MHDO Maine Health Data Organization

Information | Insight | Improvement

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MHDO Baseline Review

MHDO Priorities as defined by the Board

Legislative Objectives

MHDO's Priorities

1. Manage a high-quality, comprehensive health information data warehouse
2. Promote the release of healthcare data and information
3. Promote the transparency of healthcare cost and quality information
4. Support ongoing stakeholder engagement with our data providers, data users and consumers
5. Support a culture of change based on our stakeholders' needs

Note: Priorities Established by MHDO Board at June 2016 Retreat

MHDO Objective –Title 22 Chapter 1683

The purposes of the organization are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens **and** to issue reports, as provided in section 8712.

The primary external use of the MHDO data as defined in Rule Chapter 120 is to produce meaningful analysis in pursuit of improved health and health care quality for Maine people. Acceptable uses of MHDO data include, but are not limited to, study of health care costs, utilization, and outcomes; benchmarking; quality analysis; longitudinal research; other research; and administrative or planning purposes.

§8712. REPORTS

1. Quality
2. Payments
3. Comparison Report
4. Physician Services

(Refer to handout)

§8712. REPORTS

The organization shall produce clearly labeled and easy-to-understand reports as follows. Unless otherwise specified, the organization shall distribute the reports on a publicly accessible site on the Intel11et or via mail or e-mail, through the creation of a list of interested parties. The organization shall make reports available to members of the public upon request. [2009, c. 613, §8 (AMD).]

1. **Quality.** The organization shall promote public transparency of the quality and cost of health care in the State in conjunction with the Maine Quality Forum established in Title 24-A, section 6951 and shall collect, synthesize and publish information and reports on an annual basis that are easily understandable by the average consun1er and in a format that allows the user to compare the information listed in this section to the extent practicable. The organization's publicly accessible websites and reports must, to the extent practicable, coordinate, link and compare information regarding health care services, their outcon1es, the effectiveness of those services, the quality of those services by health care facility and by individual practitioner and the location of those services. The organization's health care costs website must provide a link in a publicly accessible format to provider-specific information regarding quality of services required to be reported to the Maine Quality Forum.

2009, c. 2, §63 (COR).]

2. **Payments.** The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payers. Beginning October 1, 2012, price infor1lation posted on the website must be posted semiannually, must display the date of posting and, when posted, must be current to within 12 months of the date of subn1ission of the information.

A. [2009, c. 613, §8 (RP).]

2011, c. 525, §1 (AMD).]

3. **Comparison report.** At a minimum, the organization shall develop and produce an annual report that compares the 15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals in the State and the 15 most common procedures for nonhospital health care facilities in the State to similar data for medical care rendered in other states, when such data are available.

2003, c. 469, Pt. C, §29 (NEW) .]

4. **Physician services.** The organization shall provide an annual report of the 10 services and procedures most often provided by osteopathic and allopathic physicians in the private office setting in this State. The organization shall distribute this report to all physician practices in the State. The first report must be produced by July 1, 2004.

[2003, c. 469, Pt. C, §29 (NEW) .]

SECTION HISTORY

2003, c. 469, §C29 (NEW). 2005, c. 391, §2 (AMD). RR 2009, c. 2, §63 (COR). 2009, c. 71, §8 (AMD). 2009, c. 350, Pt. A, §1 (AMD). 2009, c. 613, §8 (AMD). 2011, c. 525, §1 (AMD).

Continued-Baseline

MHDO Budget

- **Legislative Authorization to Spend $2.0 Million / Year**
  - Annual Assessment Generates Approximately $1.6 Million
  - $200,000 - $300,000 Collected in Data Fees Associated with Data Access and Analysis

Data Sets Available for Release (over 1 billion healthcare records)

- All Payer Claims Data (APCD)
- Maine Hospital Inpatient and Outpatient Encounter Data
- Hospital Physician Practice Data (primary and specialty care)
- Maine Hospital Quality Data
- Maine Hospital Financial Data
- Hospital Restructuring Data

Continued-Baseline

Three Categories of Ad-Hoc Data Requests Produced by MHDO

1. Requests from State Agencies, Legislators and Legislative Committees, Press and other Interested Parties for immediate information (example how many Opioid scripts are prescribed in a year; what are the top ten prescription drugs cost and utilization in Maine; how many C-sections annually; how many diabetics in the state of Maine etc.....

Continued-Baseline

2. Formal Ad-hoc data requests from external parties, examples include:

Maine Children's Alliance-aggregate report of outpatient attempted suicide/self-inflicted injuries for ages 10-19 and hospital visits for mental/substance abuse diagnoses for ages 0-19

The Maine Heritage Policy Center- report of the 20 most commonly performed medical procedures for facilities listed on the CompareMaine website as well as the number of total encounters for all hospitals in 2014 and the number of encounters for all other facilities reported on CompareMaine for the same time period.

VA Medical Center-analysis of healthcare services utilization of VA enrollees outside of the VA system.

Continued-Baseline

3. Legislative Reports MHDO data supports:

- Title 39-A section 209-A(3) and (5)-Workers Comp
- PL 488 Sec. 38- An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program
- Title 22 Chapter 1683, 8712 Reports (promoting the transparency of healthcare costs and quality)
  - CompareMaine
  - MONAHRQ
  - Annual Hospital Financial Summaries of hospital financial data over a five year span, as reported by Maine's non-governmental hospitals. Profitability, Liquidity, Capital Structure, Asset Efficiency and other common ratios are provided in these standardized reports.

Maine Health Data Organization

Summary Review of Data Access Fees as of 5/30/17

	Number of Hospital Data Requests	Value of Hospital Data Requests	Number of APCD Data Requests	Value of APCD Data Requests	Number of Custom Reports Requests	Value of Custom Reports Requests	Number of HCUP Requests	Value of HCUP Requests	Total Number of Data Requests	Total Value** of Data Access Fees
For-Profit	3	$ 10,325.00	2	$ 30,167.00	1	$ 125.00		$ -	6	$ 40,617.00
Not-For-Profit	3	$ 6,000.00	4	$ 43,450.00	1	$ 160.00		$ -	8	$ 49,610.00
State Agency	1	$ -	4	$ -	5	$ - *		$ -	10	$ -
HCUP	0	$ -	0	$ -	0	$ -	1	$ 30,950.00	1	$ 30,950.00
SFYTD-17	7	$ 16,325.00	10	$ 73,617.00	7	$ 285.00	1	$ 30,950.00	25	$ 121,177.00
Anticipated June 2017 Fees	3	$ 23,000.00	2	$ 25,650.00	-	$ -	0	$ -	5	$ 48,650.00
Total Projected SFY-17	10	$ 39,325.00	12	$ 99,267.00	7	$ 285.00	1	$ 30,950.00	30	$ 169,827.00
For-Profit	8	$ 41,500.00	4	$ 49,484.00	1	$ 1,280.00		$ -	13	$ 92,264.00
Not-For-Profit	8	$ 18,250.00	6	$ 43,440.00	4	$ 1,485.00		$ -	18	$ 63,175.00
State Agency	3	$ -	5	$ 9,620.00	5	$ -		$ -	13	$ 9,620.00
HCUP	0	$ -	0	$ -	0	$ -	1	$ 36,750.00	1	$ 36,750.00
SFY-16	19	$ 59,750.00	15	$ 102,544.00	10	$ 2,765.00	1	$ 36,750.00	45	$ 201,809.00
For-Profit	9	$ 37,800.00	1	$ 8,965.00	0	$ -	0	$ -	10	$ 46,765.00
Not-For-Profit	6	$ 22,250.00	15	$ 108,425.00	3	$ 1,920.00	0	$ -	24	$ 132,595.00
State Agency	3	$ 5,000.00	1	$ 57,900.00	0	$ -	0	$ -	4	$ 62,900.00
HCUP	0	$ -	0	$ -	0	$ -	0	$ 23,300.00	0	$ 23,300.00
SFY-15	18	$ 65,050.00	17	$ 175,290.00	3	$ 1,920.00	0	$ 23,300.00	38	$ 265,560.00

	Data Access Fees*	% of Total Annual Revenue
SFY-17 YTD ***	$ 169,827.00	10%
SFY-16	$ 201,809.00	12%
SFY-15	$ 265,810.00	15%
SFY-14****	$ 336,005.00	19%
SFY-13	$ 116,779.81	7%
SFY-12	$ 160,363.02	10%
SFY-11	$ 179,937.90	11%
SFY-10	$ 84,636.88	6%
SFY-09	$ 92,990.54	6%
SFY-08	$ 89,340.67	7%

*Requests from State of Maine Agencies and Legislative requirements are not factored into the dollar value of Custom Reports

** Total Value of Data Access Fees do not include $25 processing fee

***Projected SFY-17

****Moratorium on Data Access Fee Waiver began - Dec 5, 2013 and a one-time Data Access Fees to SAS for $125,000

Maine Health Data Organization

Review of Ad Hoc Data Requesters for last 3 years

Request #	Multi-Year Request	Name	Organization	Type of Org	Calendar Year Data Requested For	Type of Data	Description of Ad Hoc request
022117	No	David Simsarian	ME Dept of Corrections	State Agency	2015	AD Hoc Report	Ad Hoc - 2015 Inpatient overview Prison Health
051587	No	George Shaler	Muskie School of Public Service	Not-For-Profit	2013	AD Hoc Report	Number of admits, length of stay, and total paid by Medicare (Facility costs only) for AR Gould, Blue Hill Memorial, C.A. Dean Memorial, Calais Regional Hospital, CMMC, Franklin Memorial, Inland Hospital, Maine Coast Memorial Hospital, MaineGeneral, MMC, Mayo Regional, Mercy Hospital, Miles Memorial, Pen Bay Medical Center, St. Andrews, St. Mary's Regional Health Center, TAMC, and Waldo County General for calendar year 2013.
111544	No	Claire Berkowitz	Maine Children's Alliance	Not-For-Profit	2012, 2013 & 2014	AD Hoc Report	CY 2012, 2013 & 2014 Outpatient attempted suicide/self-inflicted injuries for ages 10-19 and hospital visits for mental/substance abuse diagnoses for ages 0-19.
150727	No	Pat Novell	York Hospital	Not-For-Profit	2012, 2013, & 2014	AD Hoc Report	The Rate of Falls and Falls with Injury for York Hospital compared with the Maine Hospital Association's Peer Group B and with all Acute Care, Critical Access and Rehabilitation Hospitals Statewide
171514	No	Robert Lutz	Offices of Maine Care Services	State Agency	FY-2009 - FY2014	AD Hoc Report	SFY-09 - SFY-14 Spring Harbor and Acadia Inpatient Discharge Counts and Payments
221584	Yes	Charles Bryant	DHHS, Maine Care Services	State Agency	FY 2013 - FY 2015	AD Hoc Report	FY 2013 - FY 2015 Substance Abuse Spending Analysis
261556	No	Commissioner Mayhew	DHHS	State Agency	2013 & 2014	AD Hoc Report	CY 2014 APCD and CY 2013 Hospital Inpatient and Outpatient data
261557	No	John Lipovsky	DHHS	State Agency	2012, 2013 & 2014	AD Hoc Report	2012-2014 APCD Pharmacy claims
306164	Yes	Susan Scow	Maine Health Management Coalition	Not-for-Profit	2014 - 2016	AD Hoc Report	2016 Quality Data Sets
331555	No	Liam Siguad	Maine Heritage Policy Center	For-Profit	2014	AD Hoc Report	2014 Restricted Medical Claims and Medical Eligibility Data.
351556	Yes	Wanita Paige	ME DHHS	State Agency	7/1/14 - Ongoing (Quarterly Report produced)	AD Hoc Report	2014 - ongoing Inpatient and Outpatient data

351585	No	Mary Lindsey Smith	Cutler Institute for Health and Social Policy, USM, Muskie School of Public Service	Not-For-Profit	2014	AD Hoc Report	CY 2014 Restricted Medical Claims data.
814126	No	David Goodman, MD, MS	The Dartmouth Institute of Health Policy and Clinical Practice	Not-For-Profit	2007-2010	AD Hoc Report	2007 - 2010 Restricted Medical, Pharmacy and Eligibility Claims data with practitioner identifiable data
817164	Yes	Claire Berkowitz	Maine Children's Alliance	Not-For-Profit	2014	AD Hoc Report	2014 Medical Claims Ad Hoc Report
2017042801	Yes	Tim Diomede/Johanna Buzzell	Maine DHHS	State Agency	2013-2015	AD Hoc Report	Morbidity Indicator report
2017042402		Kimberlee Barriere	Workers Comp	State Agency	2016	Legislative	Workers Comp
811165		Eric Cioppa/Thomas record	BOI	State Agency	2016	Legislative	Opioid Prescription

Maine Revised Statutes

Title 39-A: WORKERS' COMPENSATION

Chapter 5: COMPENSATION AND SERVICES

§209-A. MEDICAL FEE SCHEDULE

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Ancillary services and products" means those services and products that are necessary but peripheral to the medical procedure. [2011, c. 338, §4 (NEW).]

B. "Medical fee schedule" means a list of medical procedures and the medical codes used and fees charged for those medical procedures. [2011, c. 338, §4 (NEW).]

[2011, c. 338, §4 (NEW) .]

2. Medical fee schedule. In order to ensure appropriate limitations on the cost of health care services while maintaining broad access for employees to health care providers in the State, the board shall adopt rules that establish a medical fee schedule setting the fees for medical and ancillary services and products rendered by individual health care practitioners and health care facilities in accordance with the following:

A. The medical fee schedule for services rendered by individual health care practitioners must reflect the methodology underlying the federal Centers for Medicare and Medicaid Services resource-based relative value scale; [2011, c. 338, §4 (NEW).]

B. The medical fee schedule for services rendered by health care facilities must reflect the methodology and categories set forth in the federal Centers for Medicare and Medicaid Services severity-diagnosis related group system for inpatient services and the methodologies and categories set forth in the federal Centers for Medicare and Medicaid Services ambulatory payment classification system for outpatient services; and [2011, c. 338, §4 (NEW).]

C. The medical fee schedule must be consistent with the most current medical coding and billing systems, including the federal Centers for Medicare and Medicaid Services resource-based relative value scale, severity-diagnosis related group system, ambulatory payment classification system and healthcare common procedure coding system; the International Statistical Classification of Diseases and Related Health Problems report issued by the World Health Organization and the current procedural terminology codes used by the American Medical Association. [2011, c. 338, §4 (NEW).]

[2011, c. 338, §4 (NEW) .]

3. Annual updates. Notwithstanding Title 5, chapter 375, subchapter 2, the executive director of the board shall annually update the medical fee schedule developed pursuant to subsection 2. In order to facilitate the update, the executive director annually shall obtain from the Maine Health Data Organization the average total payments, including professional, facility, ancillary and patient cost-sharing contribution, across all providers in the Maine Health Data Organization database for the medical and ancillary services and products most commonly rendered during the immediately preceding calendar year under this Part.

[2011, c. 338, §4 (NEW) .]

4. Reimbursement rate if medical fee schedule not established or updated. If the board fails to adopt rules that establish a medical fee schedule in accordance with subsection 2 by December 31, 2011 or the executive director fails to annually update the medical fee schedule in accordance with subsection 3, the reimbursement rate for medical services is 105% of the private 3rd-party payor average payment rate for the

provider or the amount agreed to in writing by the provider and the insurance company or self-insured employer prior to the rendering of service by the provider. For purposes of this subsection, "reimbursement rate for medical services" means the total payment allowed for the medical and ancillary services and products, including any amount to be paid by a 3rd-party payor and the amount to be paid by the patient to satisfy a copayment, deductible or coinsurance obligation.

[2011, c. 338, §4 (NEW) .]

5. Periodic updates to the medical fee schedule. In addition to the annual updates to the medical fee schedule required by subsection 3, the board shall undertake a comprehensive review of the medical fee schedule once every 3 years beginning in 2014. The board shall consider the following factors in setting or revising the medical fee schedule as required by this section:

A. The private 3rd-party payor average payment rates obtained from the Maine Health Data Organization pursuant to subsection 3; [2011, c. 338, §4 (NEW).]

