
- Maryland's All-Payer Model Performance
- Model Progression
- Maryland's Proposed Enhanced Total Cost of Care All-Payer Model

Maryland's Current All-Payer Model

What Are We Trying to Do?

Maryland's All-Payer Model Goals:

- Fundamentally transform the Maryland health care system
  - Provide person-centered care
  - Improve care delivery and outcomes
  - Moderate the growth in costs

Why?

Cost and Outcomes

- Higher costs (affordability)/less favorable outcomes
- Population health/health equity

Aging of Population

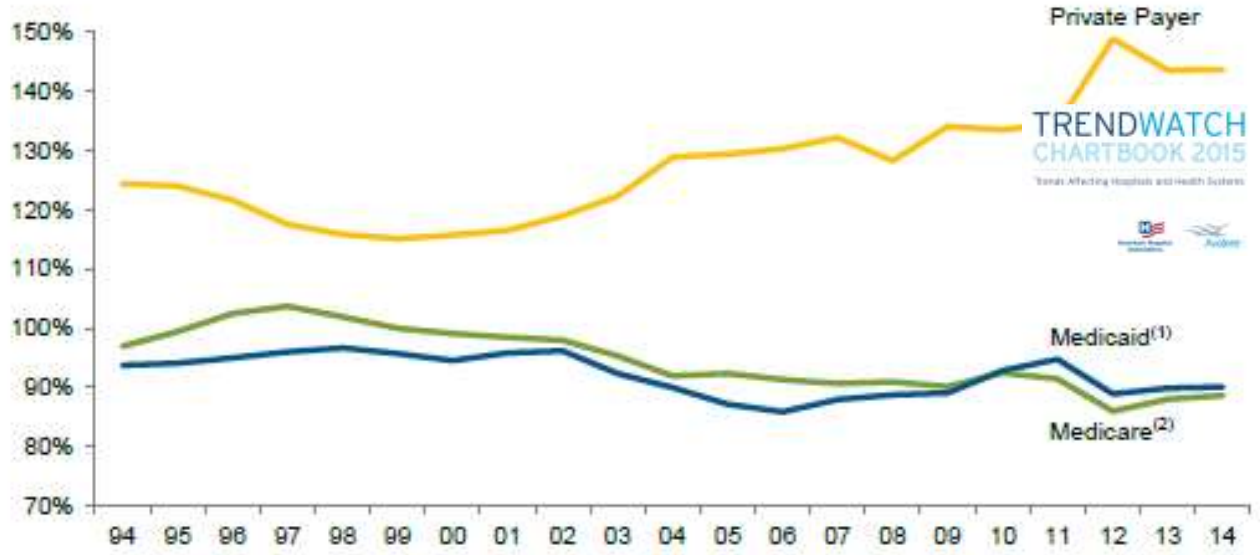
- 37% increase in Maryland's population >65-years-old over next 10 years
- Profound impact on federal and state budgets and delivery system needs

All-Payer Hospital Model Creates Incentives

- State sets broad goals and incentives with stakeholder input
  - All-Payer revenue growth, quality and outcomes goals/incentives
- Hospitals—volume to global, aligned value-based incentives
  - Fixed all-payer hospital global budgets with full responsibility
  - Quality and value-based indicators
  - Electronic Health Records/HIE requirements

Nationally, Cost-Shifting Occurs Between Private and Public Payers

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



Source: American Hospital Association

Outside of Maryland, Medicare costs are shifted onto businesses and consumers

- In Maryland, hospitals are paid using a common rate structure by ALL payers, which eliminates cost shifting

All-Payer Model: Performance to Date

Performance Measures	Targets	2014 Results	2015 Results[1]	2016 Results (preliminary)[2]
All-Payer Hospital Revenue Growth	**≤ 3.58% per capita annually**	**1.47% growth per capita**	**2.31% growth per capita**	**0.80% growth per capita[3]**
Medicare Savings in Hospital Expenditures	**≥ $330m over 5 years** (Lower than national average growth rate from 2013 base year)	**$116m** (2.15% below national average growth)	**$135m** **$251 cumulative** (2.22% below national average growth since 2013)	**$287m** **$538m cumulative[3]** (5.0% below national average growth since 2013)
Medicare Savings in Total Cost of Care	**Lower than the national average growth rate for total cost of care from 2013 base year**	**$133m** (1.53% below national average growth)	**$80m** **$213m cumulative** (0.85% below national average growth since 2013)	**$151m** **$364m cumulative[3]** (1.5% below national average growth since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	**30% reduction over 5 years**	**26%** reduction	**35%** reduction since 2013	**43%** reduction since 2013
Readmissions Reductions for Medicare	**≤ National average over 5 years**	**20%** reduction in gap above nation	**57%** reduction in gap above nation since 2013	**76%** reduction in gap above nation since 2013
Hospital Revenue to Global or Population-Based	**≥ 80% by year 5**	**95%**	**96%**	**100%**

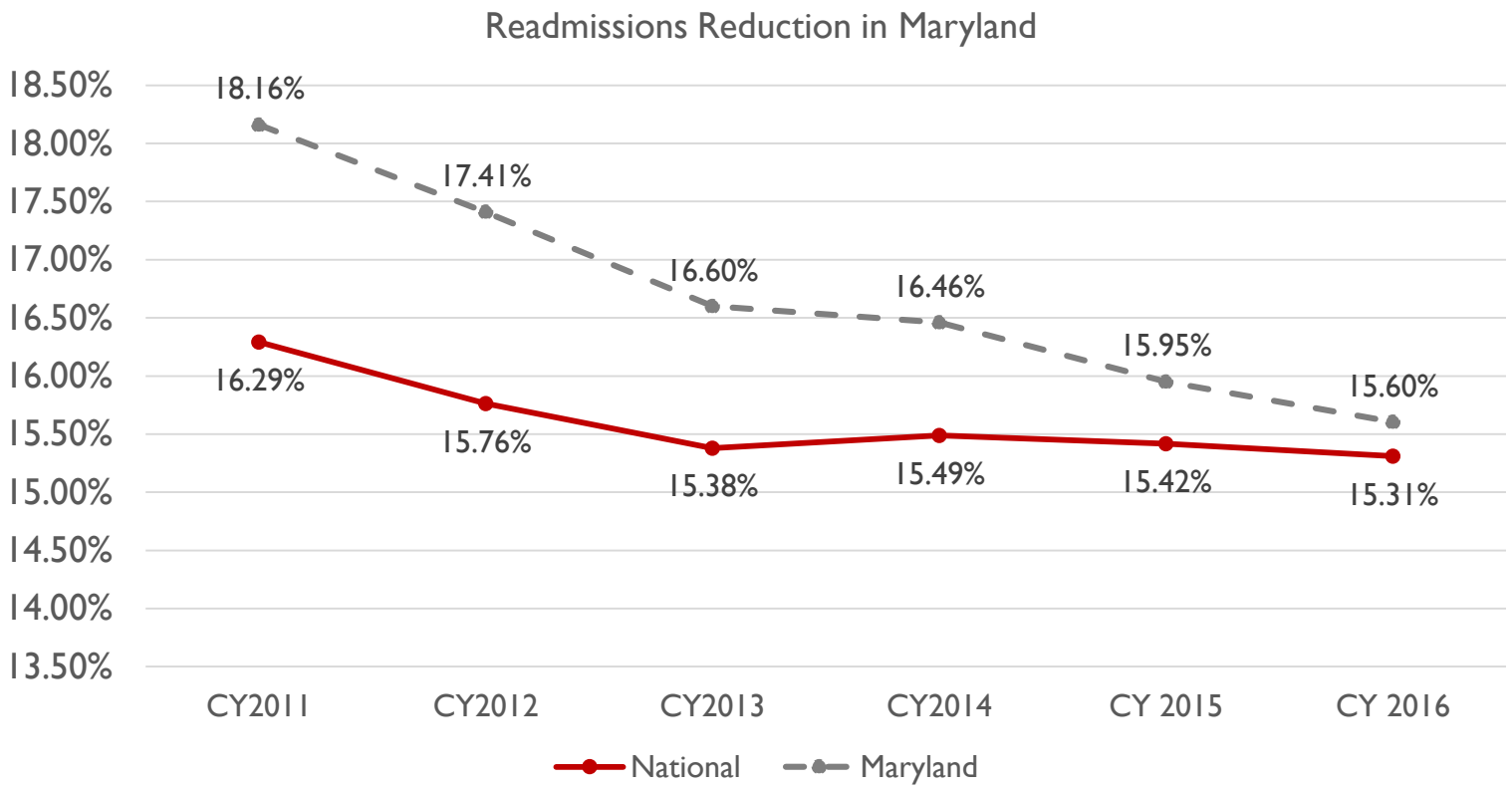
[1] 2015 figures for readmissions are preliminary because CMS is evaluating the readmission data after ICD-10.

[2] Preliminary results compare the performance available in calendar year 2016 to the same months in prior year or to the same months in the 2013 base year, these have not been validated by CMS.

[3] Actual revenues were below the ceiling for CY 2016 and these numbers have been adjusted to reflect the hospital undercharge of approximately 1% that occurred in the second half of CY 2016.

Medicare Test: At or below National Medicare Readmission Rate by CY 2018

Maryland is reducing readmission rate faster than the nation. Maryland reduced the gap from 1.22 percentage points in the base year to 0.29 percentage points in CY 2016. Our target for the gap for CY 2016 was a 0.49 percentage point difference.



The Model Progression

Progression Plan: Key Strategies

I. **Foster accountability** for care and health outcomes by supporting providers as they organize to take responsibility for groups of patients/a population in a geographic area.

II. **Align measures and incentives** for all providers to work together, along with payers and health care consumers, on achieving common goals.

III. **Encourage and develop payment and delivery system transformation** to drive coordinated efforts and system-wide goals.

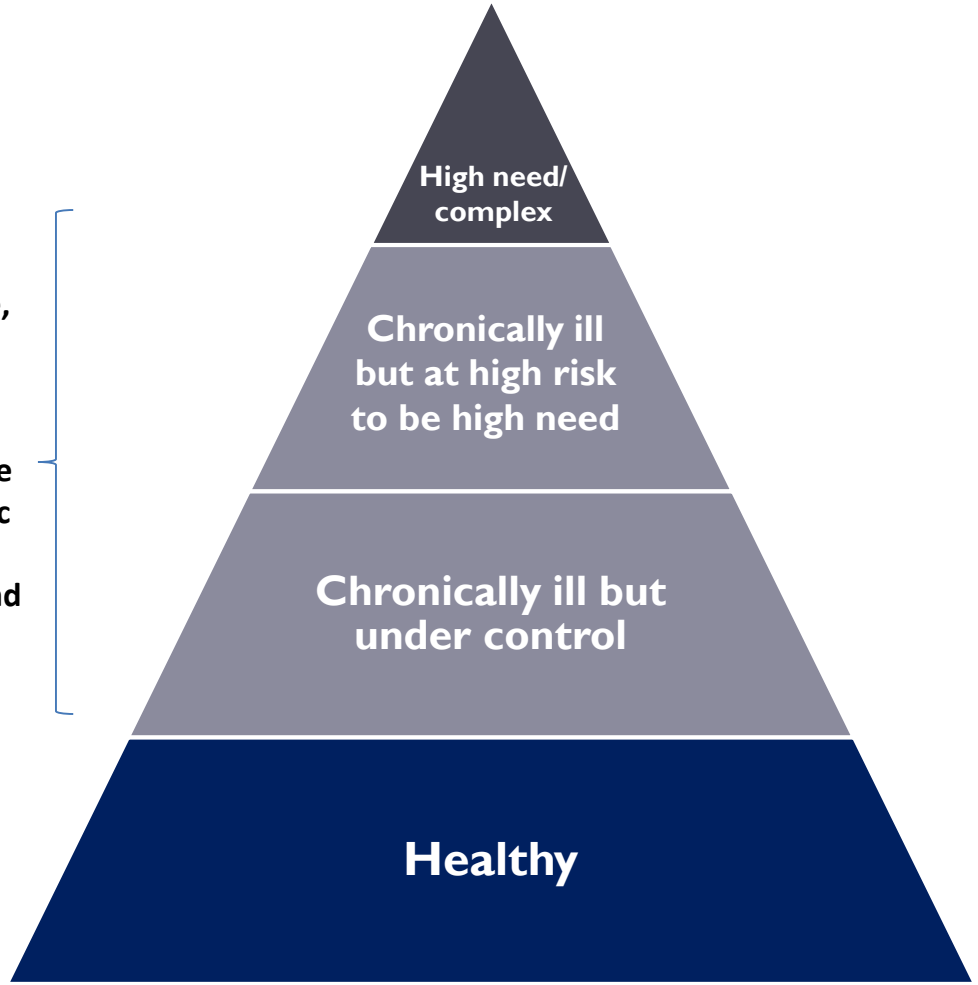
IV. **Ensure availability of tools** to support all types of providers in achieving transformation goals.

