



**VIA EMAIL**

October 28, 2022

Matthew Celentano, Executive Director  
The League of Life and Health Insurers of Maryland  
15 School Street, Suite 200  
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Dear Mr. Celantano:

Thank you for attending the Maryland Health Care Commission (MHCC) all-payor briefing on the non-claim data template and your recent letter summarizing some of the concerns raised by large payors at the meetings. This letter addresses concerns raised at the meeting or in the follow-up letter. I note that MHCC has made additional modifications to reflect the input at the all-payor meeting and suggestions in your letter.

**Authority to Collect Non-Claim information from Payors**

The MHCC has the authority to collect fee for service claims, capitated services, non-claim-based payments, enrollment data, and provider directory information. Among the purposes of the Maryland Health Care Commission, Health General §19-103(c) directs the MHCC to establish and utilize a medical care database as a primary means to compile data and information and annually report on trends and variances in fees for service and cost of care. To meet the obligation, MHCC may collect information from claims, capitated services, and non-claim-based payments. MHCC has collected information on claims, capitated encounter, patient enrollment, and provider directory data for many years. Regulation 14 in COMAR 10.25.06, adopted as final in March 2014, permitted the reporting of non-claim-based expenses:

***Each non-fee-for-service expenses report shall contain the information specified by the Commission in its annual update to the MCDB Submission Manual and be filed in a form and manner specified in the Manual.***

The collection of information on non-claim-based payments has not been needed because certain value-based arrangements or alternative payment models (APMs) have not been permitted in Maryland law. Even in the absence of law permitting two-sided value-based arrangements, Commissioners urged the staff to implement non-claims reporting because of the growing importance of one-sided value-based arrangements. These arrangements consist

of up-side only programs including some payers' PCMH programs and certain programs between payors and clinically integrated organizations. At the November 2021 meeting, multiple Commissioners commented on the need to collect information on value-based arrangements during the discussion on the adoption of the 2022 Medical Care Data Base (MCDB) Submission Manual, the document that guides payors in the submission of information to the MHCC. Staff reaffirmed their plan to engage payors in developing the submission formats for non-claim payments in the next year.

The uncodified section of Chapter 297 of the 2022 laws of Maryland (Chapter 297, House Bill 1148) requires the collection of non-claim payments in 2023. Section 2 of Chapter 297 directs the MHCC to aggregate information regarding the cost effectiveness and quality outcomes of APMs. This new requirement is consistent with COMAR 10.25.06.14 adopted in 2014.

### **Consistency with Other States' Approaches**

***Takeaway: MHCC is conforming to the evolving national standard on reporting of non-claim-based payments. The reporting of quality measures is unique to Maryland and MHCC is taking steps to ease the burden.***

MHCC's approach to APM data collection is consistent with the approaches used in five other states that collect or are developing APM collection templates. Appendix Table 1 compares Maryland's and other states' approaches. Several similarities are notable including the requirement by four of the five other states that payors provide financial information by the billing provider's national provider ID and tax ID. Like four of the other five states, the Maryland templates utilize the Health Care Plan and Learning Action Network's (HCPLAN) framework for categorizing APMs. The HCPLAN APM framework was developed by the leading national health plans and CMS to categorize stages of APM development. Our template conforms with the national best practice of breaking out payments to each provider organization participating in an APM arrangement category. MHCC has also shown flexibility in the design and scope of our reporting template. To evaluate the cost-effectiveness of APMs, aggregate fee-for-service financial information and non-claims payments by billing provider need to be compiled. Four of the five other states require payors to submit aggregate FFS data. MHCC believes the Maryland MCDB may be sufficiently robust to support the aggregation of FFS financial information by provider tax ID.

### **Data Collection Population**

***Takeaway: To ease reporting, payors have the flexibility to include additional populations that are subject to value-based arrangement in the reporting template.***



Your letter indicates that MHCC has launched a data collection beyond the scope of our authority in that we are collecting data on the self-insured populations and certain insurance products. Payors are required to provide information on APMs between fully insured plans situated in Maryland and providers with at least one Maryland location. Payors can report APM results for other populations if they believe including those populations better characterizes the performance of providers, the scope of a value-based program, or simply for the sake of payor convenience. MHCC requests that a payor indicates the populations they are reporting on in the reporting templates. The claim that MHCC is stretching the scope of our authority is not the basis for this permission.