B. Any material administrative burden imposed on providers by the nature of the workers' compensation system; and [2011, c. 338, §4 (NEW).]

C. The goal of maintaining broad access for employees to all individual health care practitioners and health care facilities in the State. [2011, c. 338, §4 (NEW).]

[2011, c. 338, §4 (NEW) .]

6. Associated services fee schedule. The board shall adopt rules that establish a fee schedule or other standards of reimbursement for providers regarding administrative, case management, medical and legal and other activities unique to the treatment of injured workers in the workers' compensation system.

[2011, c. 338, §4 (NEW) .]

7. MaineCare reimbursement. MaineCare must be paid 100% of any expenses incurred for the treatment of an injury of an employee under this Title.

[2011, c. 338, §4 (NEW) .]

SECTION HISTORY
2011, c. 338, §4 (NEW).

enhancement to the Controlled Substances Prescription Monitoring Program described in subsection 1 is implemented.

Sec. 38. Effect on out-of-pocket costs. The Bureau of Insurance within the Department of Professional and Financial Regulation shall evaluate the effect of the limits on prescriptions for opioid medication established by this Act on the claims paid by health insurance carriers and the out-of-pocket costs, including copayments, coinsurance and deductibles, paid by individual and group health insurance policyholders. On or before January 1, 2018, the bureau shall submit a report on the evaluation, along with any recommended policy and regulatory options that will ensure costs for patients are not increased as a result of new prescribing limitations on the amounts of opioid medications, to the joint standing committees of the Legislature having jurisdiction over health and human services matters and over insurance and financial services matters. The joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out legislation related to the evaluation to the Second Regular Session of the 128th Legislature.

Sec. 39. Department of Health and Human Services implementation report. The Department of Health and Human Services shall report to the joint standing committees of the Legislature having jurisdiction over health and human services matters and over occupational and professional regulation matters, no later than January 31, 2018, with progress on implementing the provisions of this Act. The report must contain information on the following:

1. Registration of prescribers and dispensers in the Controlled Substances Prescription Monitoring Program under the Maine Revised Statutes, Title 22, chapter 1603;

2. Data regarding the checking and using of the Controlled Substances Prescription Monitoring Program by data requesters;

3. Data from professional boards regarding the implementation of continuing education requirements for prescribers of opioid medication;

4. Effects on the prescriber workforce;

5. Changes in the numbers of patients taking more than 100 morphine milligram equivalents of opioid medication per day;

6. Data regarding the total number of opioid medication pills prescribed;

7. Progress on electronic prescribing of opioid medication; and

8. Improvements to the Controlled Substances Prescription Monitoring Program through the request for proposals process including feedback from prescribers and dispensers on those improvements.

FOR IFS REVIEW W/ FISCAL NOTE 5/30/17

LD 445
OTP-A
FOR IFS REVIEW

Committee: IFS
LA: CMR
File Name: G:\COMMITTEES\BAN\amends\128th 1st\048402.docx
LR (item): 0484 (02)
New Title?: n
Add Emergency?: n
Date: May 26, 2017

ROS

COMMITTEE AMENDMENT "." TO **LD 445, An Act To Encourage Maine Consumers To Comparison-shop for Certain Health Care Procedures and To Lower Health Care Costs**

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

Sec. 1. **22 MRSA §1718-B, sub-§2, ¶D** is enacted to read:

D. Beginning January 1, 2018, at the time a referral or recommendation is made for a comparable health care service as defined in Title 24-A, section 4318-A, subsection 1, paragraph A during an in-person visit, the health care entity making that referral or recommendation shall notify a patient who has private health insurance coverage of the patient's right to obtain services from a different provider. A health care entity shall comply with this paragraph by providing a written notice at the time the health care entity recommends or refers a patient for a health care service or procedure that may qualify as a comparable health care service. Any written notice provided under this paragraph must include a notification that, prior to obtaining the recommended service, the patient may review the health care price transparency tool provided by their carrier or contact their carrier directly via a toll-free number so that the patient may consider whether the recommended provider of the comparable health care service represents the best value for the patient. Any written notice provided under this paragraph shall include a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow the carrier to assist the patient in comparing prices for the comparable health care service.

Sec. 2. **22 MRSA §8712, sub-2** is amended to read:

2. Payments. The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology, ~~and~~ surgical services, comparable health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors. Beginning October 1, 2012, price information posted on the website must be posted semiannually, must display the date of posting and, when posted, must be current to within 12 months of the date of submission of the information. Payment reports and price information posted on the website must include data submitted by payors with regard to all health care facilities and

practitioners that provide comparable health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A or services for which the organization reports data pertaining to the statewide average price pursuant to this subsection or Title 24-A, section 4318-B. Upon notice made by a health care facility or practitioner that data posted by the organization pertaining to that facility or practitioner is inaccurate or incomplete, the organization shall remedy the inaccurate or incomplete data within the earlier of 30 days of receipt of the notice or the next semiannual posting date.

Sec. 3. 24-A MRSA § 4302, sub-§ 1, ¶M is enacted to read:

M. If the health plan is subject to the requirements of section 4318-A, a description of the incentives available to an enrollee and how to earn such incentives if enrolled in a health plan offering a comparable health care service incentive program designed pursuant to section 4318-A.

Sec. 4. 24-A MRSA §4303, sub-§21 is enacted to read:

21. Health care price transparency tools. Beginning January 1, 2018, a carrier offering a health plan in this State shall comply with the following requirements.

A. A carrier shall develop and make available a web site accessible to enrollees and a toll-free telephone number that enables enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A, from network providers, as well as quality data for those providers, to the extent available. A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization.

B. A carrier shall make available to the enrollee the ability to obtain an estimate that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the patient by the provider. Upon the enrollee's request, the carrier shall request additional or clarifying code information, where needed, from the provider involved with said comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's health care provider, the carrier shall provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider.

C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the health carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed admission, procedure or service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed admission, procedure or service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting the carrier to obtain more information about a particular admission, service, or procedure with respect to a particular provider.

D. Notwithstanding the provisions of this subsection and at the request of a carrier, the superintendent may grant an additional year to comply with the provisions of this subsection as long as the carrier has demonstrated a good faith effort to comply with the provisions of this subsection and has provided the superintendent with an action plan detailing the steps to be taken by the carrier to comply with this subsection no later than January 1, 2019.

Sec. 5. 24-A MRSA §4303, sub-§22 is enacted to read:

22. Denial of referral by out-of-network provider prohibited. Beginning January 1, 2018, a carrier may not deny payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a provider who is not a member of the carrier's provider network.

Sec. 6. 24-A MRSA §4318-A is enacted to read:

§ 4318-A. Comparable health care service incentive program

Beginning January 1, 2019, a carrier offering a health plan in this State shall establish, at a minimum, for all small group health plans compatible with a health savings account, a health plan design in which enrollees are directly incentivized to shop for low cost, high quality participating providers for comparable health care services. Incentives may include, but are not limited to cash payments, gift cards or premium, copayment, deductible credits or reductions. A small group health plan design created under this section must remain available to enrollees for at least 2 consecutive years, except that any changes made to the incentive program after 2 years, including but not limited to, ending the incentive, may not be construed as a change to the small group health plan design for the purpose of guaranteed renewability under sections 2808-B, subsection 4 and 2850-B. A multiple-employer welfare arrangement is not considered a carrier for the purposes of this section.

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. ""Comparable health care service" includes nonemergency, outpatient health care services in the following categories:

(1) Physical and occupational therapy services;

(2) Radiology and imaging services;

(3) Laboratory services; and

(4) Infusion therapy services;

B. "Program" means the comparable health care services incentive program established by a carrier pursuant to this section.

C. Nothing in this section shall preclude a carrier from including additional types of

nonemergency health care services or procedures to its incentive program.

2. Filing with superintendent. Products filed with the superintendent pursuant to this section shall disclose, in the summary of benefits and explanation of coverage, a detailed description of the incentives provided to a plan enrollee. The description must clearly detail any incentives that may be earned by the enrollee, including any limits on such incentives, the actions that must be taken in order to earn such incentives, and a list of the types of services that qualify under the incentive program. This subsection may not be construed to prevent a carrier from directing an enrollee to the carrier's website or toll-free telephone number for further information on the incentive program created by this section in the summary of benefits and explanation of coverage. The superintendent shall review the filing made by the carrier to determine if the carrier's program complies with the requirements of this section.

3. Availability of program; notice to enrollees. Annually at enrollment or renewal, a carrier shall provide notice about the availability of the program to an enrollee who is enrolled in a health plan eligible for the program as required by section 4302, subsection 1, paragraph M.

4. No administrative expense. An incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

5. Study and evaluation. Beginning March 1, 2020 and annually thereafter, the superintendent shall undertake a study and evaluation of the incentive program created by carriers as required by this subsection. The superintendent may request information on enrollment and utilization of incentives earned by enrollees of a carrier as necessary. By April 15, 2020 and annually thereafter, the superintendent shall submit an aggregate report relating to the performance of the program, utilization, the incentives earned by enrollees and the cumulative impact of the program to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

6. Rules. The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

7. Repeal. This section is repealed on January 1, 2024.

Sec. 7. 24-A MRSA §4318-B is enacted to read:

§4318-B. Access to lower priced services

1. Services from out-of-network provider; lower prices. Beginning January 1, 2019, if an enrollee covered under a health plan other than a health maintenance organization plan elects to obtain a covered comparable health care service as defined in section 4318-A from an out-of-network provider at a price that is the same or less than the statewide average for the same covered health care service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's charge and, upon request by the enrollee, shall apply the payments made by the enrollee for that comparable health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health

plan as if the health care services had been provided by an in-network provider. A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the Maine Health Data Organization publicly accessible website as long as the carrier uses a reasonable methodology to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee that contains, at a minimum, comparable health care services. The enrollee is responsible for demonstrating to the carrier that payments made by the enrollee to the out-of-network provider should be applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this section. The carrier shall provide a downloadable or interactive on-line form to the enrollee for the purpose of making such a demonstration and may require copies of bills and proof of payment be submitted by the enrollee. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare.

2. Rules. The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

3. Repeal. This section is repealed January 1, 2024.

SUMMARY

This amendment replaces the bill. The amendment requires carriers offering health plans in the State, beginning January 1, 2019, to establish a small group health plan benefit design for all small group health plans compatible with health savings accounts in which enrollees are directly incentivized to shop for comparable health care services from lower cost, higher quality providers. The amendment defines "comparable health care service" as a service for which a carrier offers an incentive payment and includes, at a minimum, a health care service in the following 4 categories: physical and occupational therapy services; radiology and imaging services; laboratory services; and infusion therapy service. The amendment requires the Superintendent of Insurance to study and evaluate the incentive programs used by carriers and report annually to the Legislature beginning March 1, 2020. The legislative mandate for the incentive program is repealed on January 1, 2024.

Beginning January 1, 2018, the amendment requires carriers to develop and make available a publicly accessible website and toll-free telephone number to allow enrollees to obtain information about estimated costs for obtaining comparable health care services from network providers. The amendment permits a carrier to direct enrollees to the publicly accessible health care costs website of the Maine Health Data Organization or to a third-party vendor's publicly accessible website.

Beginning January 1, 2019, the amendment requires carriers to apply the amount paid for a comparable health care service provided by an out-of-network provider toward the enrollee's member cost sharing as specified in the enrollee's health plan as if the health care services were provided by a network provider upon request by the enrollee and if the cost of the out-of-network service is the same or less than the statewide average payment for the same service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization. A carrier may use the average network price paid by the carrier in lieu of the statewide average payment for the same service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization. The amendment defines an out-

of-network provider as a provider located in Maine, Massachusetts or New Hampshire that is enrolled in the MaineCare program as a provider and that participates in Medicare. This provision is repealed January 1, 2024.

The amendment also requires providers to notify patients of their right to obtain comparable health care services from a different provider at the time a provider makes a referral or recommendation for a comparable health care service during an in-person visit.

Continued-Baseline

Bills in process this session that if passed may impact MHDO:

- LD 1406, *An Act to Promote Prescription Drug Price Transparency*
- LD 1605, *An Act to Increase Consumer Prescription Drug Protections*
- *LD 445, An Act To Encourage Maine Consumers To Comparison-shop for Certain Health Care Procedures and To Lower Health Care Costs*

Low Value Vitamin D Screening in Northern New England

Kimberly A. Murray[1], Clifford J. Rosen[2], Rebecca L. Hillyer[3], Kathleen M Fairfield[1,3]

[1]Center for Outcomes Research & Evaluation, [2]Center for Clinical and Translational Research, [3]Department of Medicine

Maine Medical Center Research Institute, Maine Medical Center

Maine Medical Center
MaineHealth

Problem

- Low vitamin D levels in the general population are of concern to physicians and patients, although the causality between serum vitamin D and chronic disease has not been established
- USPSTF graded vitamin D screening as indeterminate

Aims

- To describe vitamin D testing without a medical indication in a Northern latitude State using claims

Data Sources

- An all-payer data set
- Claims from 2012-2014 with associated ICD-9 diagnosis codes

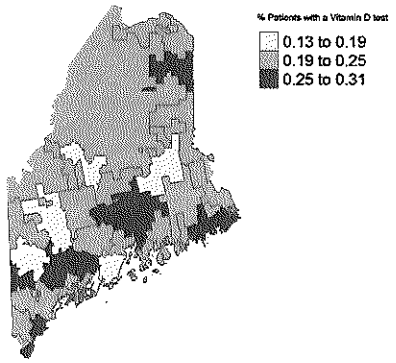
Methods

- Excluded patients with the following:
  - kidney disease
  - osteoporosis & osteomalacia
  - fractures
  - hypercalcemia & hyperparathyroidism
  - malabsorption
  - noninfectious enteritis and colitis
  - liver, pancreatic, gallbladder disease
  - gastric bypass surgery
  - granuloma-forming disorders
  - lymphoma
- Regions defined by patient ZIP code of residence, using Dartmouth atlas definitions

Preliminary Results

- Among 816,740 adults in the dataset from 2012-2014 with no medical indication for testing, 147,479 (18.1%) had at least one vitamin D test, and 36.5% had more than one test over the three years
- Testing occurred in similar proportions across all age groups and was highest in the 55-64 year old group
- Over 68% of testing had associated diagnosis codes indicating the test was done for screening, follow-up of prior abnormal testing, ill-defined symptoms such as malaise and fatigue, or other diagnoses not associated with vitamin D insufficiency (Table)
- Testing decreased over the 3 study years (Figure)

Map of Testing by Region



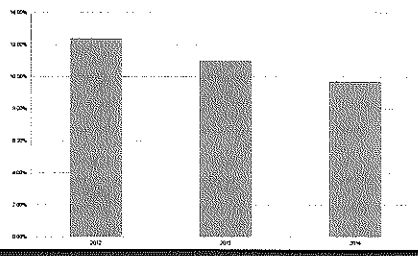
Counts of vitamin D tests aggregated for the study population during 2012-2014

Diagnoses Associated with Testing

Diagnoses (from ICD9 Codes)	Percent*
Routine medical exam or lab exam	19.8%
Vitamin D deficiency	14.4%
Hyperlipidemia	9.8%
Malaise, fatigue	7.3%
Diabetes	5.6%
Hypertension	5.5%
Hypothyroidism	3.6%
General screening	2.1%

*Does not sum to 100% as diagnoses become increasingly infrequent

Testing According to Year



Cost Estimate

- Based on Medicare reimbursement of $40.40 per test in 2014, we estimate that nearly $9,596,000 was spent during this interval on vitamin D testing without an appropriate medical indication

Limitations

- Does not include VA data or uninsured/ self pay
- Relies on ICD-9 codes to determine whether testing was inappropriate

Conclusions

- Vitamin D testing without an appropriate indication, or to follow-up on prior abnormal testing, is common, but is decreasing over time.
- Efforts to reduce unnecessary care should continue to target low-value testing.

Implications

- Vitamin D testing without a clinical indication is a costly and low-value practice.
- Providers and patients should be made aware of lack of recommendations regarding vitamin D screening in asymptomatic adults.
- Techniques such as shared decision making may help patients understand the pros and cons of vitamin D screening.