V. **Devote resources to increasing consumer engagement** for consumer-driven and person-centered approaches.

Core Approach— Person-Centered Care Tailored Based on Needs

B

Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care



A

Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources (e.g., HCIP, CCIP)

C

Promote and maintain health (e.g., Maryland Primary Care Model)

Payment and Care Delivery Alignment

- Hospitals and Providers with aligned quality targets
- Sharing information
- Driving down costs
- Improving the health of populations

Overview - Enhanced "Total Cost of Care" All-Payer Model

- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
- Improve quality of life for Marylanders
- Manage and prevent chronic and complex conditions
- Key Objectives:
  - Build on global budget model
  - Use Care Redesign Programs, and other care redesign tools
  - Improve Population Health
  - Coordinate with other State agencies

Potential Timeline

* Assuming CMS approves the MACRA status of HCIP, CCIP, and Primary Care

Steps in Maryland's Progression

- All-Payer Model Amendment
  - Enable hospitals to partner with physicians and other providers in further care improvement
  - Started with two new programs effective July 1, 2017
    - Hospital Care Improvement Program (HCIP)
    - Complex & Chronic Care Improvement Program (CCIP)
- Maryland Primary Care Program (MPCP)
  - Increase focus on prevention and primary care, effective Summer 2018
- Enhanced Total Cost of Care All-Payer Model
  - Accountability of providers for populations in a geography
  - Align measures and incentives for all providers
  - Encourage and develop further payment & delivery transformation
  - Ensure availability of tools to support providers
  - Devote resources to increasing consumer engagement

All-Payer Model Amendment

- Maryland has added an Amendment to the All-Payer Model that will provide access to the following **tools**:
  - Detailed, person-centered Medicare data (beyond hospital data across care continuum) for care coordination and care redesign
  - Medicare Total Cost of Care data for planning and monitoring
  - Approvals for hospitals sharing resources with non-hospital providers for care coordination and care improvement
  - Approvals for hospitals to share savings with non-hospital providers
  - Increasing the hospitals' reach to be inclusive of primary care, hospital-based physicians, and post-acute care – adds another tool to address the some of the core drivers in Potentially Avoidable Utilization (PAU)

Care Redesign Programs Launching Now

- Two initial care redesign programs aim to align hospitals & other providers

Hospital Care Improvement Program (HCIP)	Complex and Chronic Care Improvement Program (CCIP)
• **Who?** For hospitals and Care Partners practicing at hospitals • 10 hospitals participating • **What?** Facilitates improvements in hospital care that result in care improvements and efficiency	• **Who?** For hospitals and Care Partners practicing in the community • 6 hospitals participating • **What?** Facilitates high-value activities focused on high needs patients with complex and rising needs, such as multiple chronic conditions • Leverages Medicare Chronic Care Management (CCM) fee*

- Hospitals can select which program(s) to participate in
- Through these voluntary programs, hospitals will be able to obtain data, share resources with providers, and offer optional incentive payments

*Maryland will modify program as needed to adapt to Medicare's MACRA program and the Maryland Primary Care Program

Flexibility of the Amendment

- To provide flexibility, the Amendment is drafted with a framework that aligns categories of care redesign with partners across the delivery system
  - By using a general approach, Maryland can add/delete/modify programs on an annual basis, without requesting the approval of a new model or model amendments
    - New models or amendments can take 6+ months for approval
  - This allows for a "living" approach that can be used to meet Maryland's unique needs on an ongoing basis
    - Programs can be adjusted in response to external changes, such as those introduced by MACRA, Maryland Primary Care Program, etc.
- While the Amendment provides increased flexibility, CMS will:
  - Delegate some administrative functions to the State
  - Retain significant monitoring and oversight responsibilities

Maryland Primary Care Program Highlights

- Healthier Maryland
  - **(+) Integral to the success of the Total Cost of Care All-Payer Model**
  - **(+) Equity and reduced disparities**
- Move 500,000 Medicare FFS beneficiaries into Care Management over 6 years
  - **(+) Improve health status and lower costs**
- Strengthen and Transform Primary Care Delivery
  - **(+) Move from volume to value**
  - **(+) Align with All Payer Model and Medicare payment incentives (MACRA)**
- Federal government is making substantial financial investment to implement Maryland Primary Care Program and in support of Population Health

Enhanced Total Cost of Care All-Payer Model

Overview of Proposed Key Elements

- **10-year Model** — Ambitious, large-scale transformation for more than 800k Medicare FFS beneficiaries. Initial five-year performance period leading to an additional five years; no turning back on transformation, focus to support the scope of transformation and continuing large investments to reduce avoidable utilization.
- **Person-Centered Primary Care Transformation** — Goal is to bring 500k Medicare beneficiaries into comprehensive primary care, increasing person-centeredness while improving chronic, mental health and preventive care. CMS will invest in care management fees.
- **Care Redesign Programs** — Bring physicians, nursing homes, and other providers into aligned programs, with State flexibility in design and implementation.
- **Population health** — The State of Maryland and providers will jointly focus on health improvement initiatives. Improved population health may offset the cost of primary care investments.
- **Total Cost of Care (TCOC) Medicare Savings** — Progressive, but aggressive savings targets. Success in reaching targets rests on driving down avoidable hospital utilization and costs. Aggressive target rests primarily on hospitals, which need timely tools, care partner engagement, and CMS/State support to succeed.

Partnership and Coordination Among Stakeholders

- State Agency Governance
  - Maryland Department of Health (MDH), the Health Services Cost Review Commission (HSCRC), and the Maryland Health Care Commission (MHCC) must actively work together to advance the State's vision.
  - Internal project governance structure will allow expertise of each agency to contribute to success.
- Stakeholder Partnership
  - This ambitious project requires a strong partnership with all the key players in the health system — hospitals, payers, physicians, long term care providers, regulatory agencies, the State and federal partners.

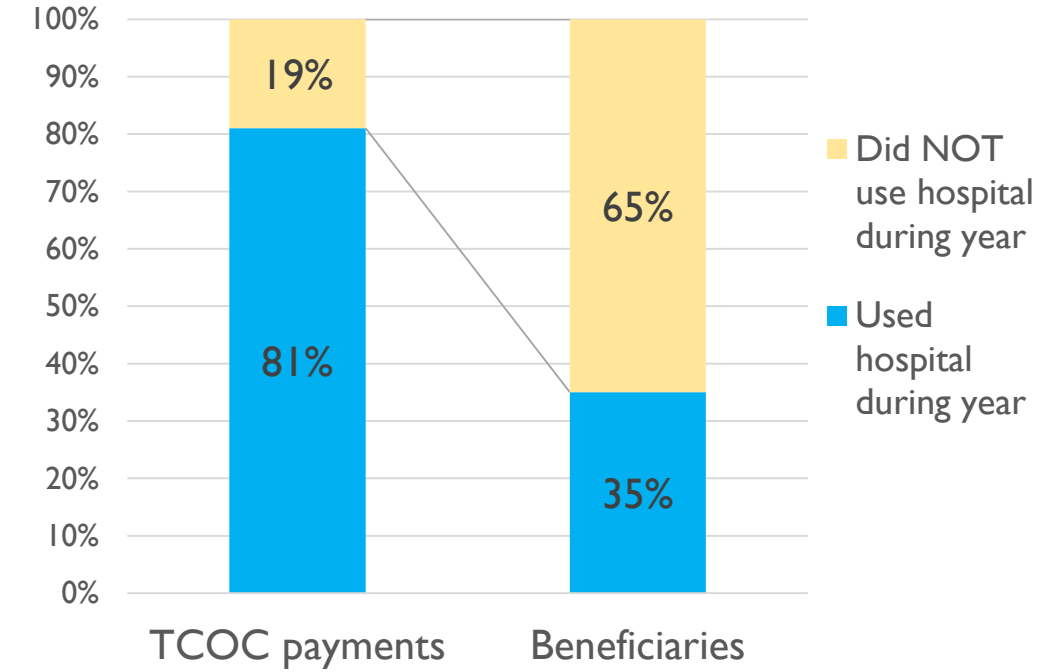
Proposed Enhanced All-Payer Model with Total Cost of Care (TCOC) Savings for Medicare

- In December 2016, Maryland submitted a plan for an enhanced Total Cost of Care Model for 800k+ Medicare FFS beneficiaries, building on the successful hospital model made possible by CMS in 2014
  - New contract needed by December 31, 2017 to support 2018 implementation of Primary Care program and continuation of efforts and investments to reduce avoidable utilization
- Expands efforts for delivery system transformation beyond hospitals (primary care providers, physicians and nursing homes)
- Limits growth in total cost of care
  - Estimated savings to Medicare of >$1 billion
  - Continues to limit all-payer hospital growth on a per capita basis
- Person-centered approaches to engage providers and consumers
- Aligns Maryland's public health resources to support providers improving population health for all Marylanders
  - Reduce opioid deaths, prevent diabetes, reduce obesity and smoking

Proposed TCOC Model

- **Goals of the Enhanced All-Payer Model**
  - Modernize to person-centered care
  - Drive TCOC savings through improved care delivery
  - Improve the health of the population
  - Leverage State flexibility

Maryland's Person-Centered Strategy for 800k+ Medicare FFS beneficiaries



- **Key Model Elements**
  - Hospital global revenues with performance adjustments
  - Care redesign programs to engage care partners (physicians, nursing homes)
    - MACRA alignment to engage clinicians in All-Payer Model goals
  - Maryland Primary Care Program to improve prevention and chronic care management and engage patients
  - Population health focus of State resources and providers
  - Medicare Performance Adjustment (MPA) to link hospitals to total cost of care

Source: Draft HSCRC analysis based on CY 2016 Medicare (CCW) data

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(Agenda Item #4)

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Surescripts Overview – A Maryland Registered HIE

(Agenda Item #5)

DRAFT

Surescripts Overview

A Maryland Registered Health Information Exchange

July 20, 2017

The MARYLAND
HEALTH CARE COMMISSION

Health Information Exchange Registration

- Organizations doing business in Maryland that meet the definition of a health information exchange (HIE) in the law are required to register with MHCC
- Registration ensures HIEs have certain policies and procedures in place in accordance with the regulations
- Nine organizations have registered

Current HIE Landscape

- Regional HIEs
  - Mostly owned by hospitals or hospital systems and serve their community practices affiliated with the hospital
  - On average serve two counties
  - Most utilize a third party vendor as part of their HIE infrastructure
- The State-Designated HIE, CRISP
  - Serves all MD counties, West Virginia, Delaware, and D.C.
  - Utilizes third party vendors and operates a decentralized model

Surescripts

- Recently, Surescripts has registered as MHCC's first nationally operating HIE
- Representatives
  - Kelly Bundy, Senior Product Analyst for the National Record Locator Service
  - India Brim, Senior Counsel

SURESCRIPTS NATIONAL RECORD LOCATOR SERVICE

PRESENTED TO THE MARYLAND HEALTH CARE COMMISSION
JULY 20, 2017

AGENDA & TODAY'S OBJECTIVE

- Surescripts overview
- National Record Locator Service (NRLS): registered health information exchange (HIE) in Maryland
  - Overview & model
  - Market status
  - Privacy and security
  - Consumer engagement

Today's Objective:

Provide education and insight into Surescripts approach to interoperability & open a dialogue for further collaboration.

PURPOSE

To serve the nation with the single most trusted and capable health information network, built to increase patient safety, lower costs and ensure quality care.

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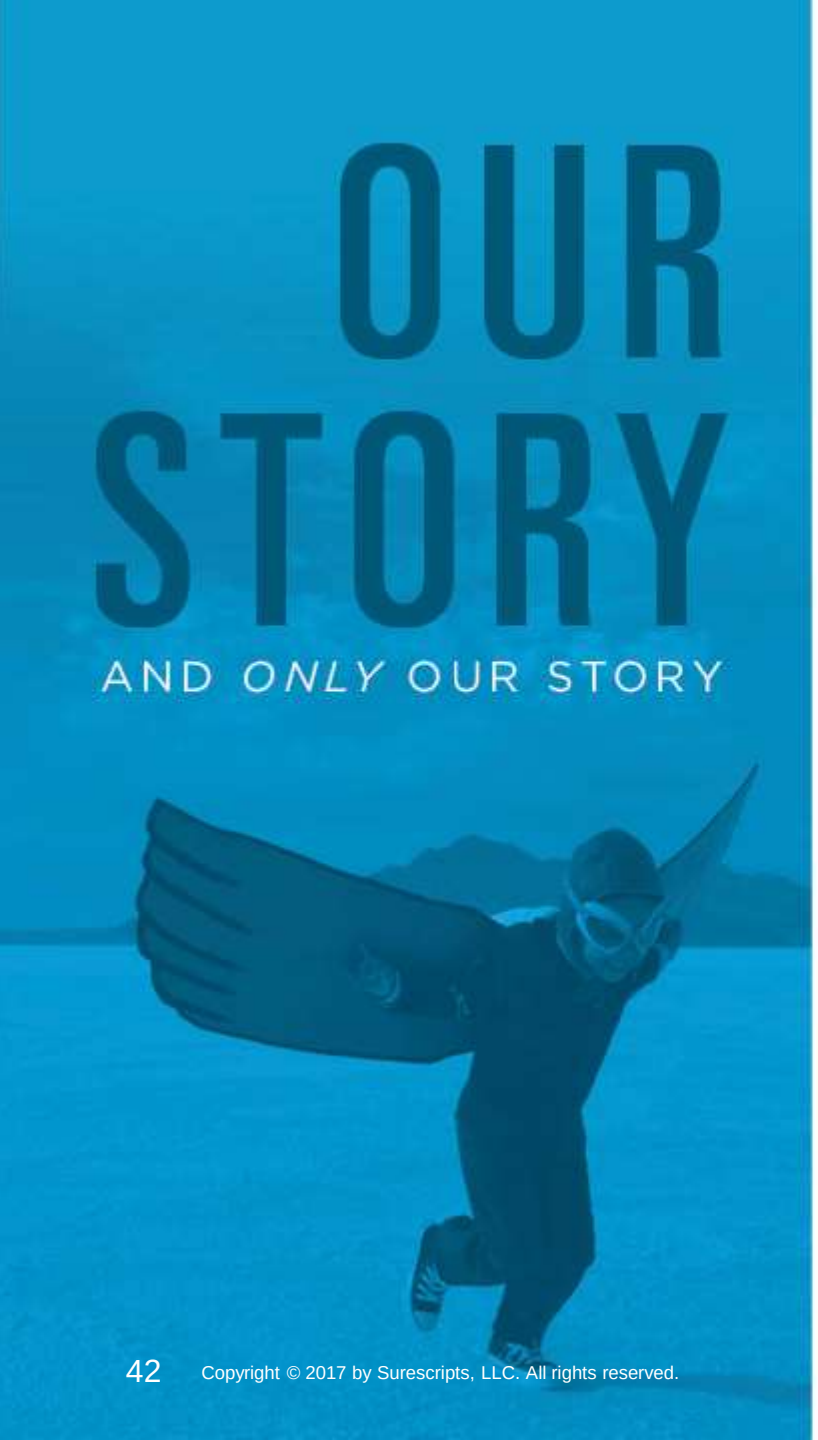


2001

Pharmacy associations formed SureScript Systems to replace paper prescriptions with more accurate e-prescribing.