### **Approach to Quality and Cost-Effectiveness Assessment**

***Takeaway: MHCC will use the HEDIS specifications for calculating AHU (Acute Hospital Utilization), EDU (Emergency Department Utilization), FUM (Follow-up After Emergency Department Visit for Mental Illness), CDC (Comprehensive Diabetes Care), COU (Risk of Continued Opioid Use), BCS (Breast Cancer Screening) and CAHPS (Composite Care Scores- Coordination of Care) are optional in 2023.***

Under Chapter 297, the MHCC will assess the quality outcomes of value-based arrangements. Quality measures are often the first threshold that providers must meet to qualify for a bonus. Failure to meet quality measures may trigger a penalty. To evaluate performance reliably and equitably, MHCC will apply standardized measures of quality across payors for provider participants. MHCC's approach conforms with Maryland payors' preferences and national best practices for assessing quality outcomes. The quality measures only include the five nationally standardized Healthcare Effectiveness Data and Information Set (HEDIS) measures. In response to comments from payors, BCS and provider-level CAHPS scores are optional in 2023.

### **Additional Changes to the Template**

***Takeaway: MHCC is waiving the reporting of quality metrics for episodes and providing additional support to payors for completing the reporting template.***

MHCC has modified the technical specifications to reflect your members' recommendations. First, MHCC is waiving the submission of quality metrics for episode-based payments for the 2023 submissions. Second, MHCC is designating two of the HEDIS quality measures as optional in 2023. Third, payors unable to calculate the quality measures will have the option to work with MHCC for MHCC to calculate the quality measures using the MCDB. Fourth, all payors will use Age/Gender factor – a long-standing actuarial risk-adjustment tool - to adjust for differences across populations. This modification reflects our desire to respond to payors that do not have access to a health status adjustment tool.



Letter to Matthew Celentano, Executive Director

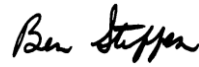
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I appreciate the League continuing to engage in a collaborative dialogue over the past six weeks. The adjustments MHCC has made in the template will enable payors to complete the reporting requirements efficiently. Post-implementation, MHCC will continue to support payors and look forward to continued collaboration. Passage of HB 1148 was an important step in enabling the spread of APMs. MHCC is committed to meeting its obligations and building a greater understanding of APMs in Maryland. The draft data submission material, including the revised template is available for review and comment at:

[https://mhcc.maryland.gov/mhcc/pages/apcd/apcd\\_mcdb/apcd\\_mcdb\\_data\\_submission.aspx](https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb_data_submission.aspx).

I look forward to working with League members to implement HB 1148.



Ben Steffen  
Executive Director

Cc: Kenneth Yeates-Trotman  
Shankar Mesta  
Janet Ennis  
Mary Jo Condon, Freedman HealthCare



**Appendix Table 1**

Alternative Payment Model Reporting Requirements		CO	DE	MA	MD	OR	RI***
1	Collects data by Billing Provider NPI, Organizational ID, and/or Tax ID?	X		X	X	X	X
2	Are data submitters required to provide non-FFS/APM financial data by provider organization?	X		X	X	X	X
3	Are data <i>submitters</i> required to provide FFS financial data by provider organization?	X		X		X	X
4	Is the population focused on member/subscriber state or residence or plan situs?	R	S	R	S*	S	R
5	Are data submitters required to provide financial data by member zip code?			X			
6	Are data submitters required to provide data on quality?				X		
7	Are results for APMs focused on pediatric populations distinguished from those focused on adult populations?			X	X		
8	Does the template utilize the HCPLAN framework that was developed by leading national health plans and the Centers for Medicare & Medicaid Services?	X	X		X	X	X
9	Are data submitters required to breakout payments to each provider organization for each APM arrangement category?	X		X		X	X
10	Are data submitters required to provide high-level descriptions of current contracts (e.g., prospective vs. retrospective, risk to provider)?	X	X	X	X		
11	Are data adjusted for differences in health status and/or age and gender?***		X	X	X		

\*Payors may include or exclude members who do not live in Maryland

\*\*Delaware, Rhode Island and Oregon collect APM data through multiple processes; the columns in this table reflect data submission requirements most closely aligning with APCD data collection. APM data collected through the cost trend processes in these states is adjusted for age and gender differences.

\*\*\* RI specifications for the APCD are draft, expected to be finalized in November.