Acknowledgement & References

Thank you to Maine Health Data Organization (MHDO) for claims data

Colla, J Gen Intern Med, 2015
The Dartmouth Atlas
IOM: Dietary Reference Intakes for Calcium & Vitamin D, 2010
USPSTF, Vitamin D Deficiency: Screening
https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/vitamin-d-deficiency-screening

Maine Hospital Association

2014 HOSPITAL INPATIENT ORIGIN REPORT

(BY COUNTY & BY HOSPITAL)

Comparative Report

24 Months (January 2013 – December 2014)

Maine Hospital
Association

33 Fuller Road • Augusta, ME 04330 • 207-622-4794 • www.themha.org

Prepared for MHA and Its Member Hospitals by Onpoint Health Data • www.onpointhealthdata.org

INTRODUCTION

MHA is pleased to provide you with the January 2013 – December 2014 *Hospital Inpatient Origin Report.* This report shows the discharges, market share, and patient days in all Maine general, acute care hospitals using two presentations: (1) by town by hospital and (2) by hospital by town. Discharges displayed using the first approach — by town by hospital — are sectioned by county; discharges using the second approach — by hospital by town — are sorted alphabetically by hospital name.

MHA's *Hospital Inpatient Origin Report* is prepared for MHA and its member hospitals by Onpoint Health Data (www.onpointhealthdata.org), an independent, nonprofit organization providing reliable data, trusted research, and independent analysis to the healthcare community and policymakers.

If you have any questions regarding this report, please contact Tamara Butts, MHA Director of Business Development and Administration, by phone (207-622-4794) or email (tbutts@themha.org).

REPORTING DISCLOSURE POLICY

The data used in this report was received from the Maine Health Data Organization (MHDO).

MHA DATA DISCLOSURE POLICY

The Board of Directors of the MHA has adopted the following policy regarding the disclosure of clinical information, which is in accordance with the MHDO's policies on data disclosure:

- Requests by hospitals for data — Requests by hospitals for reports will be processed on a timely basis.
- Requests for information by corporations and individuals other than hospitals — Information will not be provided except in an aggregated format with breakdowns either by region or bed size. All other requests will be denied unless specifically permitted by each hospital whose data would be contained in the requested release.

MHA, in compliance with MHDO regulation Chapter 120, will not disclose individual discharges for population centers of less than 20,000. All data in reports that would identify an individual discharge will be reported as "Other (*county name*)." Additionally, MHA will not release reports that will directly identify individual physicians.

Maine Hospital Association

2014 HOSPITAL INPATIENT ORIGIN REPORT

(BY COUNTY & BY HOSPITAL)

Comparative Report

24 Months (January 2013 – December 2014)

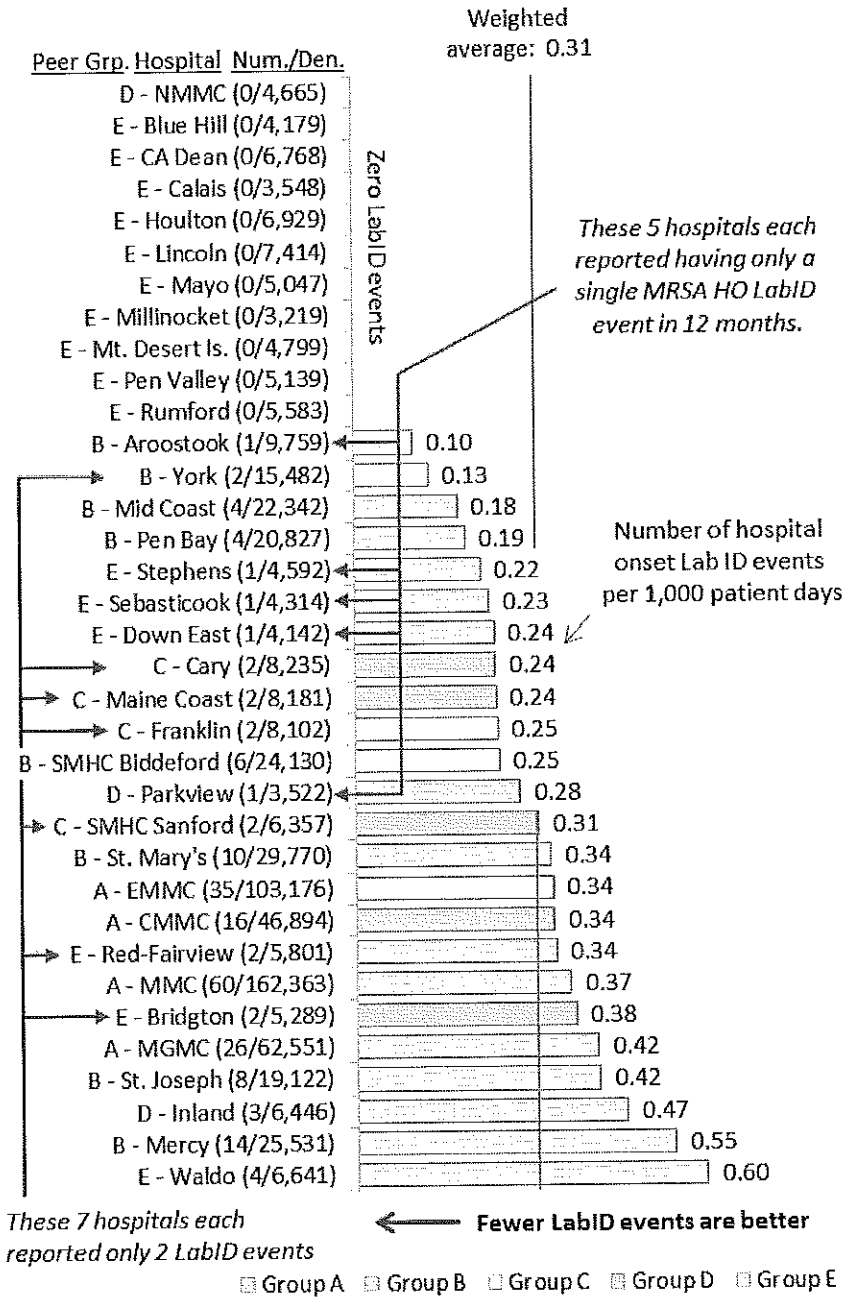
Executive Summary by County

Inpatient Origin Report - Executive Summary by County

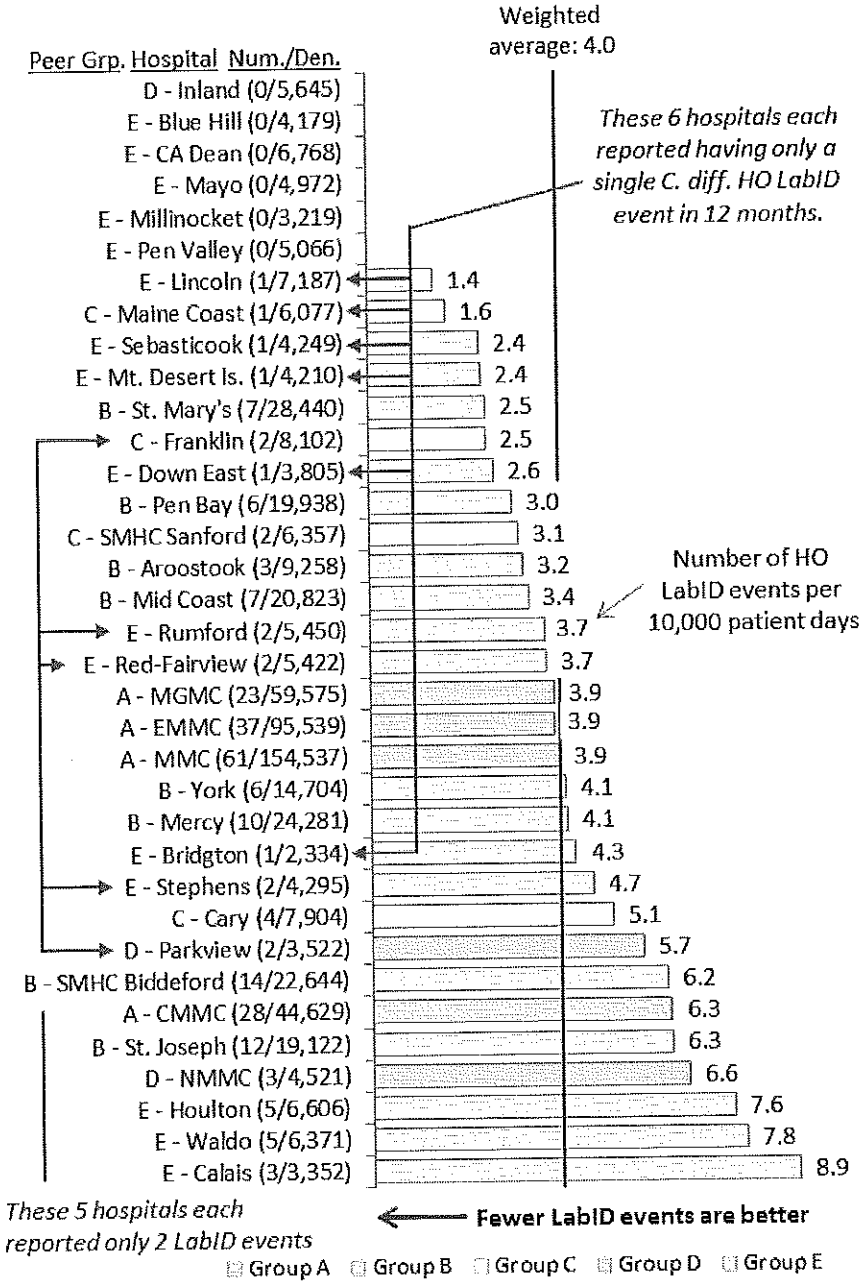
1/1/2014 to 12/31/2014 | 1/1/2013 to 12/31/2013

	DISCHARGES				% OF DISCHARGES			PATIENT DAYS				PAT DAYS/DISCHARGE			
	CURRENT	PRIOR	CHG	%CHG	CURRENT	PRIOR	CHG	CURRENT	PRIOR	CHG	%CHG	CURRENT	PRIOR	CHG	%CHG
CUMBERLAND	23,550	23,628	-78	-0.3%	17.6%	17.8%	-0.1%	137,149	120,504	16,645	13.8%	5.82	5.10	0.72	14.1%
YORK	16,465	16,903	-438	-2.6%	12.3%	12.7%	-0.4%	93,937	79,252	14,685	18.5%	5.71	4.69	1.02	21.8%
PENOBSCOT	15,886	16,600	-714	-4.3%	11.9%	12.5%	-0.6%	108,066	84,897	23,169	27.3%	6.80	5.11	1.69	33.1%
KENNEBEC	12,522	12,504	18	0.1%	9.4%	9.4%	0.0%	255,283	65,917	189,366	287.3%	20.39	5.27	15.12	286.9%
ANDROSCOGGIN	11,703	11,053	650	5.9%	8.8%	8.3%	0.5%	60,458	50,122	10,336	20.6%	5.17	4.53	0.64	14.1%
AROOSTOOK	8,395	8,246	149	1.8%	6.3%	6.2%	0.1%	45,932	41,111	4,821	11.7%	5.47	4.99	0.48	9.6%
HANCOCK	5,657	5,749	-92	-1.6%	4.2%	4.3%	-0.1%	26,197	25,582	615	2.4%	4.63	4.45	0.18	4.0%
OXFORD	5,418	5,430	-12	-0.2%	4.1%	4.1%	0.0%	24,533	25,790	-1,257	-4.9%	4.53	4.75	-0.22	-4.6%
SOMERSET	5,323	5,356	-33	-0.6%	4.0%	4.0%	0.0%	27,875	24,845	3,030	12.2%	5.24	4.64	0.60	12.9%
KNOX	4,358	4,265	93	2.2%	3.3%	3.2%	0.1%	24,244	21,560	2,684	12.5%	5.56	5.06	0.50	9.9%
LINCOLN	3,935	3,729	206	5.5%	2.9%	2.8%	0.1%	20,570	17,922	2,648	14.8%	5.23	4.81	0.42	8.7%
WASHINGTON	3,769	3,898	-129	-3.3%	2.8%	2.9%	-0.1%	18,705	18,826	-121	-0.6%	4.96	4.83	0.13	2.7%
WALDO	3,767	3,772	-5	-0.1%	2.8%	2.8%	0.0%	18,354	18,680	-326	-1.8%	4.87	4.95	-0.08	-1.6%
SAGADAHOC	3,610	3,402	208	6.1%	2.7%	2.6%	0.1%	31,060	16,066	14,994	93.3%	8.60	4.72	3.88	82.2%
FRANKLIN	3,012	2,724	288	10.6%	2.3%	2.0%	0.2%	13,542	12,126	1,416	11.7%	4.50	4.45	0.05	1.1%
OTHER - USA	2,729	2,250	479	21.3%	2.0%	1.7%	0.4%	15,784	10,738	5,046	47.0%	5.78	4.77	1.01	21.2%
PISCATAQUIS	1,988	2,100	-112	-5.3%	1.5%	1.6%	-0.1%	9,517	9,937	-420	-4.2%	4.79	4.73	0.06	1.3%
NEW HAMPSHIRE	1,376	1,395	-19	-1.4%	1.0%	1.0%	0.0%	8,127	8,589	-462	-5.4%	5.91	6.16	-0.25	-4.1%
OTHER - WORLD	152	83	69	83.1%	0.1%	0.1%	0.1%	1,105	286	819	286.4%	7.27	3.45	3.82	110.7%
	133,615	133,087	528	0.4%				940,438	652,750	287,688	44.1%	7.04	4.90	2.13	43.5%

MRSA: Maine Hospital MRSA HO LabID Rates per 1,000 Patient Days for July 2014 through June 2015, by hospital peer groups.



C. difficile: The *C.difficile* Hospital onset (HO) LabID event rate per 10,000 patient days for July 2014 through June 2015, by hospital peer groups.



Cases are categorized as "hospital onset" if first identified in a sample taken on or after the 4th day after hospital admission.

The reader should note that MRSA and *C. difficile* rates are traditionally measured on different scales. MRSA infections are measured in cases per 1,000 patient days, while *C. difficile* is measured in cases per 10,000 patient days.

Appendix C: Outcomes and process measures

1. Summary of Maine Hospital Outcomes Measures, July 2014 to June 2015

The following table displays hospital infection or LabID event rates for four outcomes measures presented in Appendix B. For all four measures, lower rates are better. Hospitals with zero infections are highlighted in blue.

Peer Group	Hospital	Number of infections per: 1,000 central line days		Number of HO Lab ID events per: 1,000 patient days	10,000 patient days
		HAI-1 CLABSI (ICU)	HAI-2 Neonatal ICU	MRSA	*C. difficile*
A	CMMC	1.1	0.0	0.34	6.3
	EMMC	0.9	2.6	0.34	3.9
	MGMC	0.9	n/a	0.42	3.9
	MMC	1.5	2.8	0.37	3.9
B	Aroostook	0.0	n/a	0.10	3.2
	Mercy	1.6	n/a	0.55	4.1
	Mid Coast	0.0	n/a	0.18	3.4
	Pen Bay	n/a	n/a	0.19	3.0
	SMHC Biddeford	0.0	n/a	0.25	6.2
	St. Joseph	0.0	n/a	0.42	6.3
	St. Mary's	1.2†	n/a	0.34	2.5
	York	0.0	n/a	0.13	4.1
C	Cary	0.0	n/a	0.24	5.1
	Franklin	0.0	n/a	0.25	2.5
	Maine Coast	0.0	n/a	0.24	1.6†
	SMHC Sanford	0.0	n/a	0.31	3.1
D	Inland	0.0	n/a	0.47	0.0
	NMMC	0.0	n/a	0.00	6.6
	Parkview	0.0	n/a	0.28	5.7
E	Blue Hill	n/a	n/a	0.00	0.0
	Bridgton	0.0	n/a	0.38	4.3†
	CA Dean	0.0	n/a	0.00	0.0
	Calais	n/a	n/a	0.00	8.9
	Down East	0.0	n/a	0.24	2.6†
	Houlton	0.0	n/a	0.00	7.6
	Lincoln	0.0	n/a	0.00	1.4†
	Mayo	n/a	n/a	0.00	0.0
	Millinocket	0.0	n/a	0.00	0.0
	Mt. Desert Is.	0.0	n/a	0.00	2.4†
	Pen Valley	0.0	n/a	0.00	0.0
	Red-Fairview	0.0	n/a	0.34	3.7
	Rumford	0.0	n/a	0.00	3.7
	Sebasticook	0.0	n/a	0.23	2.4†
	Stephens	0.0	n/a	0.22	4.7
	Waldo	0.0	n/a	0.60	7.8
Statewide weighted average		1.0	2.7	0.31	4.0

† While this infection rate may seem high, it's due to only a single reported infection in 12 months.
n/a = hospital did not have any patients to whom the measure applied

2. Summary of Maine Hospital Compliance Rates for Process Measures, July 2014 to June 2015

The following table displays hospital documented compliance rates for three Healthcare Acquired Infection (HAI) process measures and six Surgical Care Improvement Project (SCIP) measures seen in APPENDIX B. For all seven measures, higher scores are better. All performance rates at 95%-or-better are highlighted in blue.