The three largest PBMs formed RxHub
Caremark, Express Scripts and Medco Health came together to create a link between payers and prescribers.

2008

These competing organizations formed a historical alliance as Surescripts to build a national network to connect clinicians, EHRs, hospitals, PBMs, pharmacies and technology vendors.

TODAY

Surescripts leads the movement to turn data into *actionable patient intelligence.* Surescripts is credited as being the pioneer of the field.

MATURE AND MUSCLE BOUND

A NETWORK BUILT TO SERVE

4.4 MILLION
E-PRESCRIPTIONS DAILY
surpassing Amazon in daily packages shipped (1.4 million) and Uber in daily rides (2 million)

1.6 BILLION
E-PRESCRIPTIONS ANNUALLY

10.9 BILLION
TRANSACTIONS ANNUALLY

1.3 MILLION
CONNECTED HEALTHCARE PROFESSIONALS

surescripts

SURESCRIPTS PRODUCTS AND SERVICES

CLINICAL INTEROPERABILITY SERVICES

ELECTRONIC PRESCRIBING

ELECTRONIC PRESCRIBING BENEFIT INFORMATION

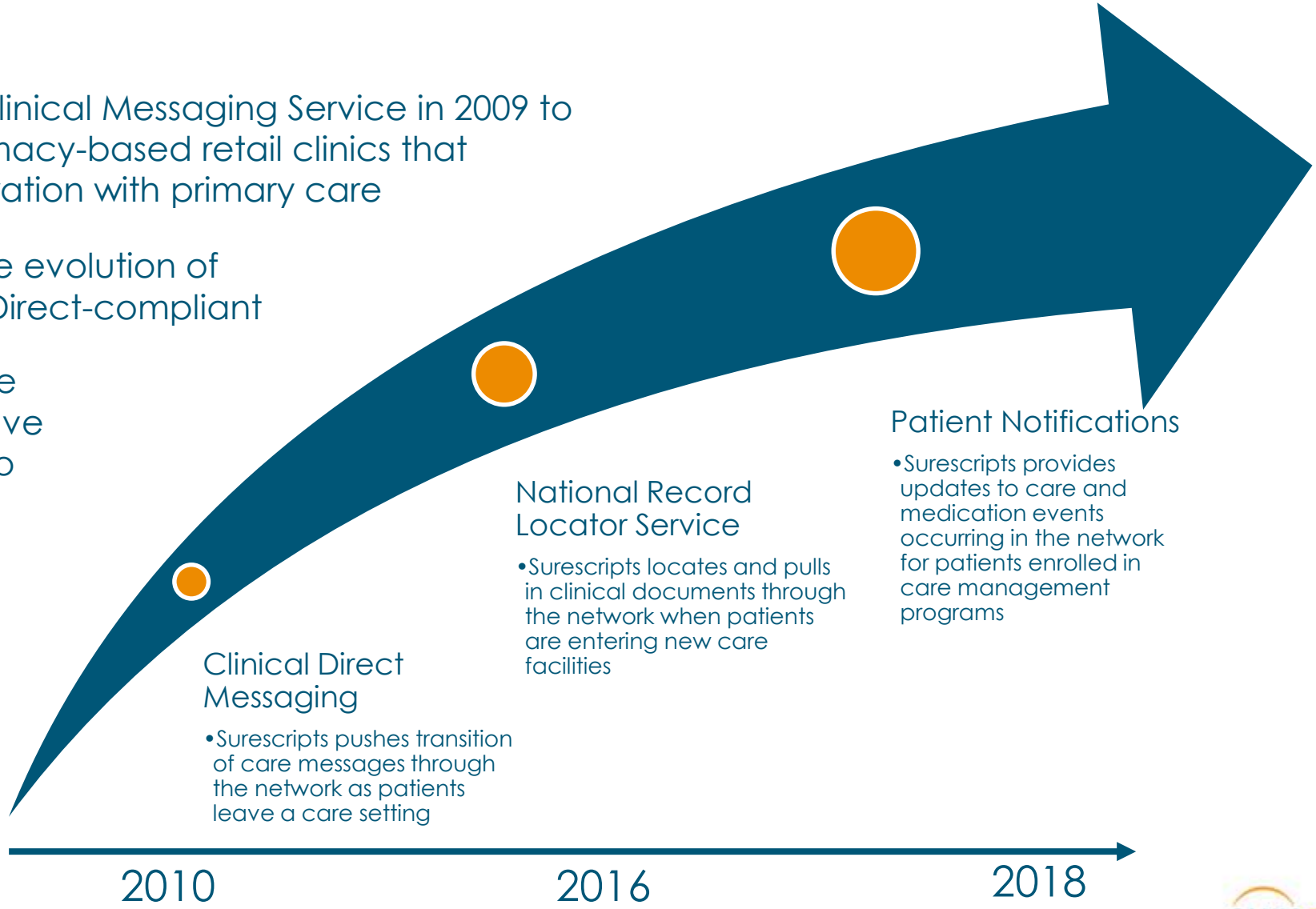
ELECTRONIC PRIOR AUTHORIZATION

MEDICATION HISTORY

MEDICATION MANAGEMENT SOLUTIONS

SURESCRIPTS INTEROPERABILITY SERVICES

- Surescripts launched a Clinical Messaging Service in 2009 to meet the needs of pharmacy-based retail clinics that desired stronger collaboration with primary care
- Meaningful Use drove the evolution of our solution to become Direct-compliant
- Our customers have since asked us to partner to solve broader needs leading to NRLS and Patient Notifications



NATIONAL RECORD LOCATOR SERVICE

DISPARATE HEALTH DATA: WHERE THERE ARE WALLS, THERE ARE CONSEQUENCES.

A LACK OF CARE COORDINATION COSTS AN ESTIMATED

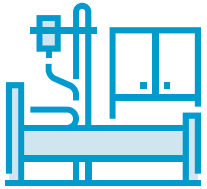
$148–$226 BILLION

ANNUALLY. [1]

OF ALL ACTIVITY WITHIN A REFERRAL REGION HAPPENS OUTSIDE THE WALLS OF THE LARGEST HOSPITAL IN THAT REGION. [2]

ONLY 12-34%

OF HOSPITAL DISCHARGE SUMMARIES REACH OUTPATIENT CARE TEAMS IN TIME FOR PATIENT APPOINTMENTS. [3]



TRANSFER DOCUMENTS FOR CRITICALLY ILL PATIENTS ARE OFTEN ABSENT OR HAVE A "COMPLETENESS"

OF ONLY 58%. [2]

1. Bipartisan Policy Center Health Information Technology Initiative – Accelerating Electronic Information Sharing to Improve Quality and Reduce Costs in Health Care.
2. Surescripts 2017 whitepaper, "All Healthcare is Not Local: The Human Cost of Disparate Health Data."
3. Kripalani, Sunil, et al. "Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care." Jama 297.8 (2007): 831-841.

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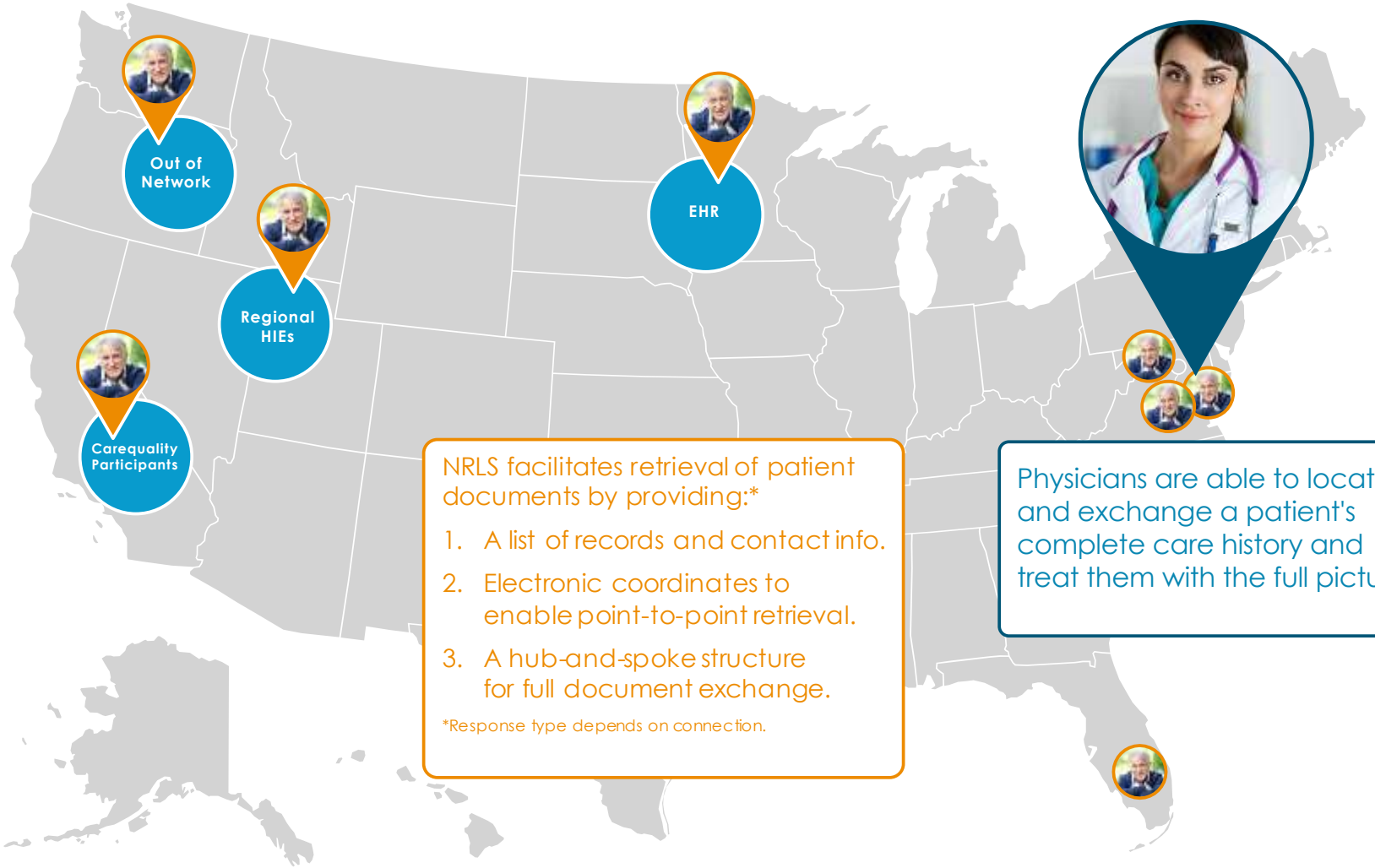
WITH NRLS, A PATIENT'S CARE HISTORY IS READILY AVAILABLE NO MATTER WHERE THEY RECEIVE CARE.



NRLS facilitates retrieval of patient documents by providing:*

1. A list of records and contact info.
2. Electronic coordinates to enable point-to-point retrieval.
3. A hub-and-spoke structure for full document exchange.

*Response type depends on connection.

Physicians are able to locate and exchange a patient's complete care history and treat them with the full picture.

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WE PROVIDE LOCATION SERVICES

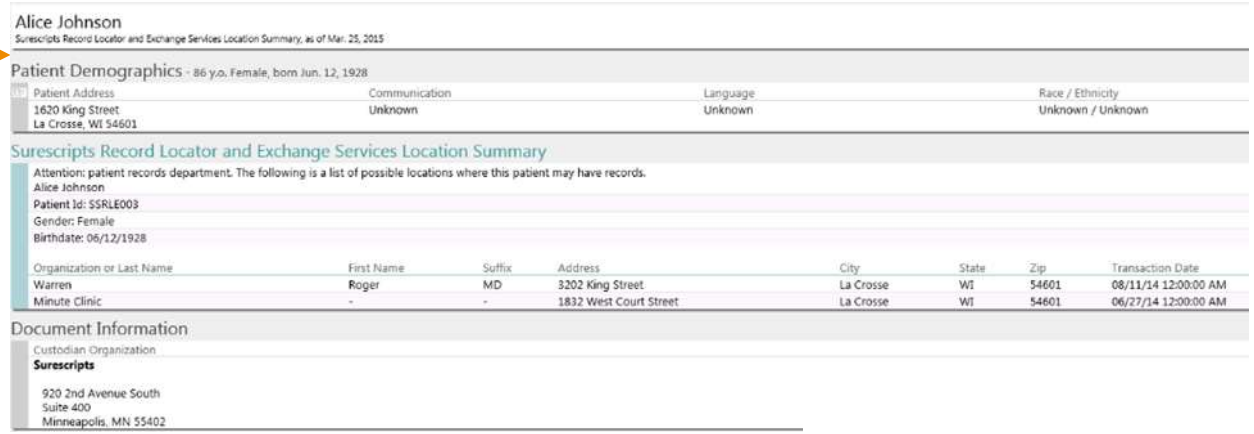
surescripts

230 Million Patients
4 Billion+ record locations

Endpoints to query to retrieve clinical documents

Send Document Queries

List of encounters to identify high risk patients



Alice Johnson

Surescripts Record Locator and Exchange Services Location Summary, as of Mar. 25, 2015

Patient Demographics - 86 y.o. Female, born Jun. 12, 1928

Patient Address	Communication	Language	Race / Ethnicity
1620 King Street La Crosse, WI 54601	Unknown	Unknown	Unknown / Unknown

Surescripts Record Locator and Exchange Services Location Summary

Attention: patient records department. The following is a list of possible locations where this patient may have records.
Alice Johnson
Patient Id: SSRLE003
Gender: Female
Birthdate: 06/12/1928

Organization or Last Name	First Name	Suffix	Address	City	State	Zip	Transaction Date
Warren	Roger	MD	3202 King Street	La Crosse	WI	54601	08/11/14 12:00:00 AM
Minute Clinic	-	-	1832 West Court Street	La Crosse	WI	54601	06/27/14 12:00:00 AM

Document Information

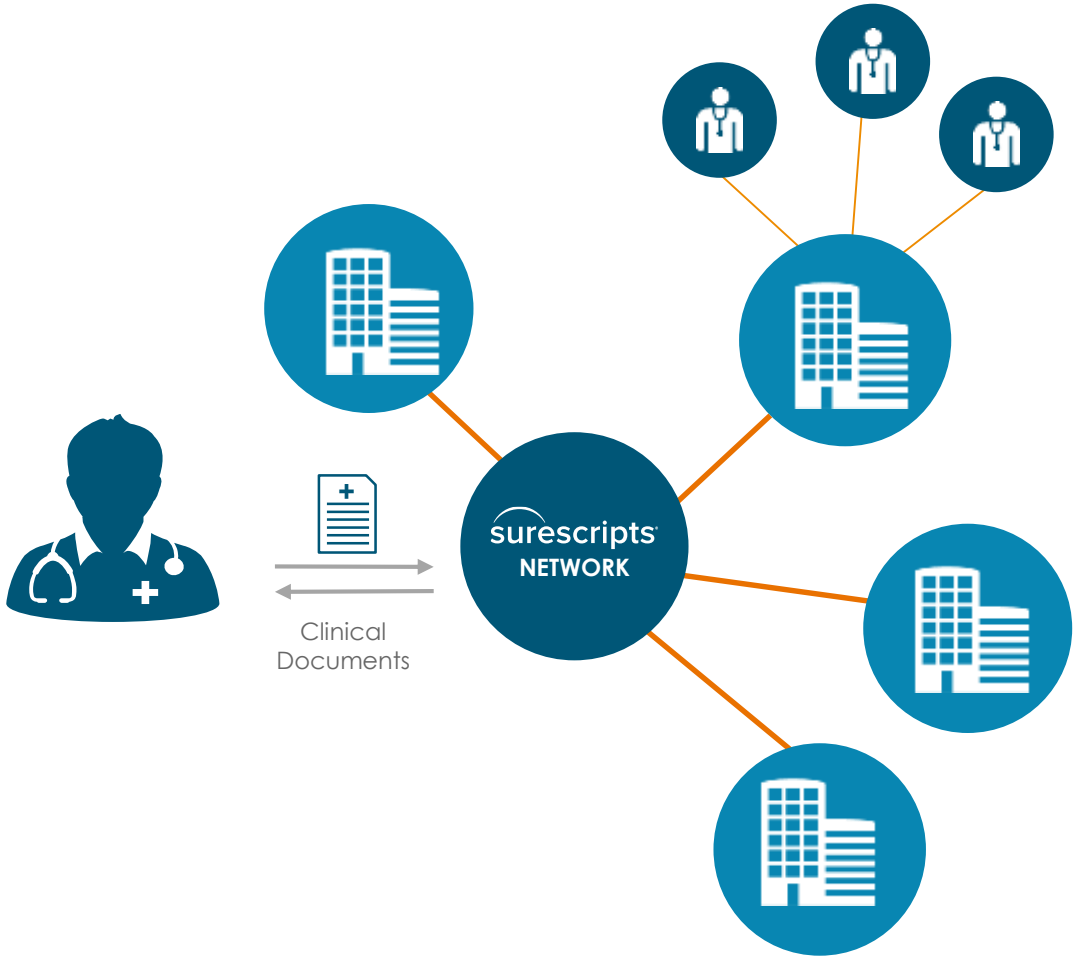
Custodian Organization
Surescripts

920 2nd Avenue South
Suite 400
Minneapolis, MN 55402

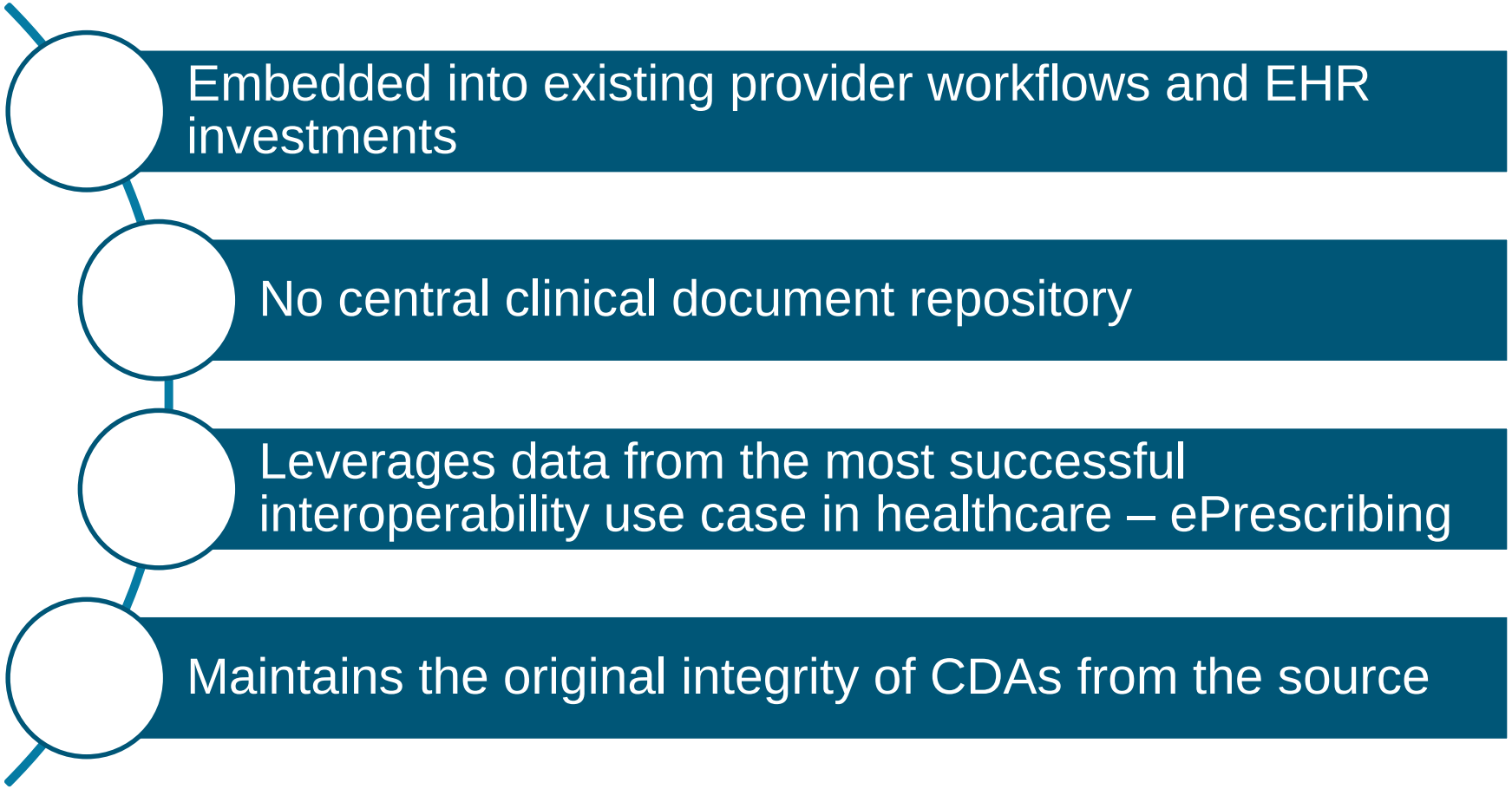
surescripts

WE FACILITATE THE EXCHANGE OF CLINICAL DOCUMENTS (OPTIONALLY)

NRLS is a hub for exchanging documents. Surescripts **retrieves documents on behalf of the requester.**

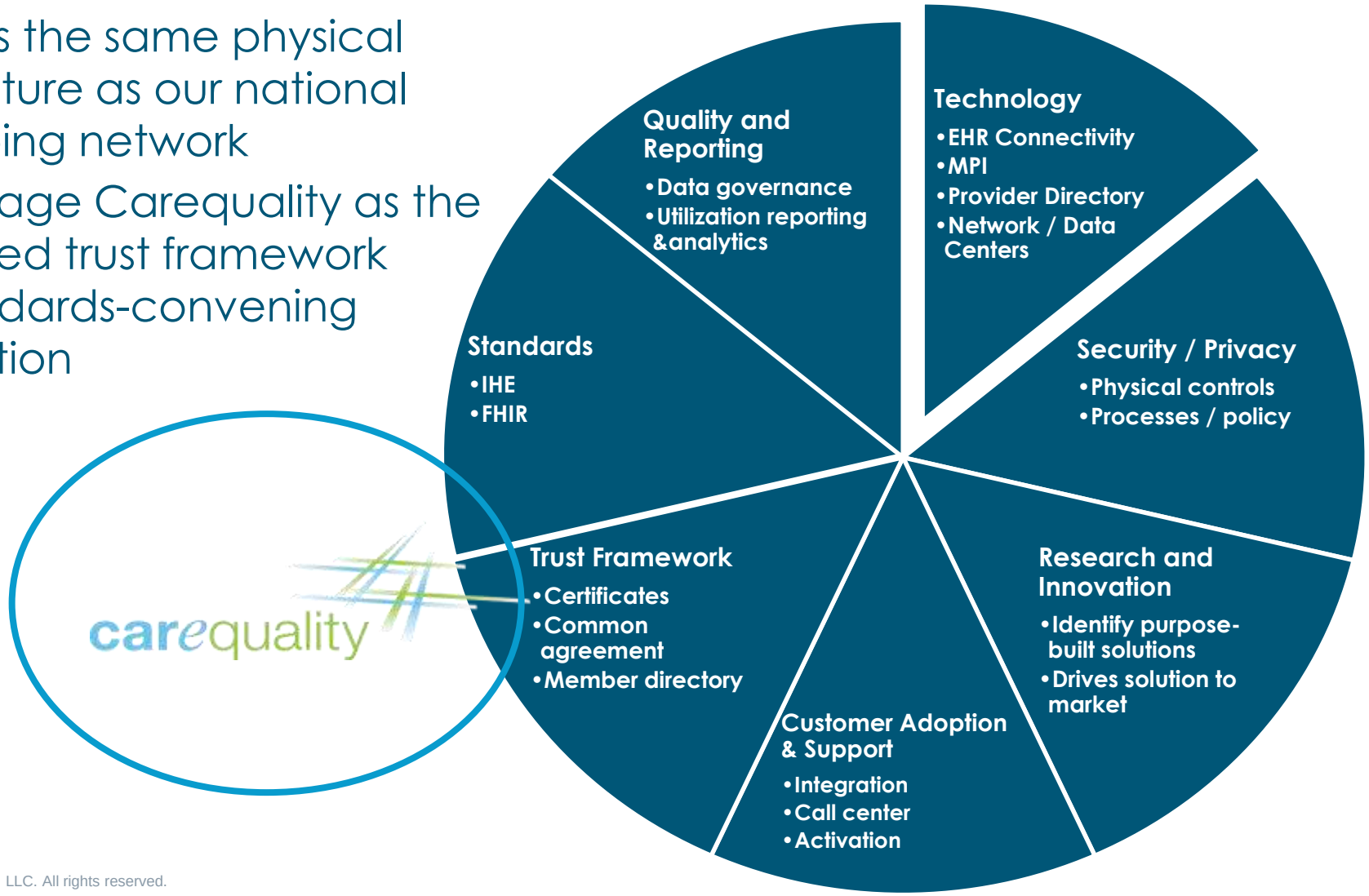


HOW WE'RE DIFFERENT



NRLS OPERATES ON THE NATION'S MOST TRUSTED AND CAPABLE HEALTH INFORMATION NETWORK

- NRLS uses the same physical infrastructure as our national ePrescribing network
- We leverage Carequality as the designated trust framework and standards-convening organization



NRLS IS FLOURISHING

1.

SERVING THE NATION

- In 12 major metropolitan areas
- Over 43k providers affiliated with over 400 health systems and ambulatory physician groups
- With 3 top EHR vendors

2.

REALIZING TRUE INTEROPERABILITY

- Responded to over 14.4 million patient discovery requests
- Provided over 8.4 million location summary documents

3.

PROVIDING ACTIONABLE INTELLIGENCE

- Covers 230 million patient lives – 20x more than any other record locator
- With more than 4 billion care interactions
- From a single connection

surescripts

PRIVACY AND SECURITY

Surescripts is committed to the Carequality Principles of Trust around:

- HIPAA compliance
- Implementation specifications
- Acceptable use
- Identity proofing and authentication
- Information handling transparency

NRLS is integrated into EHR vendor software

- End user access granted and monitored by the health system
- Health systems are required to use mutual TLS authentication

NRLS is not a clinical data repository

- Clinical documents are not stored at Surescripts
- NRLS does not alter any protected health information (PHI) or other clinical content in messages as they pass through our network

OPT-OUT PROCESS

NRLS Provider Participants shall develop, maintain and distribute a Notice of Privacy Practices that describe uses and disclosures of PHI, including those contemplated through the Participant's participation in NRLS.