Peer Group	Hospital	HAI-3*	HAI-4	HAI-5
A	CMMC	100%	98%	100%
	EMMC	100%†	100%	100%
	MGMC	100%	90%†	100%
	MMC	80%	90%	87%
B	Aroostook	100%	100%	100%
	Mercy	100%	93%	100%
	Mid Coast	100%	n/a	100%
	Pen Bay	85%	100%	45%
	SMHC Biddeford	95%	100%	98%†
	St. Joseph	100%	n/a	100%
	St. Mary's	100%	n/a	100%
	York	100%	100%	96%
C	Cary	100%	100%	100%
	Franklin	95%†	100%	100%
	Maine Coast	100%	100%	100%
	SMHC Sanford	78%	100%	82%
D	Inland	94%†	100%	100%
	NMMC	100%	100%	100%
	Parkview	100%	n/a	100%
	Blue Hill	100%	n/a	n/a
	Bridgton	100%	n/a	n/a
	CA Dean	n/a	n/a	n/a
	Calais	100%	100%	n/a
	Down East	75%†	100%	n/a
	Houlton	100%	100%	0%
	Lincoln	100%	100%	100%
	Mayo	n/a	n/a	n/a
	Millinocket	100%	100%	100%
	Mt. Desert Is.	100%	100%	100%
	Pen Valley	100%	100%	n/a
	Red-Fairview	100%	100%	93%†
	Rumford	n/a	n/a	n/a
	Sebasticook	100%	100%	100%
	Stephens	91%†	n/a	100%
	Waldo	100%	100%	100%
Statewide weighted average		93.7%	98.8%	96.1%

† This hospital missed a perfect score due to only a single lapse in 12 months.

** See brief descriptions of each measure on the next page*

n/a = hospital did not have any patients to whom the measure applied

List of the Maine Chapter 270 quality indicators included in Appendix C: Outcomes and Process Measures

Summary of Maine Hospital Outcomes Measures

HAI-1	Central line catheter-associated blood stream infection rate for intensive care unit patients, per 1,000 central line days
HAI-2	Number of catheter-related blood stream infections among neonatal intensive care unit patients per 1,000 central line catheter or umbilical days
MRSA	Number of hospital onset associated Methicillin-resistant Staphylococcus aureus LabID events per 1,000 inpatient days
C. difficile	Number of hospital onset associated *Clostridium difficile* LabID events per 10,000 inpatient days

Summary of Maine Hospital Process Measures

HAI-3	Percent documented compliance with all five evidence-based interventions for patients with intravascular central catheters (central line bundle compliance) in intensive care units
HAI-4	Percent documented compliance with the four insertion-related, evidence-based interventions for patients with intravascular central catheters (central line bundle compliance) placed preoperatively, in pre-operative areas, operating rooms, and recovery areas
HAI-5	Percent documented compliance with all five evidence-based interventions for patients with mechanical ventilation (ventilator bundle compliance) in intensive care units

Lessons from Medicaid: Evaluation of an Opioid Prior Authorization Policy in Maine

Kun Zhang, Ph.D., Health Scientist
National Center for Injury Prevention and Control, CDC

Study Objectives

- What are the impacts of the PA policies on opioid use among MaineCare patients?
- What are the impacts of the PA policies on MaineCare patients' health outcomes?

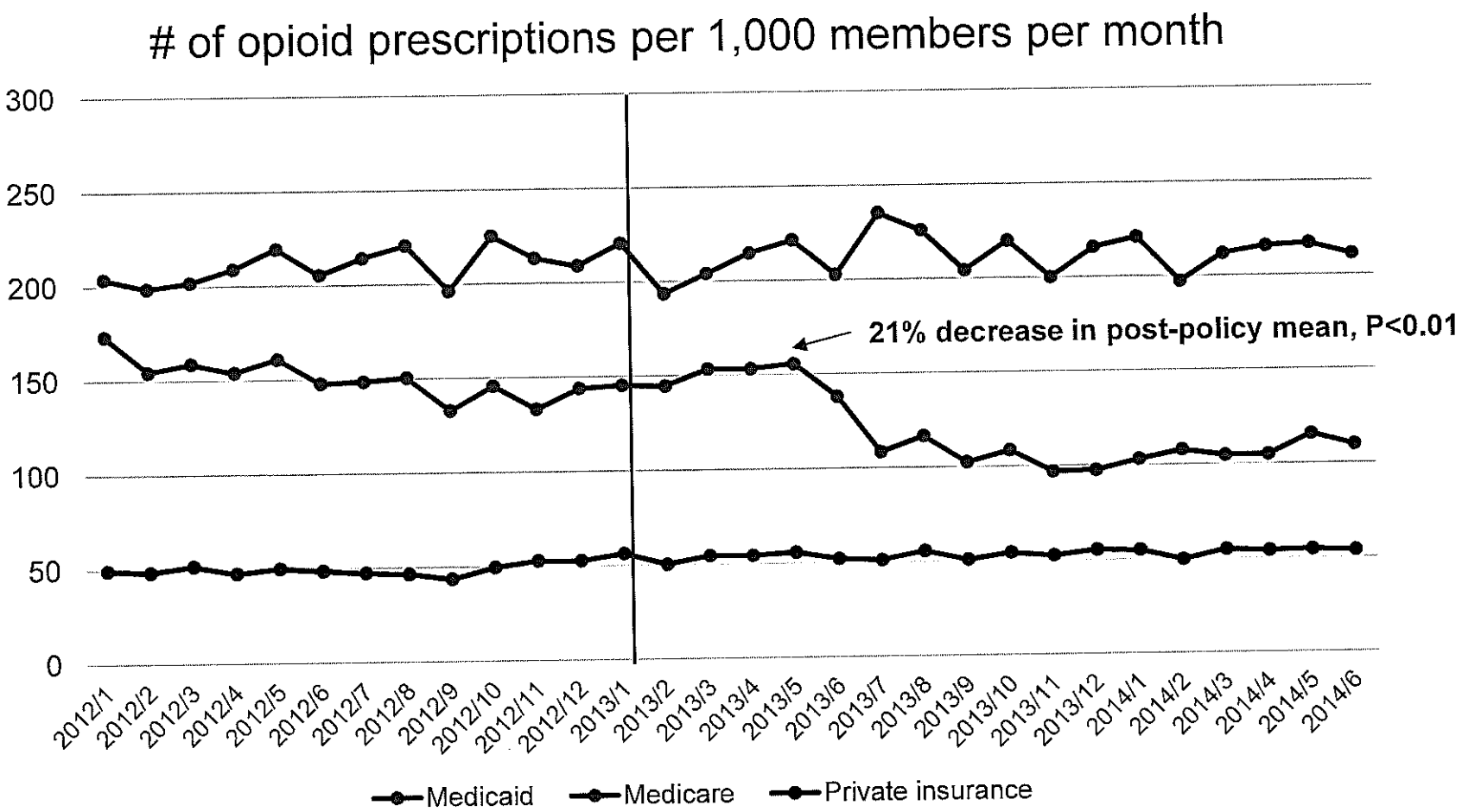
Study Methods

- **Data**
  - **All Payer Claims data from Maine Health Data Organization (MHDO), 2012 – 2014 Q2**
    - Medicaid, Medicare, privately-insured
    - Close to 97.5% of all insured population in Maine
    - Outpatient pharmaceutical claims, outpatient medical claims, inpatient claims, eligibility files (denominator file)
  - **Four pre-policy quarters, six post-policy quarters**

Study Results: summary statistics of patients with at least one opioid prescription, 2012-2014

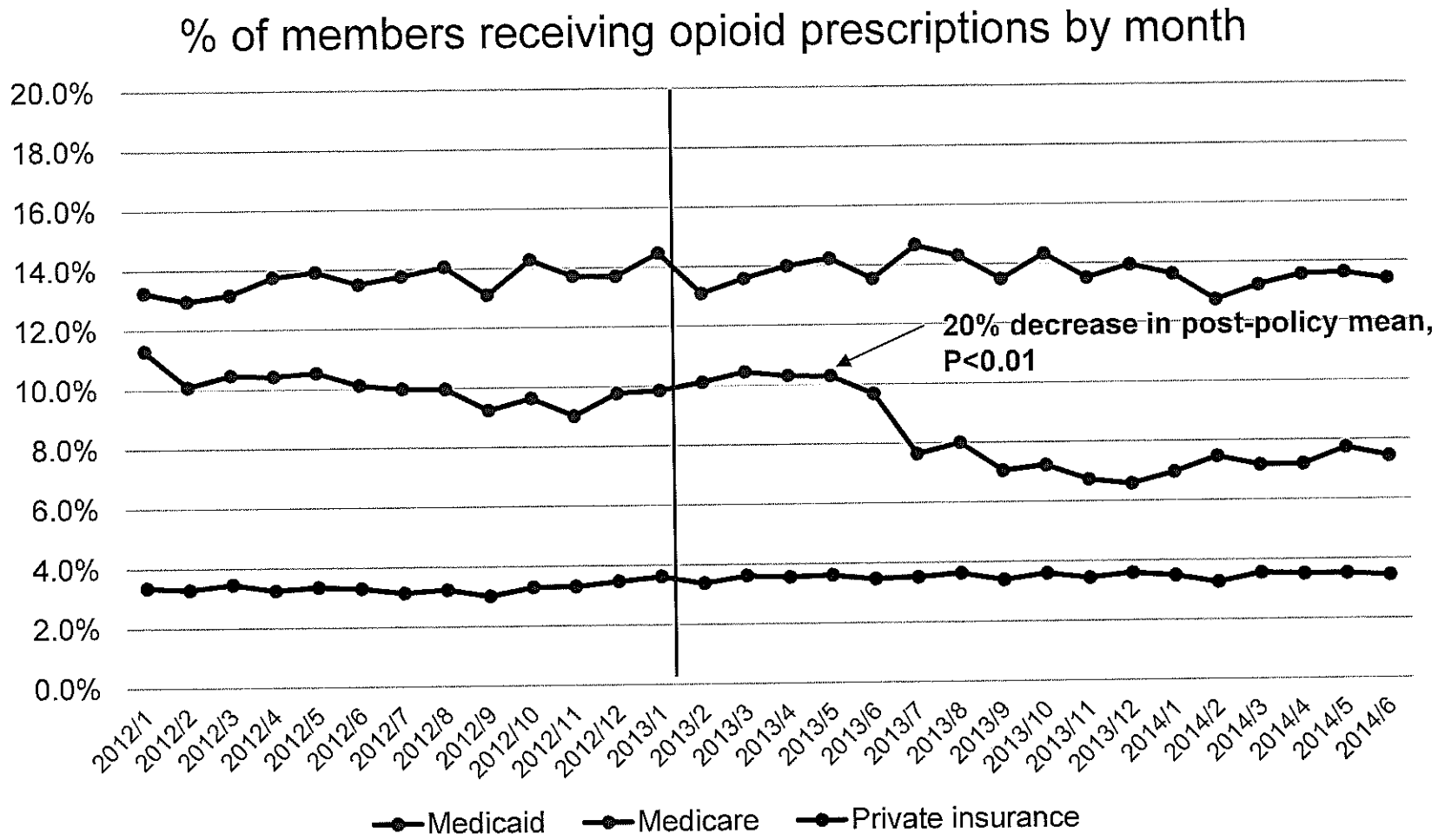
	Medicaid	Medicare	Privately insured
	N=113,358	N=110,035	N=187,466
Female (%)	61.7%	58.3%	54.5%
Age (mean)	44	68	47
Opioid fills per patient (mean, SD)	9 (14.4)	10 (16.4)	4.5 (9.6)
Total prescribed days per patient (mean, SD)	155 (327)	202 (396)	71 (233)