NRLS operates on an opt-out basis

- Surescripts provides a mechanism for providers/organizations to opt a patient out, and back into, NRLS
- Once a patient is opted-out of NRLS, information about that patient will not be available via NRLS. No healthcare provider will be able to receive information regarding the locations of previous healthcare visits or receive medical records from those visits, via NRLS.

PATIENT & CONSUMER EDUCATION

- NRLS improves consumer satisfaction and patient outcomes and strengthens the physician-patient relationship.
- Surescripts provides materials to assist NRLS participants with consumer education and awareness:
  - What is NRLS?
  - What are the benefits of NRLS and health information exchange?
  - What information is stored and exchanged?
  - Who has access to information?
  - How is information kept safe?
  - How do patients opt out of NRLS?
  - How does opting out potentially affect patient treatment?

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Thank You!

The MARYLAND
HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**

2. **UPDATE OF ACTIVITIES**

3. **PRESENTATION**: Maryland's All Payer Model (HSCRC)

4. **ACTION**: Certificate of Need
   - Riva Road Surgical Center, L.L.C. (Docket No. 17-02-2392)
   - Visiting Nurse Association of Maryland, L.L.C. d/b/a VNA of Maryland (Docket No. 17-R1-2393)

5. **PRESENTATION**: Surescripts Overview – A Maryland Registered HIE

6. **PRESENTATION**: Spending and Use among Maryland's Privately Fully Insured

7. **OVERVIEW OF UPCOMING EVENTS**

8. **ADJOURNMENT**

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Spending and Use among Maryland's Privately Fully Insured

(Agenda Item #6)

Privately Fully-Insured Report

Commission Meeting

July 20, 2017

MHCC | MARYLAND HEALTH CARE COMMISSION

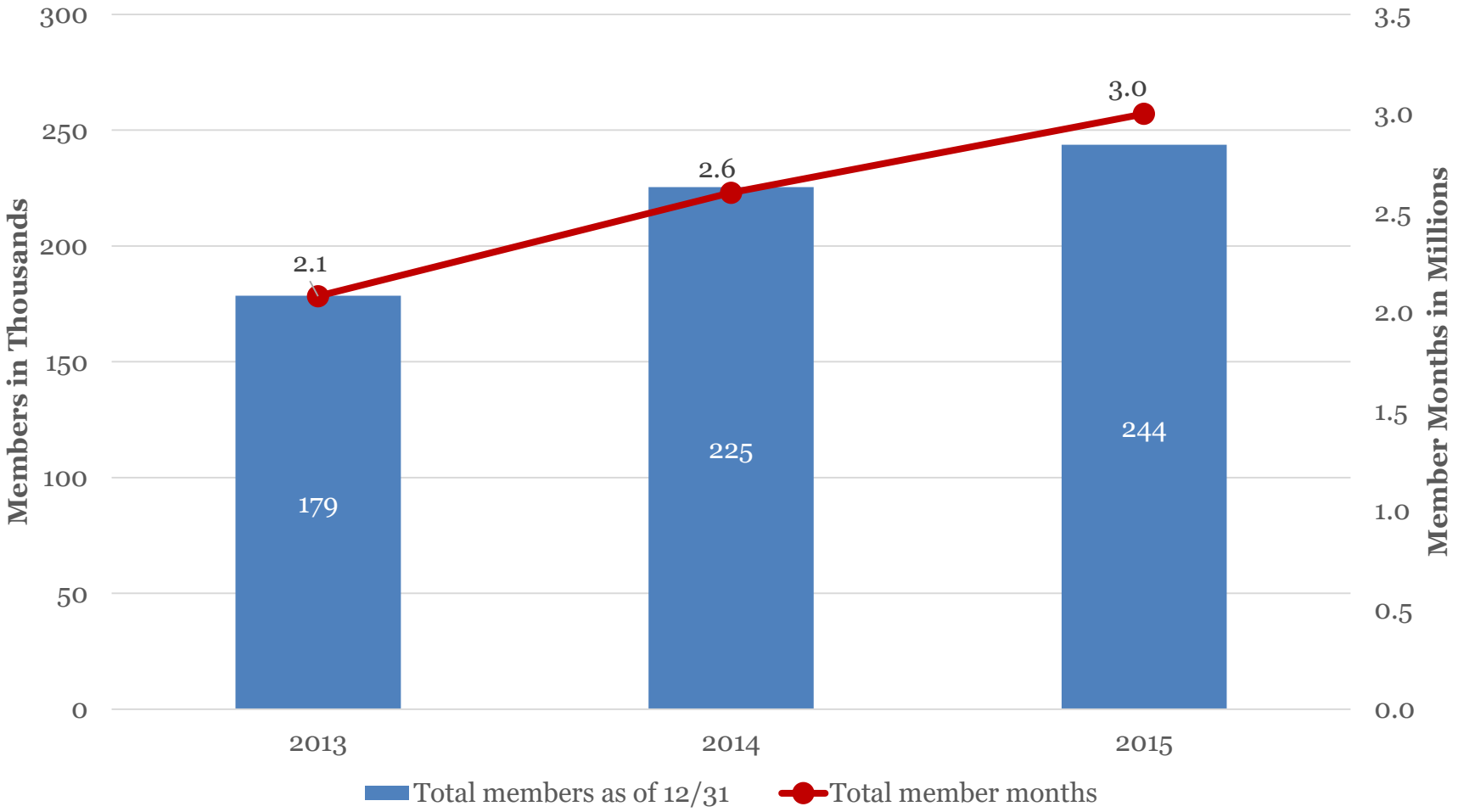
Takeaways – Significant increase in PMPM spending continues in the individual market for 2015

- Total members as of 12/31/2015 in the Individual Market (ACA-compliant & non-compliant plans) increased by about 8%, compared to a 26% increase at the end of 2014
- Total PMPM spending in the Individual Market (ACA-compliant & non-compliant plans) for all services combined increased by about 33% from 2014 to 2015, compared to over a 30% increase from 2013 to 2014
- Utilization per 1,000 members increased in the Individual Market (ACA-compliant & non-compliant plans) for all service categories from 2014 to 2015, ranging from about 10% for labs/imaging services to about 30% for prescription drugs
- Prescription drugs PMPM spending increase of 75% leads all services categories in the individual market (ACA-compliant & non-compliant plans) for 2015, compared to a 62% increase in 2014
- Prescription drugs PMPM spending is about 20% higher on the exchange than off the exchange in the individual market (ACA-compliant plans) for 2015
- Total Per Member Per Month (PMPM) spending across all market segments and service categories increased by about 12% from 2014 to 2015, compared to a 3% increase from 2013 to 2014

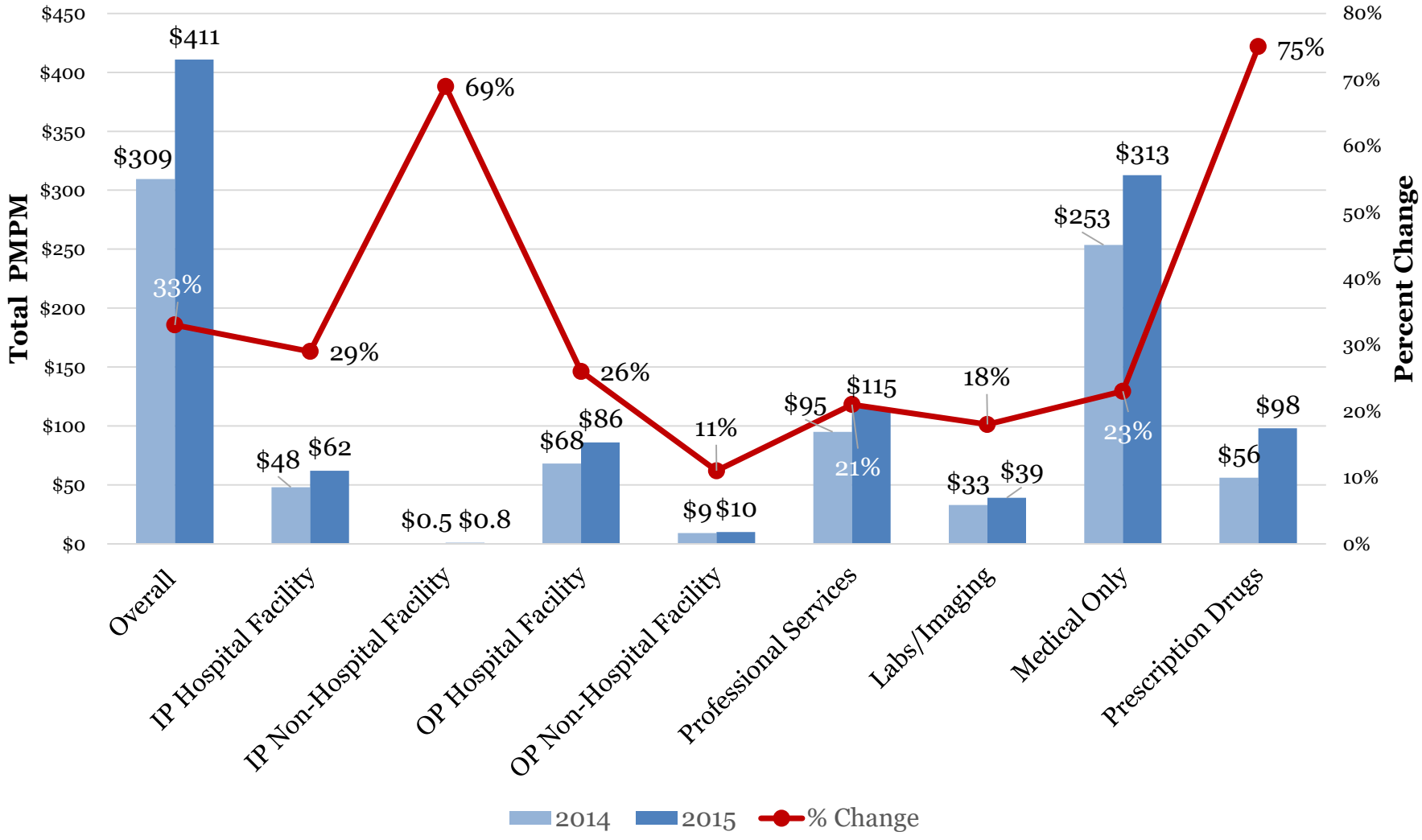
Background

- MHCC is required to report annually on healthcare spending and utilization
  - Source: Medical Care Data Base (2014 and 2015 data)
  - Fully-insured private plans, Maryland residents
  - Study variation by market segment, geography, age, and service category
- Special focus on the Individual Market Continues
  - Many individuals with significant medical conditions who had previously been covered through the state-based "high-risk" pool (MHIP) have transitioned into the Individual Market since the ACA went into effect on 1/1/2014. MHIP was phased out by the end of 2014.
  - Many individuals who did not have health insurance before 2014 and 2015 also entered the Individual Market as a result of health insurance expansion due to ACA enactment.

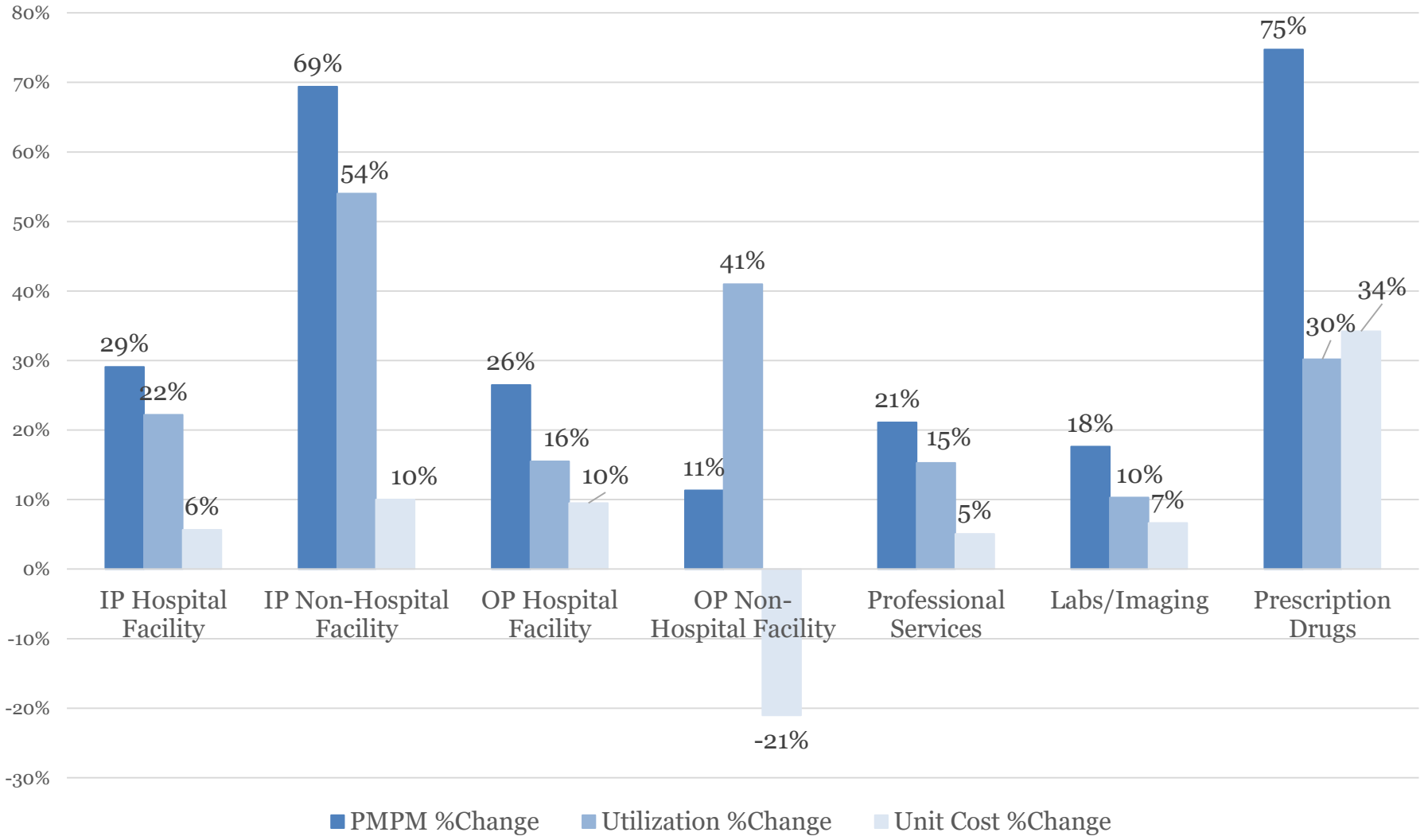
Members as of 12/31 and Member Months, Individual Market (ACA-Compliant and Non-Compliant Plans) (2013 to 2015)



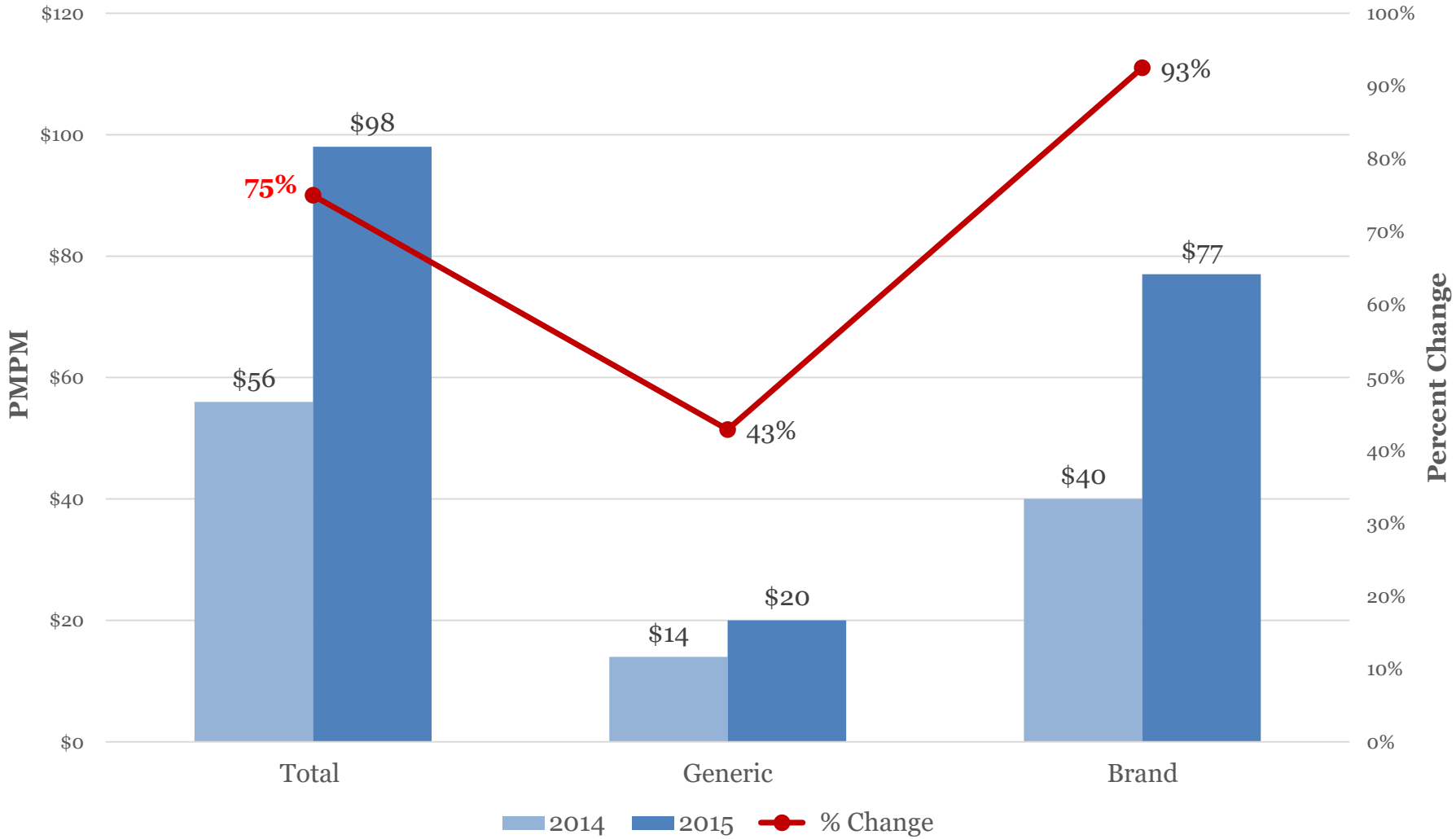
Total PMPM Changes by Service Category, Individual Market (ACA-Compliant and Non-Compliant Plans), 2014 to 2015



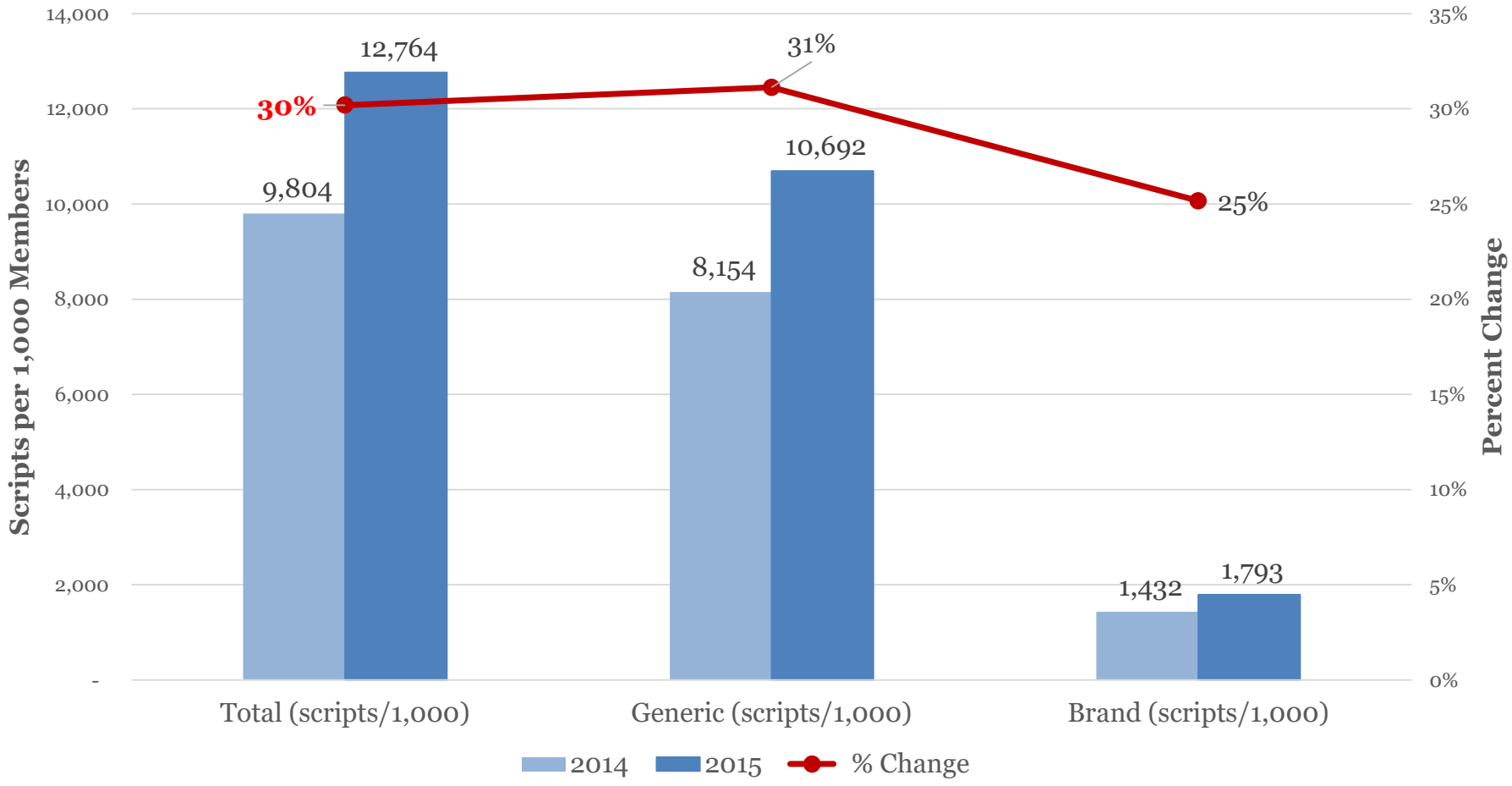
Annual Changes in PMPM Spending, Utilization Per 1,000 Members, and Cost Per Unit by Service Category, Individual Market, 2014 to 2015



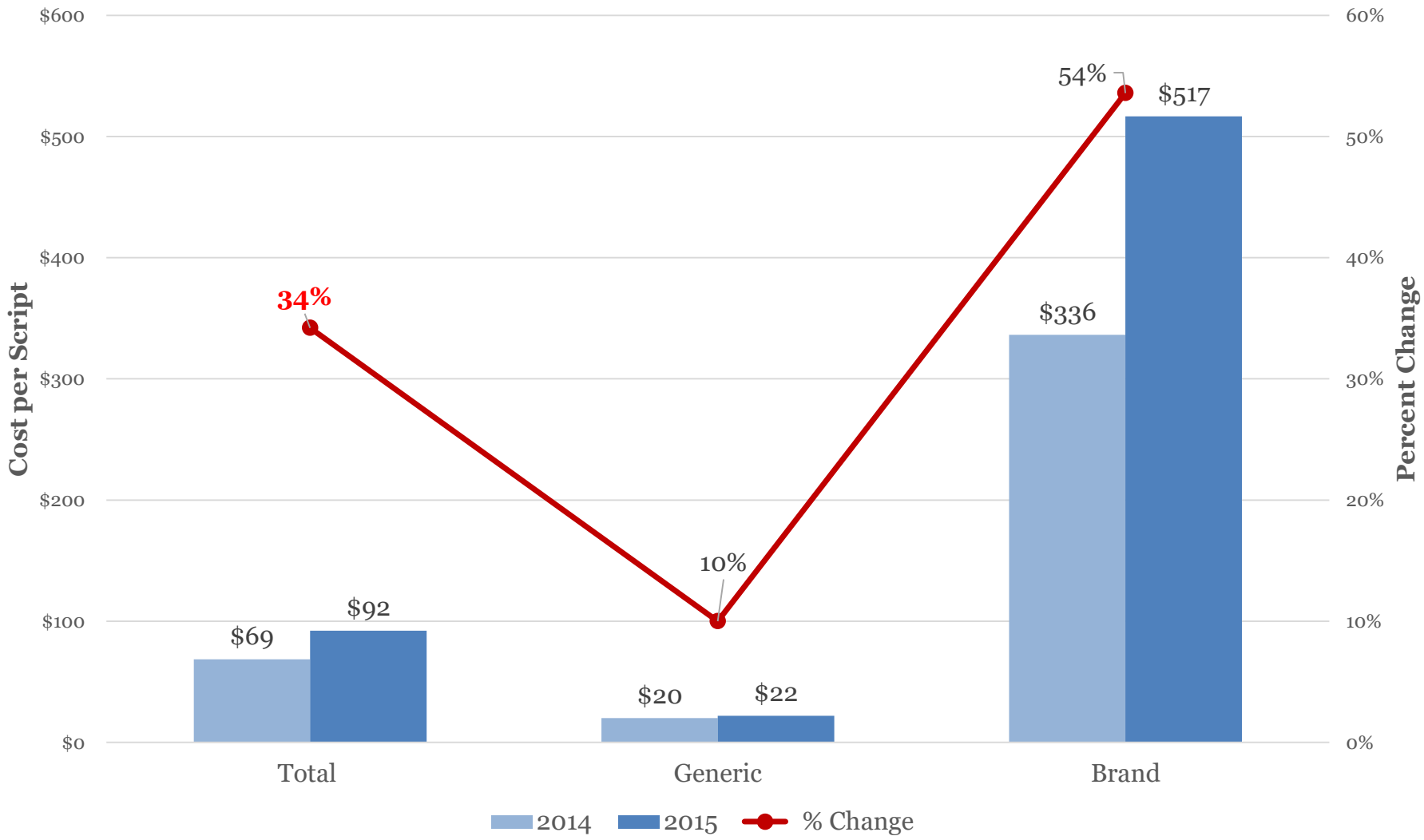
Prescription Drug PMPM Changes by Drug Type, Individual Market (ACA-Compliant and Non-Compliant Plans), 2014 to 2015