Study Results: opioid prescribing rate



NATIONAL Rx Drug Abuse & Heroin SUMMIT

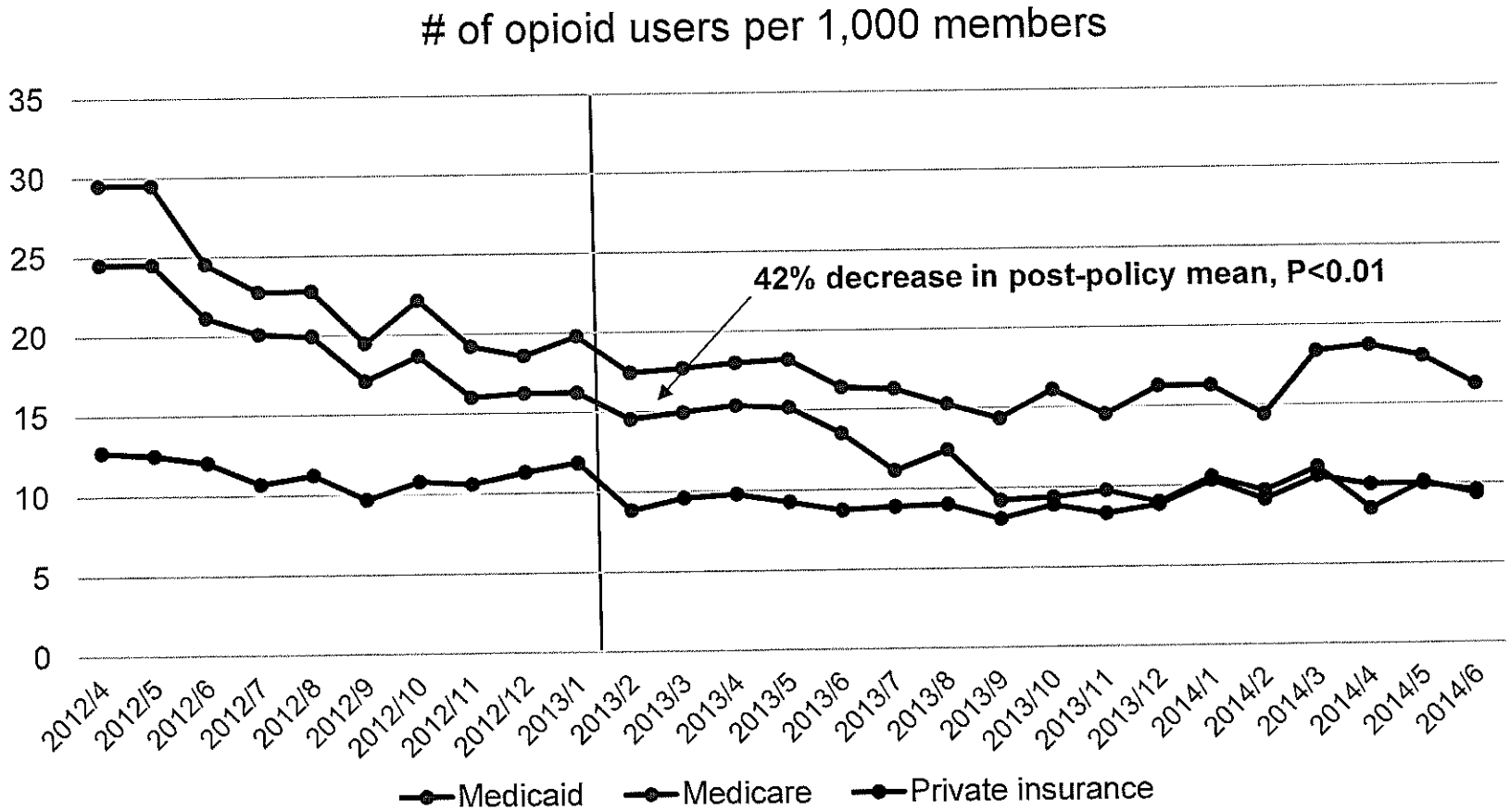
Study Results: prevalence of opioid use



NATIONAL Rx Drug Abuse & Heroin SUMMIT

Study Results: prevalence of opioid use for acute pain

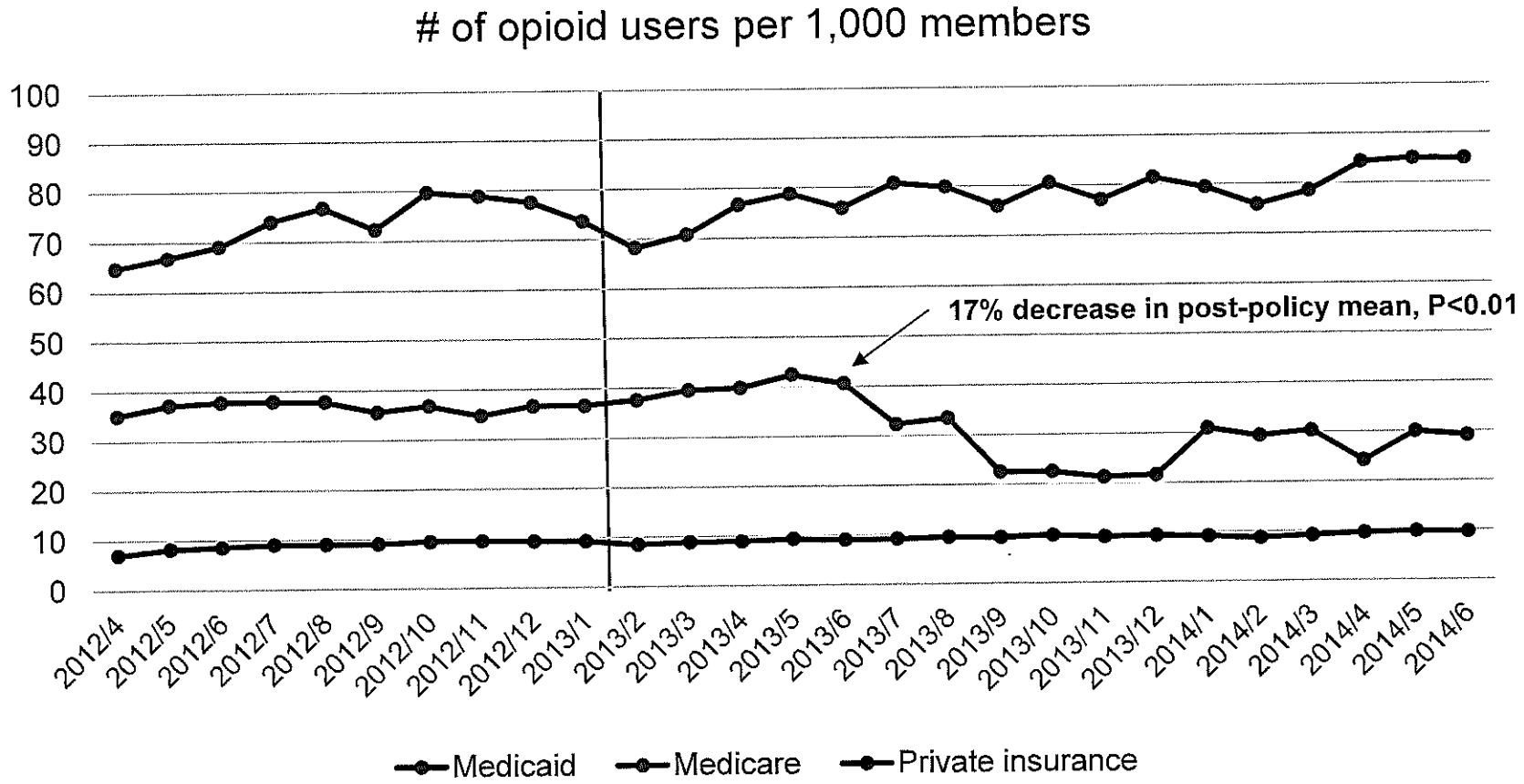
Definition: people without any opioid prescription in the prior three months, and the days supply of first prescription is equal or less than 15 days



NATIONAL Rx Drug Abuse & Heroin SUMMIT

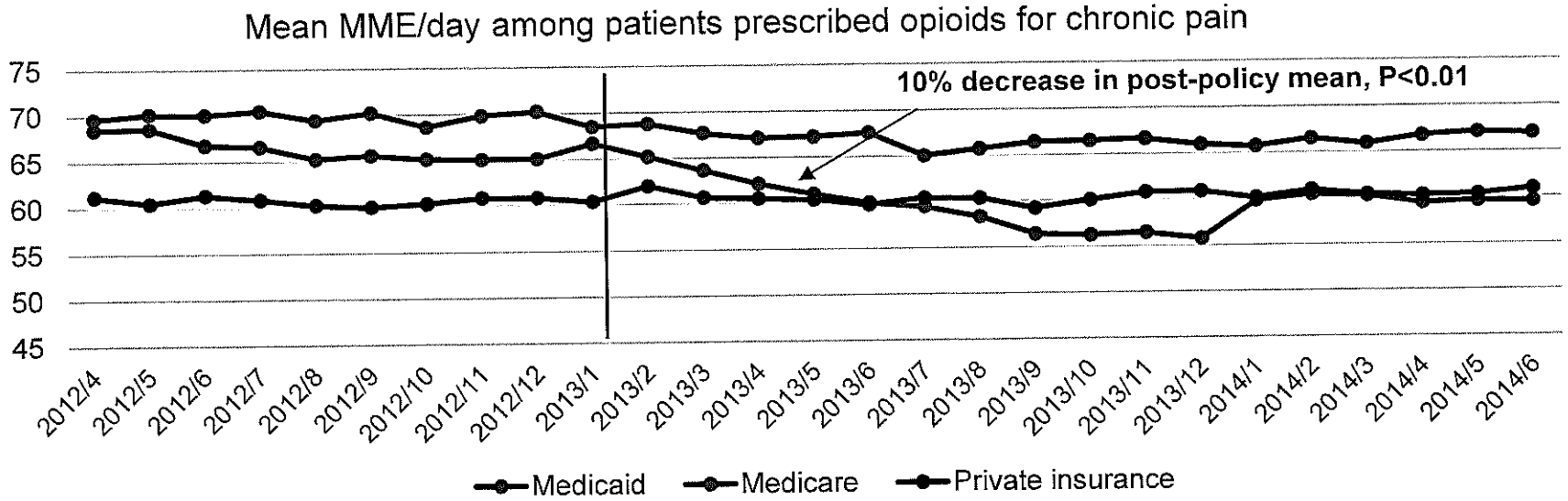
Study Results: prevalence of opioid use for chronic pain

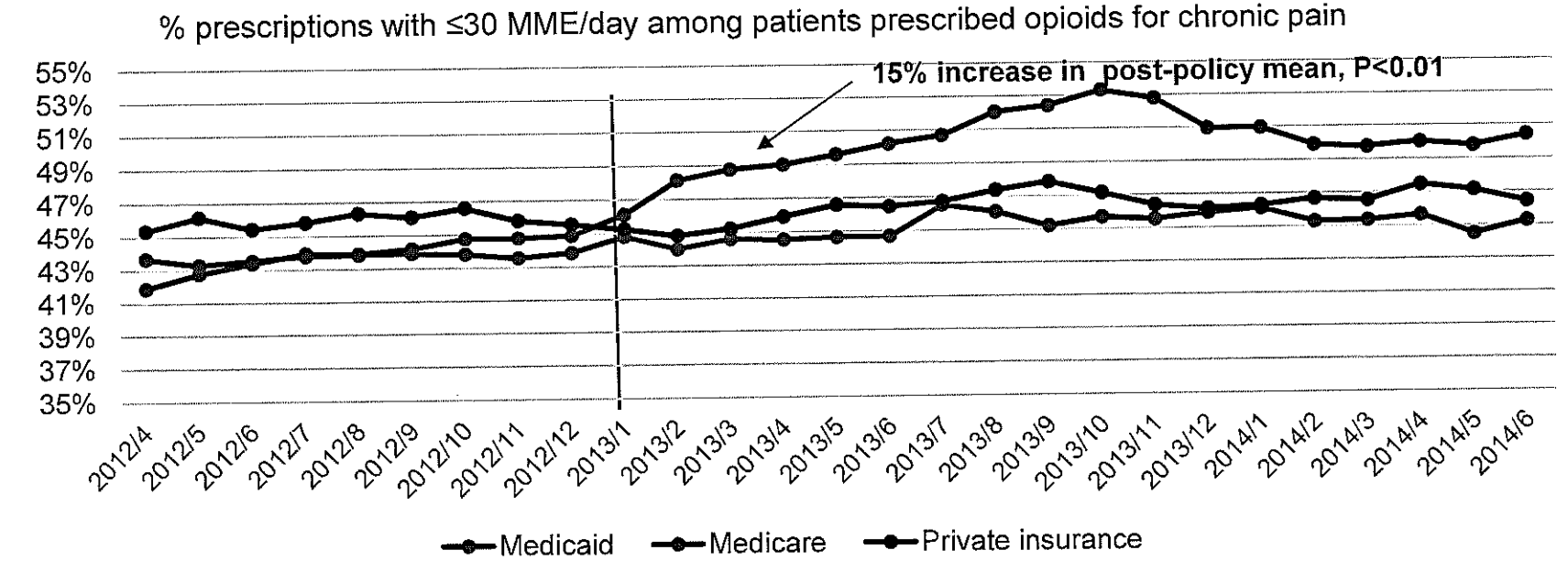
Definition: people with at least three opioid prescriptions in the past 90 days and with at least 60 days supply



NATIONAL Rx Drug Abuse & Heroin SUMMIT

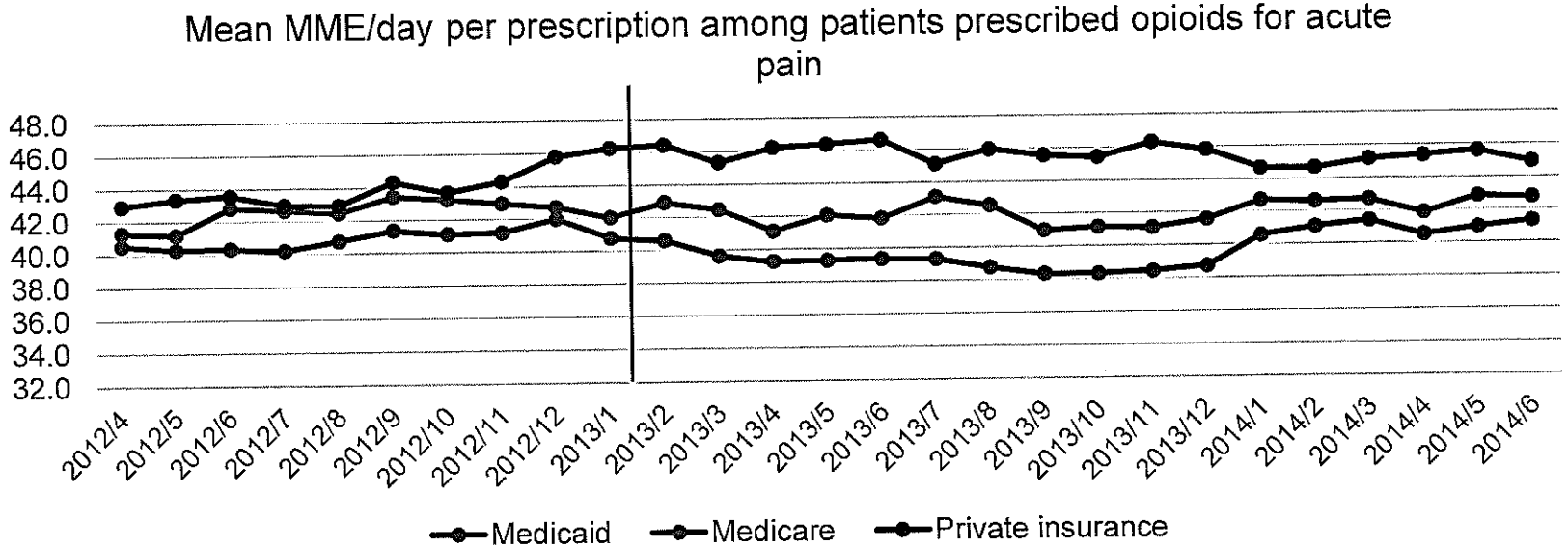
Study Results: daily dose of opioid prescriptions