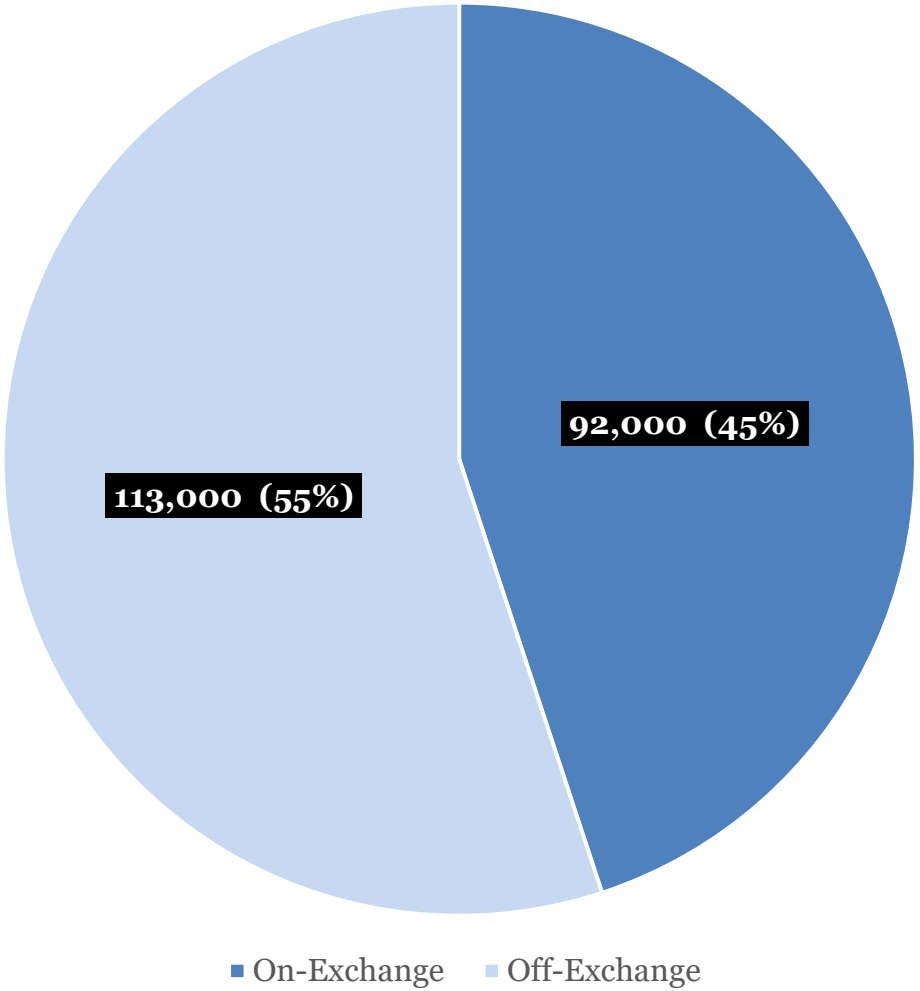
Prescription Drug Utilization Changes by Drug Type Individual Market (ACA-Compliant and Non-Compliant Plans), 2014 to 2015



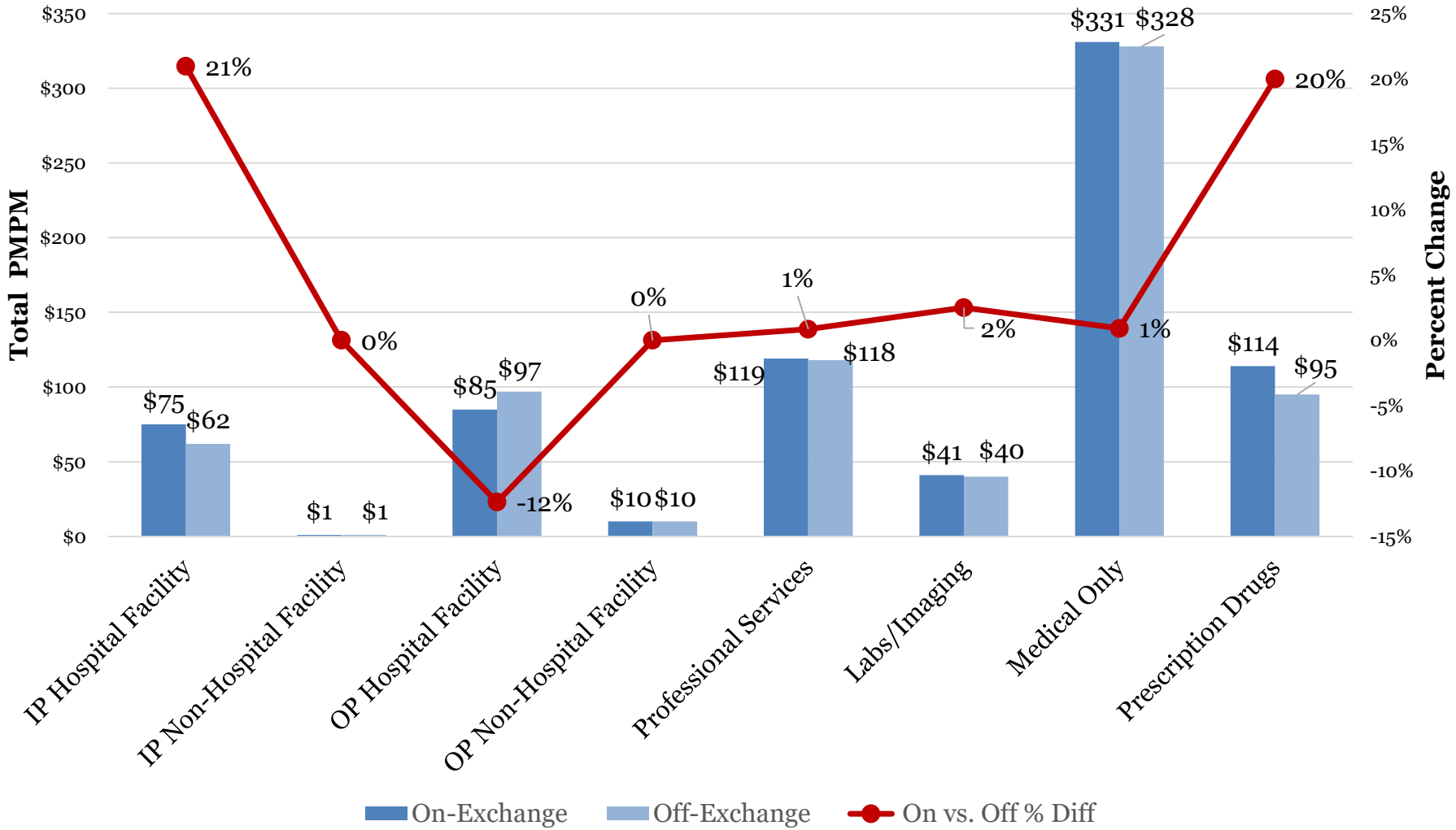
Prescription Drug Unit Cost Changes by Drug Type, Individual Market ACA-Compliant and Non-Compliant Plans), 2014 to 2015



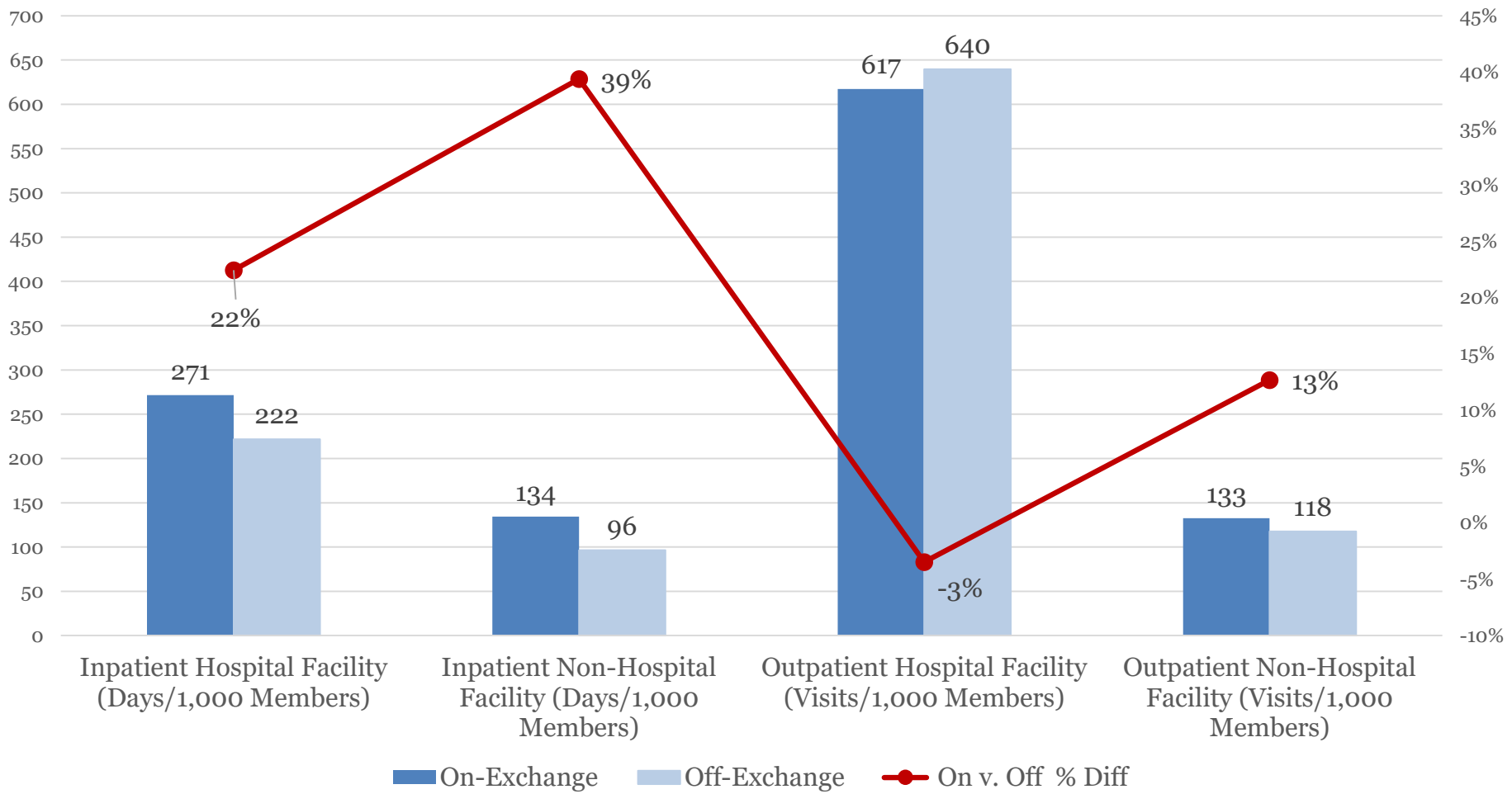
On-Exchange vs. Off-Exchange (ACA-Compliant Plans Only)
Total Members as of 12/31, Individual Market, 2015



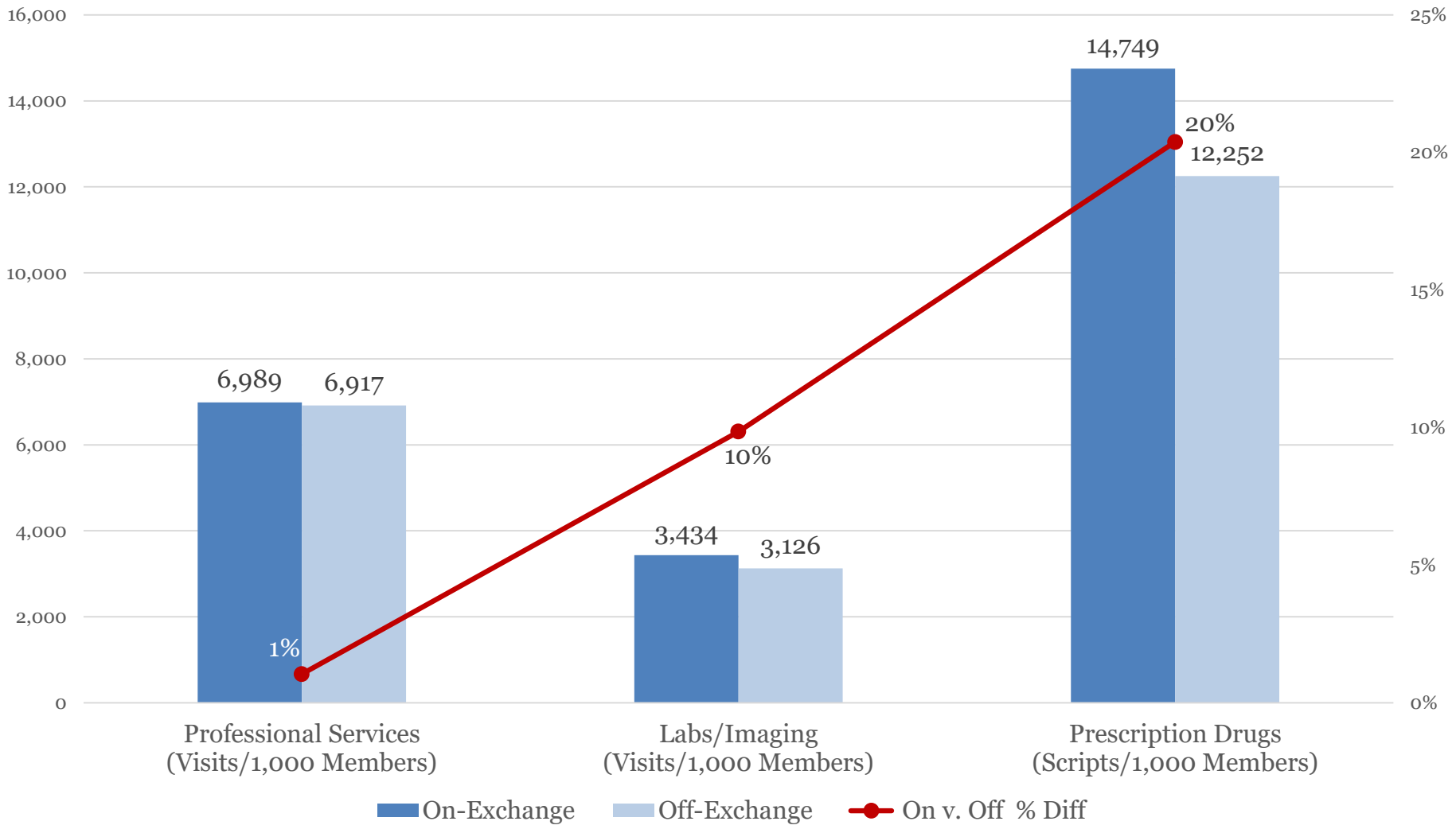
On-Exchange vs. Off-Exchange (ACA-Compliant Only) Total PMPM and Differences in PMPM by Service Category, Individual Market, 2015