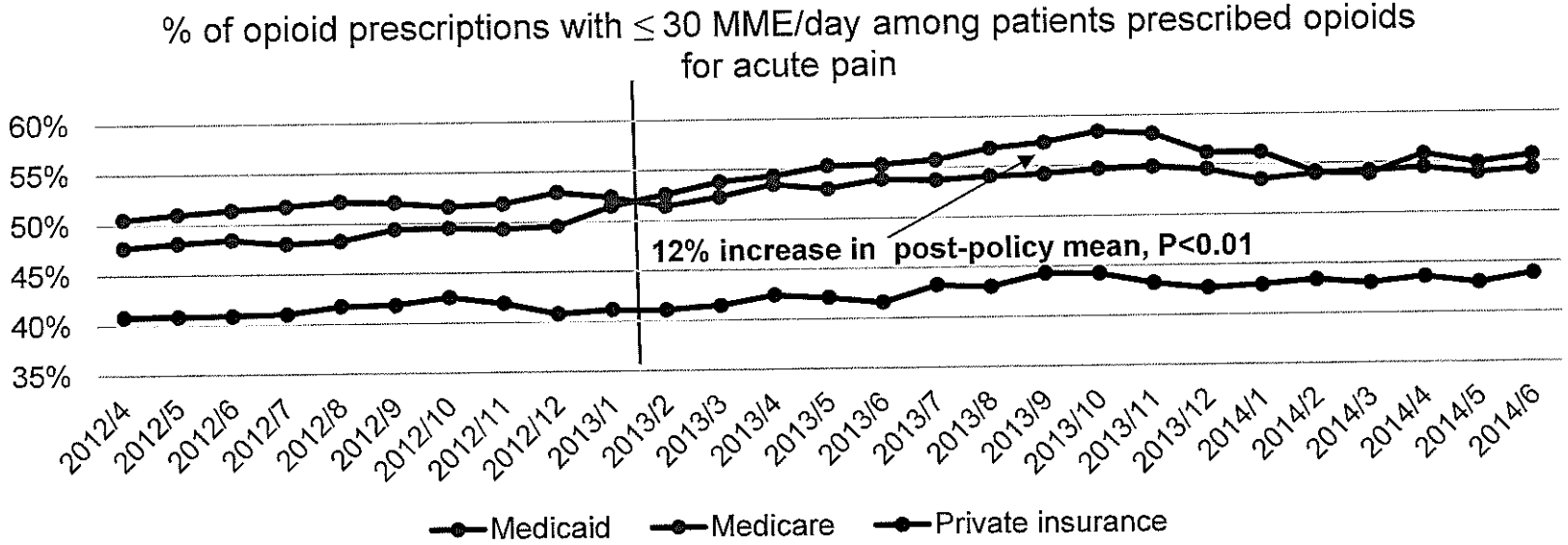




NATIONAL Rx Drug Abuse & Heroin SUMMIT

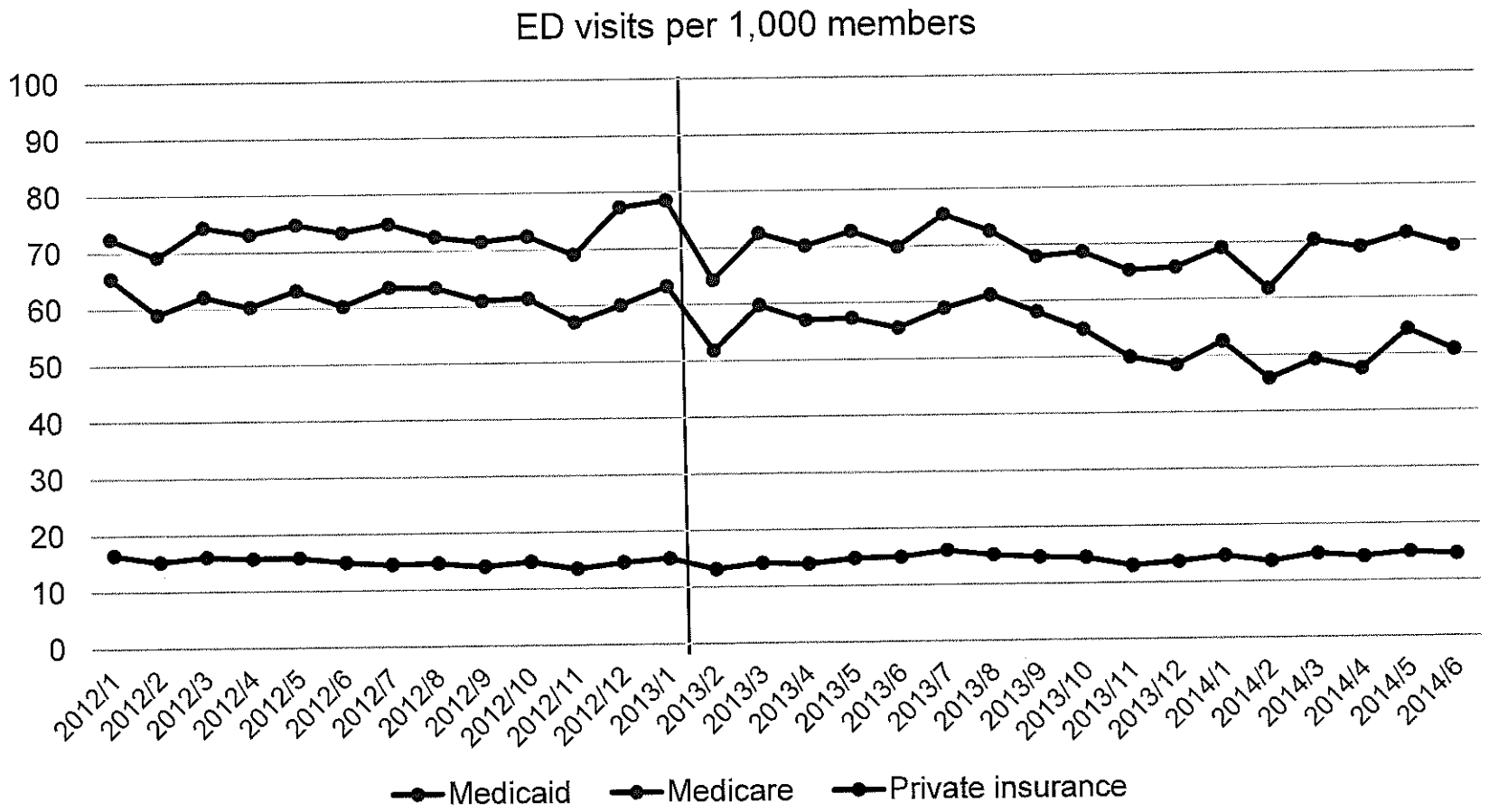
Study Results: daily dose of opioid prescriptions





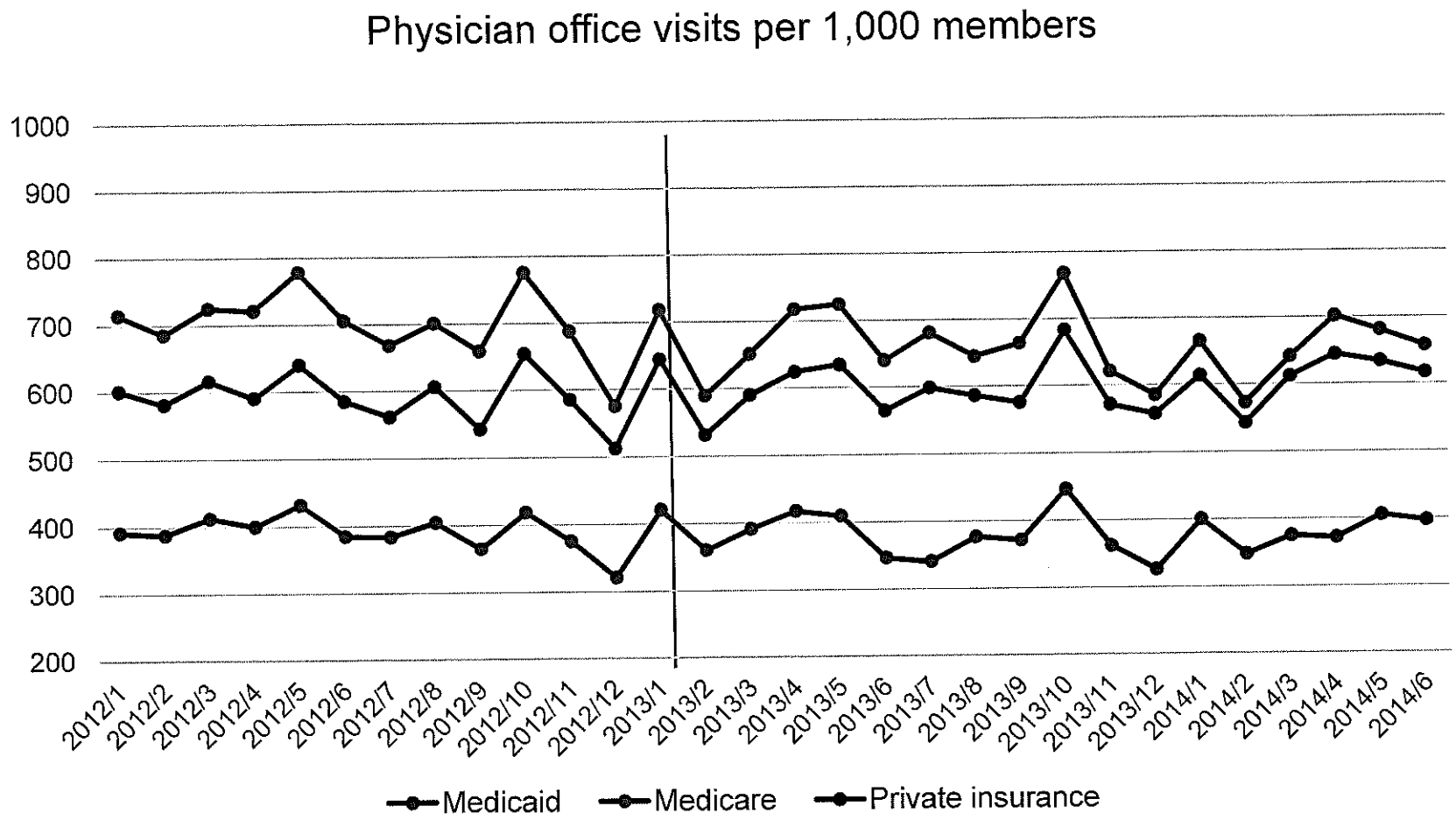
NATIONAL Rx Drug Abuse & Heroin SUMMIT

Study Results: health care utilization (ED)



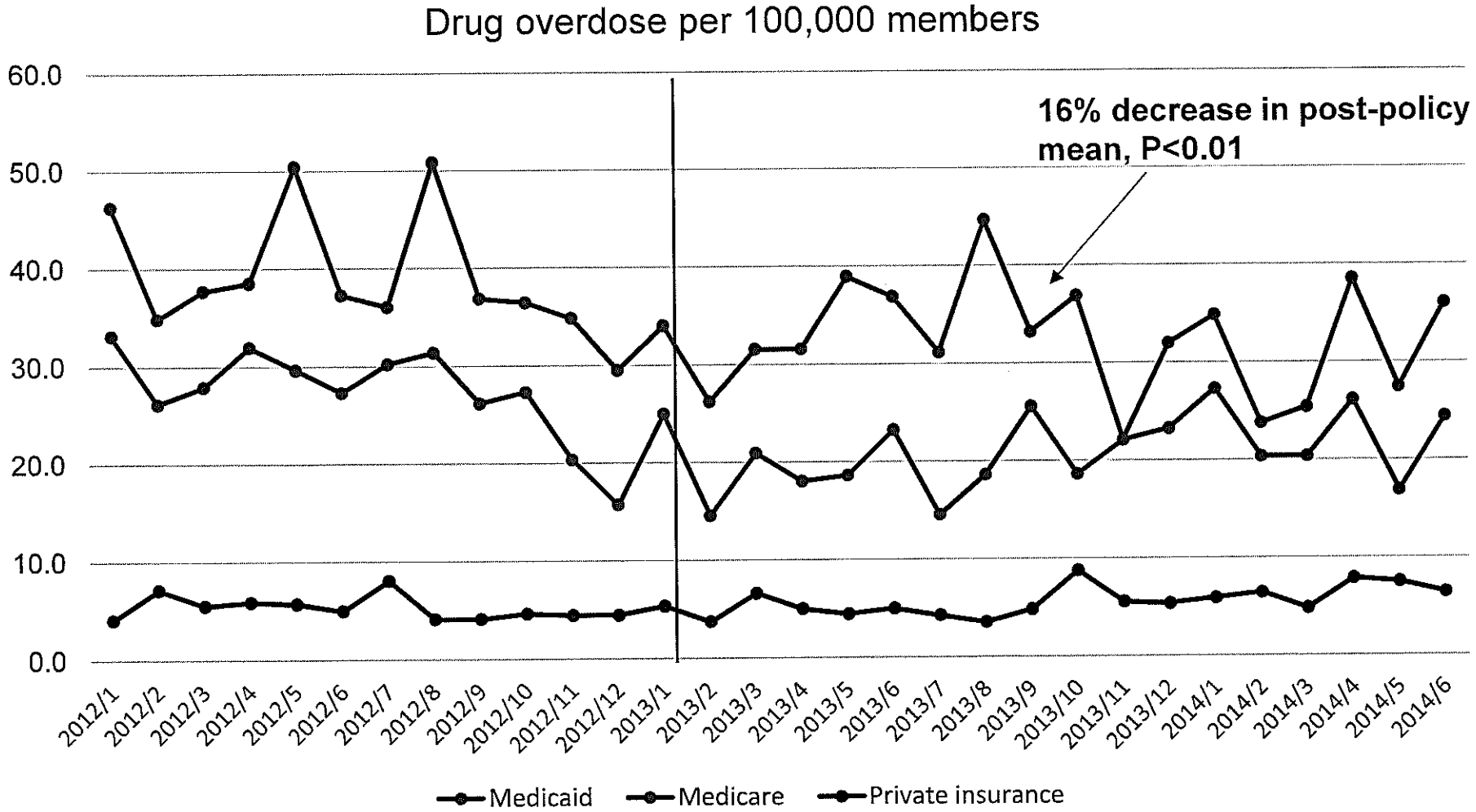
NATIONAL Rx Drug Abuse & Heroin SUMMIT

Study Results: health care utilization (office)



NATIONAL Rx Drug Abuse & Heroin SUMMIT

Preliminary Results: drug overdose rate



NATIONAL Rx Drug Abuse & Heroin SUMMIT

The Healthcare Cost and Utilization Project Fact Sheet

What is the Healthcare Cost and Utilization Project (HCUP)?

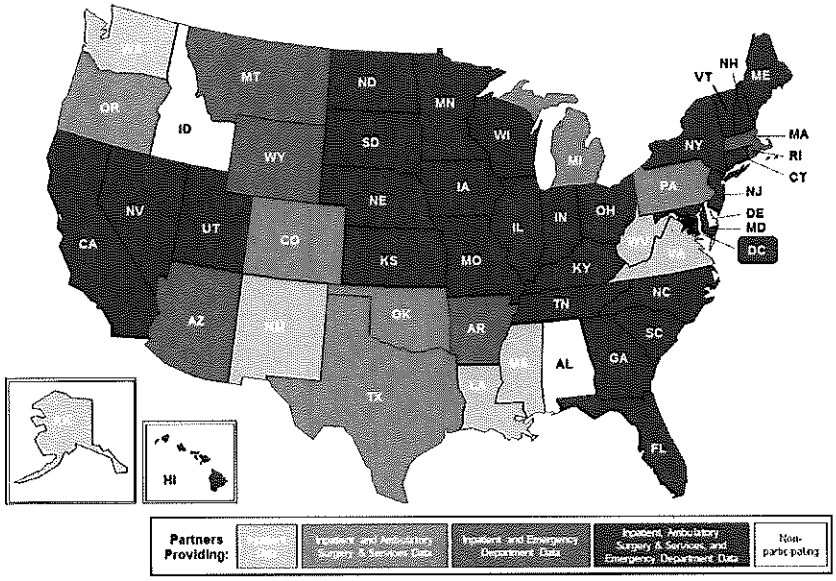
HCUP is a family of health care databases, software tools, supplemental files, reports, and other related products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). The project builds on the data collection efforts of State data organizations, hospital associations, and private data organizations (known as "HCUP Partners"). Without HCUP Partners' voluntary data contributions, this national resource for health services research and policy would not be possible.

Why is HCUP important?

HCUP includes the largest collection of all-payer, encounter-level hospital care data in the United States. HCUP provides reliable, comprehensive information that can be used to answer questions about health care use, access, outcomes, and costs related to hospital inpatient stays, ambulatory surgery and services, emergency department visits, and readmissions. HCUP databases, software tools, and reports enable research on a broad range of current health care issues and trends that are useful to policymakers, researchers, administrators, and consumers.

How are the HCUP databases developed?

HCUP Partners



- AHRQ transforms administrative health care data acquired from HCUP Partners into research-ready, uniform databases with a common set of data elements.
- Currently, 48 Partners (47 States and the District of Columbia) provide HCUP with statewide inpatient data, 35 Partners provide ambulatory surgery and services data, and 35 Partners provide emergency department data. The inpatient data represent 97 percent of inpatient discharges from community hospitals.

What databases are available from HCUP?

- **The National (Nationwide) Inpatient Sample (NIS)** is the largest publicly available all-payer inpatient database in the United States, yielding national estimates of hospital inpatient stays. The NIS approximates 20 percent of the discharges from all U.S. community hospitals and contains data from more than seven million hospital stays each year. Researchers and policymakers use the NIS to identify, track, and analyze national trends in health care utilization, access, charges, quality, and outcomes. The NIS is released yearly.
- **The Kids' Inpatient Database (KID)** is the largest publicly available, all-payer pediatric database in the United States, and was designed to facilitate study of hospital services, outcomes and charges for children and adolescents. It contains a sample of two to three million hospital pediatric discharges per year. The KID database is available every three years from 1997-2012.
- **The Nationwide Emergency Department Sample (NEDS)** is a unique and powerful database that yields national estimates of emergency department (ED) visits. The NEDS database was designed to permit enables researchers to study a broad range of conditions and procedures related to ED use. It includes approximately 30 million records each year for patients who were either treated in the ED and released or treated in the ED and admitted to the same hospital. The NEDS is released yearly.

- **The Nationwide Readmissions Database (NRD)** supports analyses of repeat hospital visits in a year, addressing the need for nationally representative information on hospital readmissions for all ages and payers, including the uninsured. The NRD is released yearly.
- **The State Inpatient Databases (SID)** contain a powerful collection of hospital inpatient discharge information. The SID can be used to investigate questions that are unique to one State or to compare data from two or more States.
- **The State Ambulatory Surgery and Services Databases (SASD)** include encounter-level data for ambulatory surgery and other outpatient services from hospital-owned facilities. In addition, some States provide data for ambulatory surgery and outpatient services from nonhospital-owned facilities.
- **The State Emergency Department Databases (SEDD)** contain discharge information on all ED visits that do not result in a hospital admission.