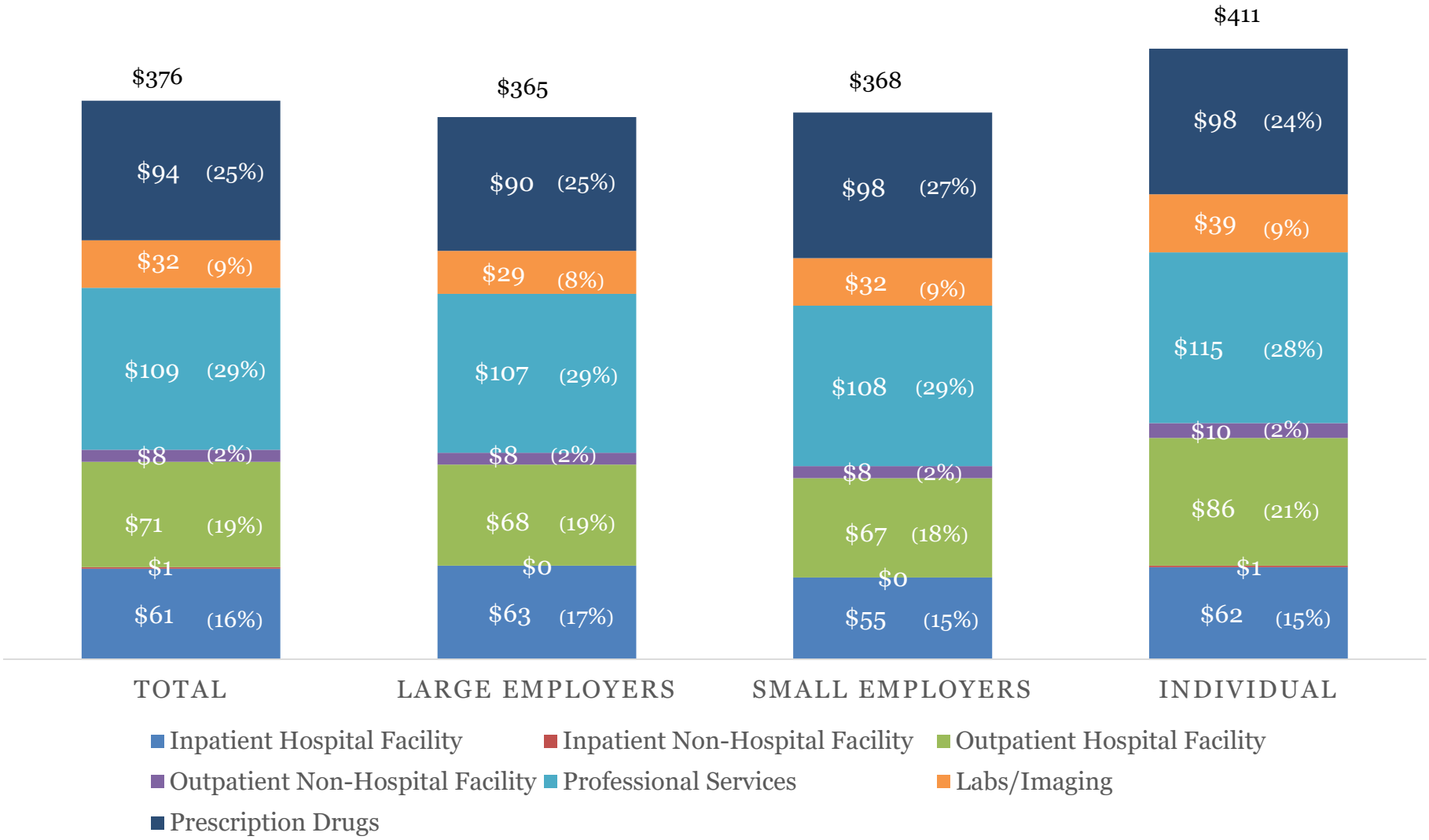
On-Exchange vs. Off-Exchange (ACA-Compliant Plans Only) Institutional Inpatient and Outpatient Utilization, Individual Market, 2015



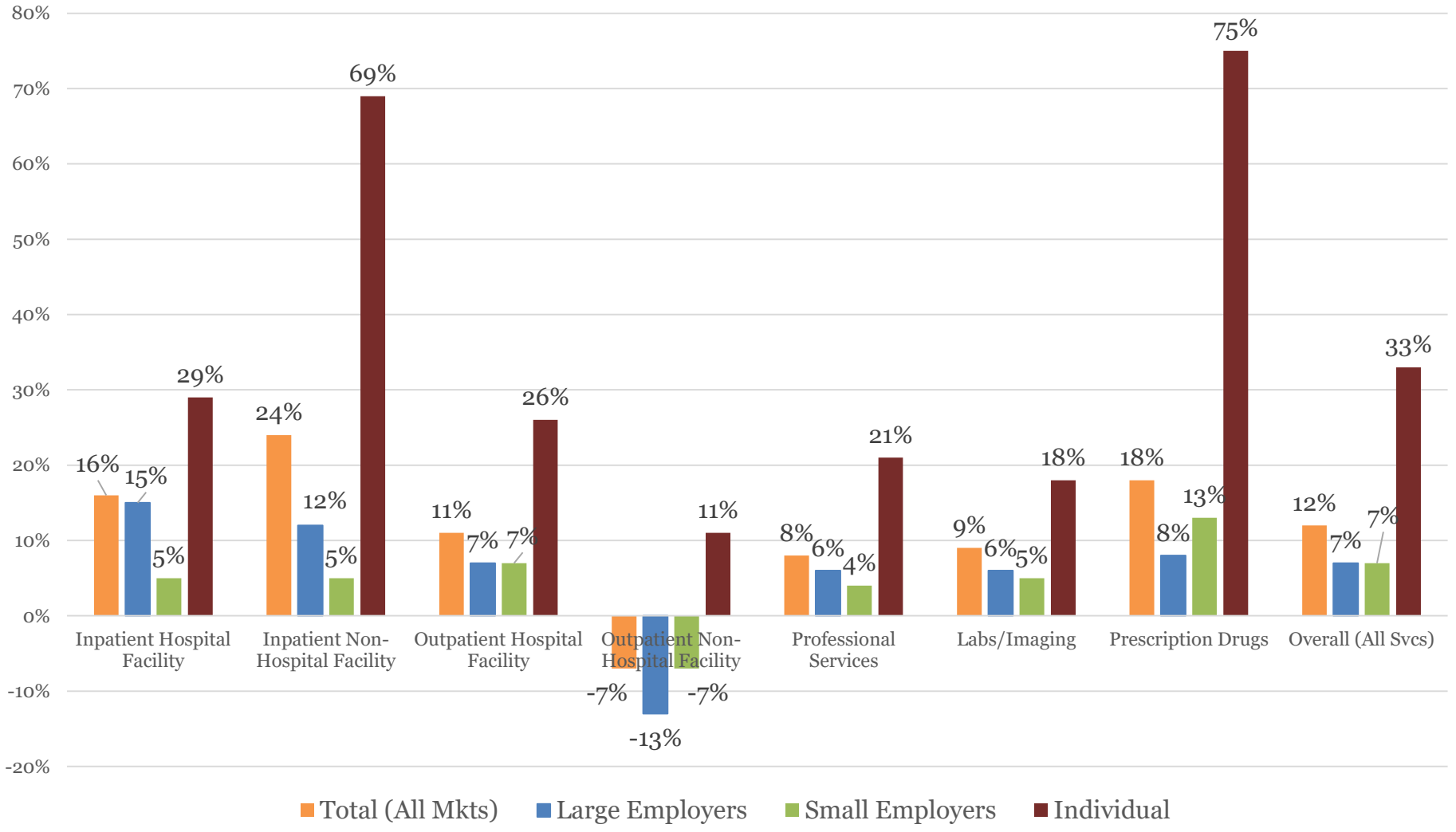
On-Exchange vs. Off-Exchange (ACA-Compliant Plans Only) Utilization of Professional Services, Labs/Imaging, and Prescription Drugs, Individual Market, 2015



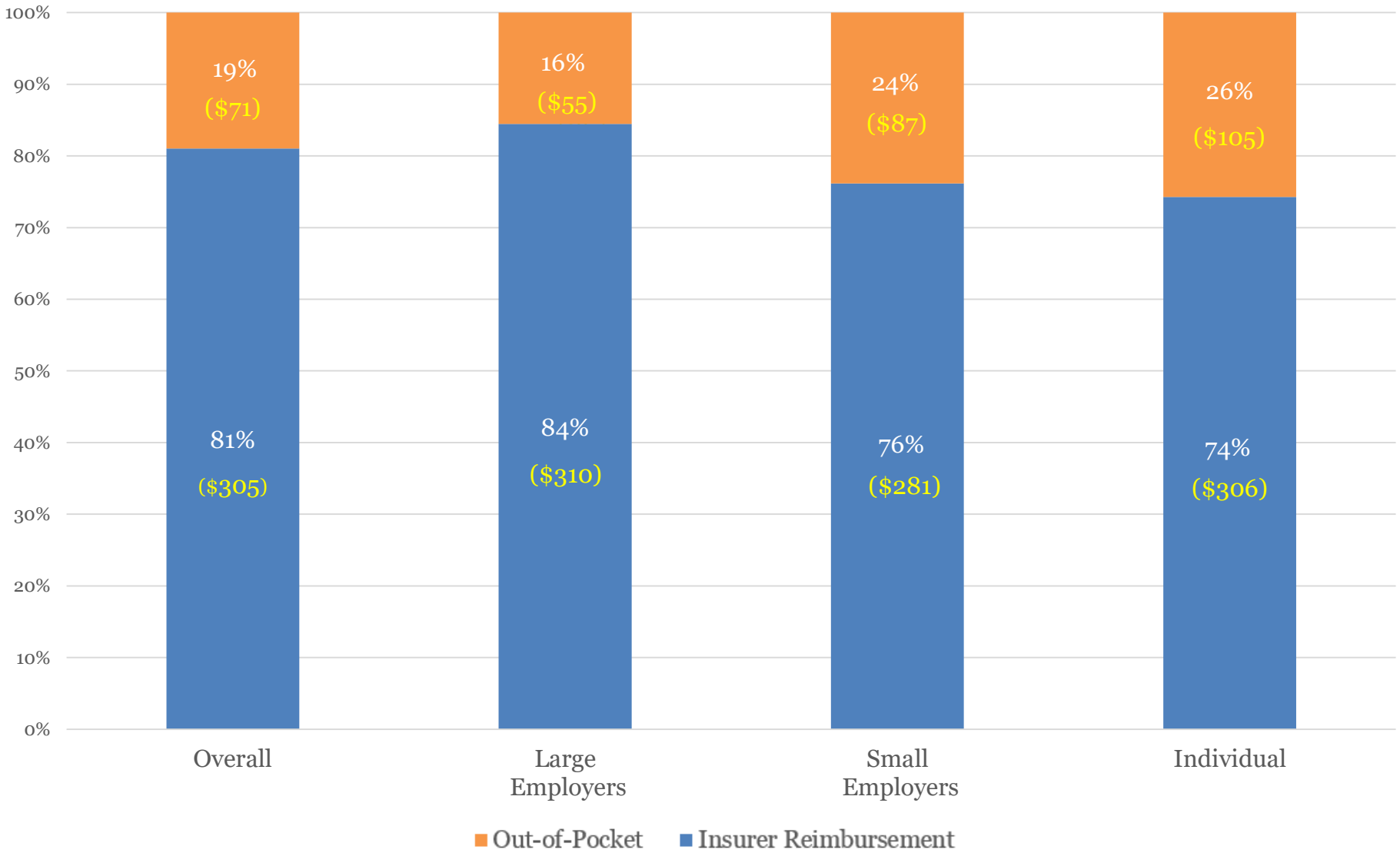
PMPM SPENDING & DISTRIBUTION BY MARKET AND SERVICE CATEGORY (2015)



PMPM Spending Changes by Market and Service Category (2015 over 2014)



Out-of-Pocket Share and Reimbursed Share of Total Spending by Market (2015)



Development Plans for Privately Insured Report

- Build infrastructure to speed up delivery of annual report
  - Influence payor behavior to provide correct, complete data files by due dates
    - During Sept 2016 - July 2017, held weekly meetings with non-compliant payers, sent letters of intent to fine payers with chronic performance problems
  - Create report master document detailing business rules for report analysis
  - 2016 report ready in January 2018
    - Expand report to show trend of three years of year-over-year changes in results (i.e., PMPM year-over-year changes for 2014, 2015, and 2016)

- Define process, build database infrastructure, and create schedule for quarterly updates for key measures in report
  - Quarterly updates to begin in second half of 2018

Questions?

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #7)


ENJOY THE REST OF
YOUR DAY