Additional information about these databases is available at www.hcup-us.ahrq.gov/databases.jsp.

How do researchers obtain HCUP databases?

Restricted-Access Public Release Databases with nationwide data and State data may be purchased through the HCUP Central Distributor at www.hcup-us.ahrq.gov/tech_assist/centdist.jsp. Starting March 1, 2016, the nationwide databases are delivered via secure digital download. The State-specific databases include data elements approved by each participating State while excluding data that might directly or indirectly identify a person. All purchasers and users of HCUP data must complete a brief online Data Use Agreement (DUA) training course and sign a DUA.

What software tools and supplemental files are available from HCUP?

- **Software Tools and Supplemental Files** are developed and maintained by AHRQ to enhance the value of the HCUP databases. HCUP tools also can be used with HCUP data as well as with other non-HCUP administrative databases. HCUP tools include Clinical Classifications Software (CCS), the Chronic Condition Indicator (CCI), Elixhauser Comorbidity Software, Procedure Classes, Surgery Flags, and Utilization Flags. All tools are free of charge and available for download from the HCUP-US Web site. HCUP also offers several supplemental files that are designed for use with and add value to HCUP databases, including the Revisit Analysis Variables, Cost-to-Charge Ratio Files (CCR Files), Hospital Market Structure Files (HMS Files), American Hospital Association (AHA) Linkage Files, NIS Hospital Ownership Files, and NIS and KID Trend Weight Files. Additional information is available at www.hcup-us.ahrq.gov/tools_software.jsp.
- **HCUPnet** is a free, online query system that uses HCUP data to provide quick access to statistical information about hospital inpatient and ED utilization. HCUPnet delivers statistics at the national and regional levels and, for States that have agreed to participate, at the State and community levels. Users can generate tables and graphs with HCUPnet's easy-to-use, step-by-step query system. This interactive tool can be accessed at www.hcupnet.ahrq.gov/.
- **AHRQ Quality Indicators (QIs)** are measures of health care quality associated with processes of care that occur in the inpatient setting. The AHRQ QIs consist of four modules measuring various aspects of quality: Prevention Quality Indicators (PQIs), Inpatient Quality Indicators (IQIs), Patient Safety Indicators (PSIs), and Pediatric Quality Indicators (PDIs). The QIs are analyzed with free software available from AHRQ that is designed to be used with HCUP and other administrative data. Additional information is available at www.qualityindicators.ahrq.gov/.
- **HCUP Fast Stats** provides easy access to the latest HCUP-based statistics on health information topics. HCUP Fast Stats uses visual statistical displays in stand-alone graphs, trend figures, or simple tables to convey complex information at a glance. Information is updated quarterly or annually, as newer data become available. Additional information is available at www.hcup-us.ahrq.gov/faststats/landing.jsp.

What reports does HCUP produce?

- **HCUP Statistical Briefs** – short, focused reports with descriptive statistics on hospital use and cost topics
- **HCUP Infographics** – visual representation of Statistical Brief data
- **HCUP Projection Reports** – national and regional health care projections created using HCUP longitudinal data
- **HCUP Methods Series Reports** – helpful reports addressing methodological issues for users of HCUP databases, tools, and supplemental files

Additional information is available at www.hcup-us.ahrq.gov/reports.jsp.

What support services are offered to HCUP users?

Technical Support is available to facilitate use of HCUP. The user-friendly HCUP User Support (HCUP-US) Web site, www.hcup-us.ahrq.gov, contains extensive documentation about the project. Online FAQs answer many user questions. Self-directed HCUP online tutorials teach a range of HCUP use topics. HCUP presentations at professional conferences and HCUP training workshops educate users. User questions are responded to by experienced technical support staff by telephone at 866-290-HCUP and email at hcup@ahrq.gov. More information is available at www.hcup-us.ahrq.gov/techassist.jsp and www.hcup-us.ahrq.gov/news/events.jsp.

HCUP Fast Stats - Opioid-Related Hospital Use

HCUP Fast Stats provides easy access to the latest HCUP-based statistics for health information topics. This section provides trends in opioid-related inpatient stays and emergency department visits at the national and State levels.

Opioid-Related Hospital Use

Initial Selection:

National Level or State: Maine* * ED data available

Characteristic: All stays or visits

Hospital Setting: (•) Inpatient Stays ( ) ED Visits

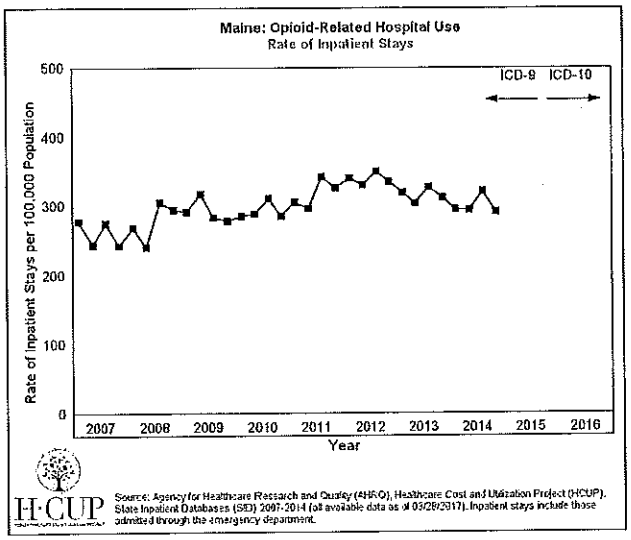
Compare to:

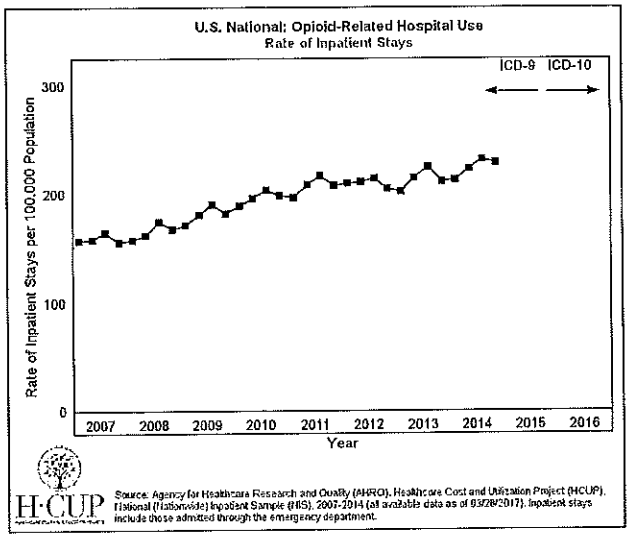
National Level or State: National * * ED data available

Characteristic: All stays or visits

Hospital Setting: (•) Inpatient Stays ( ) ED Visits

Refresh





⊕ Show Underlying Data Tables
⊕ Show Definitions
⊖ Hide Data Export Options

Use this export feature to download all of the underlying data for opioid-related hospital use in Microsoft Excel (.xls) format.

1. Click this Excel Export link to request the download.
2. Follow the prompts to save a copy of the Excel file to your computer. Prompting will vary by browser.
3. If you decide to use these data for publishing purposes please refer to Requirements for Publishing with HCUP Data.

- HCUP Fast Stats FAQs

Internet Citation: HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). April 2017. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/faststats/opioid/opioiduse.jsp?location1=ME&characteristic1=01&setting1=IP&location2=US&characteristic2=01&setting2=IP&expansionInfoState=hide&dataTablesState=hide&definitionsState=hide&exportState=hide.

Are you having problems viewing or printing pages on this Website?

If you have comments, suggestions, and/or questions, please contact hcup@ahrq.gov.

Privacy Notice, Viewers & Players

Last modified 4/24/2017

MHDO Data Request **#811165** - Maine Bureau of Insurance
Instance Number 2017041401
Opioid Rx Summary Ad Hoc

Table 1 Opioid Prescription Summary

	Unduplicated Count of Pharmacy Members with Rx Claims	Unduplicated Count of Pharmacy of Members w/ Opioid Rx	Unduplicated Count of Opioid Rx Claims	Unduplicated Count of Opioid Scripts	Total Plan Paid	Total Member Paid
Q1 2016	337,767	34,056	75,466	75,545	$2,811,997	$923,759
Q2 2016	302,495	29,727	64,300	64,302	$2,444,551	$644,610
Overall Q1 & 2 2016	**393,434**	**51,253**	**139,754**	**139,835**	**$5,256,548**	**$1,568,369**
Q1 2017						
Q2 2017						
Overall Q1 & 2 2017						
Overall Total						

MHDO Data Request **#811165** - Maine Bureau of Insurance
Instance Number 2017041401
Opioid Rx Summary Ad Hoc

Purpose of Report	To allow client to examine trends in opioid prescription activity over time.
Data Source	APCD Rx Commercial Data
Date Range	Prescriptions filled in Q1 & Q2 of 2016
Data Release Depencency	2016 Q4 Commercial Data Release
Methodology	Analysis is to use the same methodology that was used for Table 1 of the report DR_811165 Opioid Data Summary_20161110.docx dated 11/10/2016, although there is no longer any need to include the MME lines.
	Table should exclude Buprenorphine, as before. No other exclusions should be made.
	This is part of a trend analysis; the same payers should be included in both 2016 and the future 2017 instance of this report. This may require removing payers from 2016 report if it is known they will not be in 2017 report. It is also possible that the 2016 report may need to be revised when the 2017 report is prepared if there are unanticipated
	2016 list, which removed codes from 2015 list. What is the preferred list to be used for this analysis? We also assume another update will be made by the time 2017 data are available. 5/5/17-Jonanne (with the BOI) confirmed that they want us to use the 2016 list for both the Q1-Q2 2016 and Q1-Q2 2017 data pull.
Deliverable Format	Excel document with table, support table showing the names of all included payers and analytic notes
Estimate of Delivery to MHDO	**TBD**
Part of Ongoing Series	Yes; report will be produced annually with the next round including prescriptions filled in Q1 & Q2 of 2017.
Supporting Documents	Opioid Data Summary_20161110.docx

Impact of Gobeille

Summary of Ruling

Pre and Post Gobeille

Next Steps

Impact of Gobeille v. Liberty Mutual Insurance Company and Voluntary Data Submissions

The decision in 2016 by the US Supreme Court held that the Employee Retirement Income Security Act (ERISA) invalidates state APCD reporting requirements for self-funded ERISA employee health plans.

Impact of Gobeille

- Depending on the cycle, self-funded ERISA claims data represents approximately 25-35% of APCD data.
- MHDO has maintained approximately 84% of the volume of medical, pharmacy and eligibility records in 2016 (post Gobeille) vs. 2015 (post Gobeille) data.
  - Established a goal of maintaining 80% of claims data post-Gobeille.
  - Revised data submissions rule (Chapter 243) in 2017 to accommodate voluntary claims data submissions.
  - Outreach effort to promote voluntary submissions.
  - MHDO is creating a set of historical files pre-Gobeille that more closely align with the data set post-Gobeille.
  - Documented the volume variance by payer in our data release notes.

Impact of Gobeille

For the last year the MHDO has participated in two bi-weekly meetings with the other APCD States and Payers to develop a National Common Data Layout (CDL).

- The CDL is part of the Comments on Department of Labor Notice of Proposed Rulemaking-Docket # EBSA-2016-0010; RIN 1210-AB63, submitted by the National Academy for State Health Policy (NASHP), National Association of Health Data Organizations (NAHDO) and the APCD Council.
- The comments lay out a proposal that the Department of Labor study the collection of additional health care claims and related data from self-funded ERISA plans under Schedule J through pilot programs in states with APCD capacities. To address administrative burdens, the states and payers have developed a CDL that would replace the current state structures.

Gobeille –Next Steps

Recommendation:

- Continue to promote the voluntary submission of self-funded claims data;
- Continue to support a national pilot program through the DOL;
- Do not implement the CDL until there is a path forward to collecting self-funded ERISA data at the national level.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)- -Rule 42 CFR Part 2

Summary of Rule

MHDO's Strategy for uniform redaction

Anticipated Impact on MHDO claims

Next Steps

SAMHSA- Rule 42 CFR Part 2

- Department of Health and Human Services, Substance Abuse and Mental Health Services Administration -Rule 42 CFR Part 2 concerning the confidentiality of patient records that are maintained in connection with the performance of any federally assisted program or activity relating to substance abuse (now referred to as substance use disorder)
- MHDO is working on implementing a uniform approach that meets the requirements described in the rule and creates a structure where data submissions are standardized across our data submitters

Continued-Rule 42 CFR Part 2

- The Centers for Medicare & Medicaid Services (CMS) redacts any substance abuse related claim from their Medicare and Medicaid data files based on codes within the claims
- MHDO ran our claims through the CMS filter-results are as follows:

Results

Payer Type	% of SUD claims based on ResDAC ICD-9 codes 10/1/2014 - 9/30/2015 Paid Dates	% of SUD claims based on ResDAC ICD-9 & ICD-10 codes 1/1/2015 – 12/31/2015 Paid Dates	% of SUD claims based on ResDAC ICD-10 codes 1/1/2016 – 12/31/2016 Paid Dates
Commercial	1.076%	1.163%	1.252%
Medicare	0.008%	0.037%	Data not yet available
MaineCare	4.482%	4.565%	4.894%

Continued-Rule 42 CFR Part 2

- The code list from CMS may be more inclusive than needed (over 800 codes) but it provides a uniform redaction of SUD claims
- MHDO has received an updated code list from CMS. As soon as CMS posts on website (June 1) MHDO will forward to claims data submitters
- All claims data submissions going forward to include the redaction of these specific claims.
- MHDO has redacted these claims from historical claims data sets
- MHDO will now review hospital encounter data

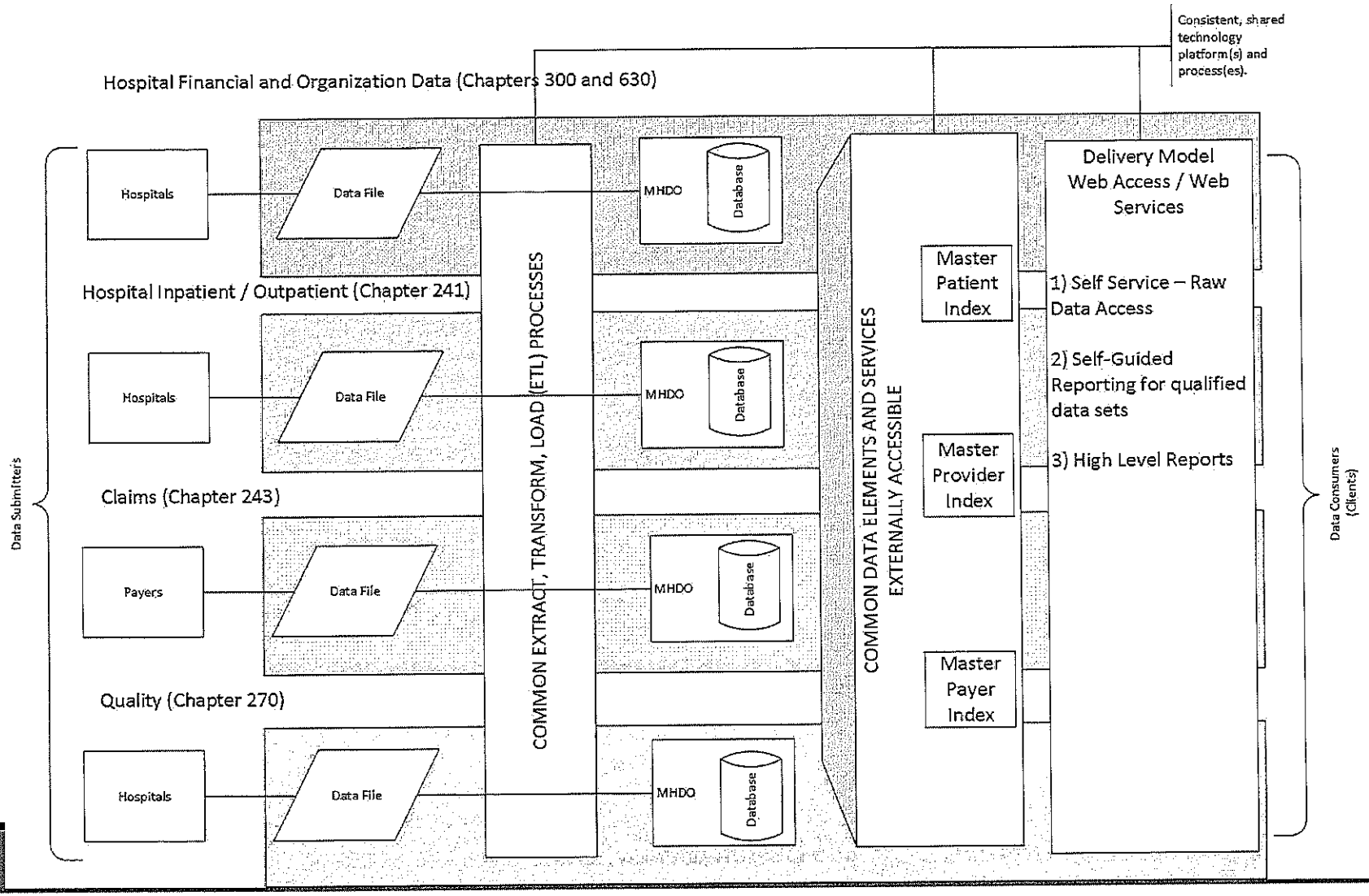
MHDO Data Delivery Model

MHDO Transformation

Framework-Data & Information Delivery and Pricing

Next Steps

MHDO Data Streams and Infrastructure – Proposed Future State



MHDO Data Delivery Model Strategy

- Access to Data & Information
- Pricing Framework

Framework-Access to Data & Information

Public Facing Information

Free information that is available on a MHDO website.

- CompareMaine
- Quality Measures/Chapter 270
- MONAHRQ
- AHRQ Toolkit
- HCUP
- 8712 Report s
- Hot Topics Dashboard Report
- External Report Library
- Quarterly Newsletter

MHDO Produced Custom Reports

MHDO creates the query and static reports.

- Reports required per legislation
- Reports requested by Stakeholders

Self-Guided Access & Reporting Services

Access to rolled-up data in Tableau or other analytic tools.

MHDO Data Users that are not equipped to work with the clean & transformed data files but do have the capacity to work with a claims based analytic tool

Secure Remote Access to MHDO Data

Access to clean & transformed data within the Enclave.

- Metadata
- Statistical and Programming Applications
- National Code Sets
- Access to data updates in real time
- Secure computing environment

Secure Access to MHDO Data

Access to clean and transformed data via secure download.

- Access to clean and transformed Data via a secure download
- Metadata

Feedback from Data Users

Access to MHDO Clean & Transformed Data

- Four MHDO Data Users (MHMC, EMH, Contractor for DHHS and MH) are interested in exploring the benefits of accessing MHDO data via the Enclave
  - Benefits to accessing MHDO data via the Enclave may include: storage, security, access to data and updates in real time; available code sets and statistical tools.
  - MHDO actively setting up four feasibility tests of the Enclave

Continued-Feedback

Additional Data Transformations Users Requested

- Calculate DRG's in the Claims Data
- Calculate APC's in the Claims Data
- Include Rx Reference Tables that Organize Rx codes into therapeutic classes
- Consolidate claims before releasing data
- Link Medical and Pharmacy Claims before releasing data
- Create pre Gobeille data files (back to 2013) that are consistent with the content of the post data

Continued-Feedback

- Collect Hospital encounter data more timely and release data quarterly vs. 6 months after end of calendar year
- Ability to link MHDO data with other data sets
- Ability to link MHDO data with lab data
- Continue to staff bi-monthly data user group and hospital and claims subcommittee meetings

MHDO Delivery Model

Pricing Framework:

- Subscription model that allows a customer to purchase a level of service in the Enclave for a specific period of time for a set price
- Maintain current pricing structure defined in Chapter 10 for accessing MHDO data as structured today with the exception of increasing our hourly rate of $80/hour to $150/hour

CompareMaine

Review Current Website Stats

Review Feedback from Legislature

Review Upcoming Releases 4.0 & 5.0 (Refer to handout)

CompareMaine Website Stats & Feedback

October 1, 2015-April 30, 2017

- 29,600 hits to CompareMaine
- 20,700 unique users

Feedback from Users & Legislators

- Add more quality measures at the procedure level

Top Ten Procedures October 1, 2015 – April 30, 2017

Vaginal Delivery

Knee Replacement

Hip Replacement

Gallbladder Removal

New patient Preventative Care Visit for Adult, Ages 18 to 39

Physical Therapy Evaluation

C-section (Cesarean Delivery)

Colonoscopy Without Biopsy for Encounter for Preventative Health Services

MRI Scan of Leg Joint

MRI Scan of Brain

Continued-CompareMaine

Release 4.0 & 5.0 (Refer to handout)

CompareMaine

June MHDO Board Retreat

Data Update Requirements

Title 22, Chapter 1683 section 8712 (2) Payments. The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors. **Beginning October 1, 2012, price information posted on the website must be posted semiannually (every six months or 2x/year), must display the date of posting and, when posted, must be current to within 12 months of the date of submission of the information.**

Update Schedule

Site Updated	Version	Cost Data Period	Quality Measures Updated[1]	Status
June 30, 2016	2.0	10/1/2014-9/30/2015	HCAHPS Patient Experience Summary Star, SIR for C. diff and MRSA	Complete
November 30, 2016	3.0	4/1/2015-3/31/2016[2]	HCAHPS Patient Experience Summary Star, Serious Complications (PSI90), SIR for C. diff and MRSA	Complete
August 31, 2017	4.0	10/1/2015-12/30/2016	HCAHPS Patient Experience Summary Star, SIR for C. diff and MRSA	In progress
November 30, 2017	5.0	4/1/2016-3/31/2017	HCAHPS Patient Experience Summary Star, PCMH / CG CAHPS Overall Provider Rating, Serious Complications (PSI90), SIR for C. diff and MRSA	Upcoming
June 29, 2018	6.0	10/1/2016-9/30/2017	HCAHPS Patient Experience Summary Star, SIR for C. diff and MRSA	Upcoming
November 30, 2018	7.0	4/1/2017-3/31/2018	HCAHPS Patient Experience Summary Star, Serious Complications (PSI90), SIR for C. diff and MRSA	Upcoming

[1] HCAHPS Patient Experience Summary Star will be updated annually in June - the data currently on CompareMaine are from 7/1/2014-6/30/2015, data are downloaded from CMS Hospital Compare, https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html#.
PCMH/CG CAHPS Overall Provider Rating will be updated every two years in November - the data currently on CompareMaine are from 2014 and 2015, data are downloaded from Patient Experience Matters http://www.mainepatientexperiencematters.org/about-the-data.php; CAHPS Database (Westat).
Serious Complications will be updated annually in November - the data currently on CompareMaine are from 7/1/2013-6/30/2015, data are downloaded from CMS Hospital Compare, https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html#.
SIRs for C. diff and MRSA will be updated every June and November - the data currently on CompareMaine are from 10/1/2014-9/30/2015, data are downloaded from CMS Hospital Compare, https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html#

[2] The data update originally scheduled for November 30, 2016 will not take place due to the impact of the *Gobeille vs. Liberty Mutual.*

CompareMaine 4.0; August 31, 2017

- Update HCAHPS Patient Experience Summary Star (7/1/15-6/30/16) and SIRs (7/1/15-6/30/16)
- Update cost data (10/1/15-12/30/16)
- Implement MAD
- Implement new facility review process
- Revise methodology for skin lesion removal procedures
- Regroup rural health facility locations together instead of separately
- Breakout professional and facility costs in current display

CompareMaine 5.0; November 30, 2017

- Update PCMH/CG CAHPS Overall Provider Rating (2016-2017), HCAHPS Patient Experience Summary Star (10/1/15-9/30/16), Serious Complications (7/1/14-6/30/16), and SIRs (10/1/15-9/30/16)
- Update cost data (4/1/2016-3/31/17)
- Detailed display for researchers
- Explore adding a feature to filter results in the data display by facility type
- Revised quality data display with new measures **at the procedure level**
- Cost data trend comparison

Details on CompareMaine 4.0 Enhancements

Implement Median Absolute Deviation (MAD) Process

The Median Absolute Deviation (MAD) Process automatically identifies outliers on CompareMaine and flags them for further investigation. The MAD is used to investigate how widely data points deviate from the median. The process will indicate how much a facility's cost estimate for a healthcare procedure deviates from the statewide median for that procedure.

The MAD will identify combinations of facilities, payers and procedures that are higher or lower than the established thresholds for deviation from the statewide median for that procedure. Given that health care costs have natural variation, this procedure will be used to identify extreme outliers that are artifacts of the APCD data. Once outliers have been identified, we will drill down internally to determine the potential cause for the result. The facility and/or payer will also be contacted if its median is above or below the statewide median by a pre-determined amount (*to be determined w/ MHDO*).

Revised Methodology for Skin Lesion Removal

In previous versions of CompareMaine, skin lesion estimates for CPT codes 17000 and 17110 were calculated using the 3M's Medical Episode Grouper, a tool that creates episodes of care by analyzing claims data to identify diagnoses. The MEG created some high cost episodes for these codes that involved some intensive services such as cancer treatments. We felt these episodes were not representative of the code and removed both procedures from the site. We are currently investigating the best way to calculate estimates for these procedures on CompareMaine.

Regroup Rural Facilities

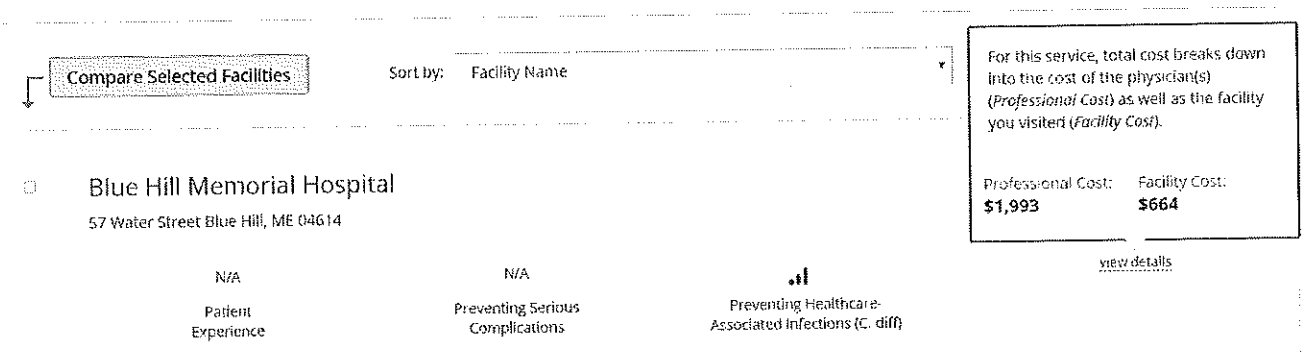
During the QC of CompareMaine 2.0, the following organizations requested that we regroup their facilities. Previously, each location of the network was displayed separately. In CompareMaine 4.0, the locations will be grouped together into their respective networks. This has following potential impacts: an increase in the number

of facilities reporting data in the network, and increase in the number of procedures displayed on CompareMaine for that network, and an increase in the number of claims per procedure. Italics indicate facilities not previously included on CompareMaine due to low N issues.

- Community Clinical Services
  - B Street Health Center
  - CCS Family Health Center
  - *CCS Psychiatry at Central Maine Family Practice*
  - Second Street Health Center
- Penobscot Community Health Care
  - Brewer Medical Center
  - *Capehart Community Clinic*
  - Helen Hunt Health Center
  - *Jackman Community Health Center*
  - *Pediatrics*
  - Penobscot Community Health Center
  - Seaport Community Health Center
  - Specialty Clinic
  - *Summer St. Community Clinic*
  - Winterport Community Health Center
- Pines Health Services
  - *Kimball Community Health Center*
  - Pines Caribou Health Center
  - Presque Isle Health Center
  - St. John Valley Health Center
  - *Washburn Health Center*
  - Women and Children's Center
- Portland Community Health Center
  - Portland Community Health Center (PCHC)
  - *PCHC at Brickhill*
  - *PCHC at Franklin Towers*
  - *PCHC at Preble St.*
  - *PCHC at Riverton Park*
- HOMETOWN Health Center (Formerly Sebasticook Family Doctors)
  - *Canaan*
  - *Dexter*
  - *Dover-Foxcroft*
  - Newport
  - *Pittsfield*

Breakout of Professional and Facility Costs

Average Total Cost will be broken out by professional and facility costs. The following mock-up conveys the general concept:



- **Roll-over Text for Average Total Cost:** The average amount paid for a healthcare procedure, calculated using the median. The median is the middle number in a range of numbers from lowest to highest. This cost includes payments from an insurance company, as well as co-pays, co-insurance or deductibles from the patient.
- **Replace the "View details" Roll-over Under the Average Total Cost in the Image Above with "Cost Breakdown":** The average total cost is broken out into costs paid to the healthcare facility and professional(s) providing services.
    - **Facility Cost: $XYZ** paid to the organization providing healthcare services and procedures.
    - **Professional Cost: $XYZ** paid to the healthcare providers, such as nurses, doctors or therapists, for providing healthcare services and procedures.
- **Dictionary Definition for Professional** (Same as Ad Hoc Consumers)**:** An individual healthcare provider, such as a nurse, doctor or therapist, who provides direct services or procedures to a patient.
- **Dictionary Definition for Facility:** An organization that provides healthcare services and procedures. This includes hospitals, surgical centers, diagnostic imaging centers, health centers, laboratories, and clinics.

Updated Language:

Is this website useful to individuals without health insurance?

Yes! A provision in the Affordable Care Act addresses what hospitals may charge individuals eligible for financial assistance for emergency and medically necessary care: "Section 501(r)(5) requires a hospital organization to limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care." The cost information presented on CompareMaine is the average amount paid by insured individuals and their health insurance companies for a variety of procedures. *An uninsured patient should expect to pay an amount close to these amounts listed on CompareMaine and patients are strongly encouraged to talk with the hospital billing department to get an estimate of the actual price prior to receiving the procedure.*

Discussion Item

- Including the data we provide to workers comp on CompareMaine

LD 1740 Phase 2 Subcommittee

Baseline Review of Issue

Review Charge of subcommittee developed by Board in 2014

Determine membership of subcommittee and timeframe for report back to board

Continued-LD 1740 Phase 2

Developing health care quality metrics based on administrative claims data has become increasingly common over the years. NCQA's (National Committee for Quality Assurance) HEDIS (Healthcare Effectiveness Data and Information Set) measures have been a standard for health plan quality reporting for over two decades, and more recently, newer programs such as the CMS Pioneer ACO (Accountable Care Organization) program and Oregon CCO (Coordinated Care Organization) program have included claims based quality measures as requirements for program participation.

- Most claims-based measures are process based, evaluating if appropriate services are provided for specified groups of patients, or identifying potential over-utilization of services
- claims data are not the sole source of quality measurement
- Survey data are often used for patient experience and operational measures, and
- Increasing use of lab results and EMR (electronic medical record) data to expand the clinical components of quality that can be measured

Source: Milliman Healthcare Analytics Blog

Continued-LD 1740 Phase 2

Despite the expansion of claims-based quality measures, some still question the merit of these measures. Those citing concerns point out known limitations with claims data including:

- Availability of required data sources may be constrained if components of benefits are administered by multiple sources.
- Lack of clinical information.
  - No diagnostic coding for blood pressure, laboratory results or pathology results
  - Clinical information is limited to conditions for which the patient was treated and submitted a claim. A noncompliant diabetic may have no claim history of the disease.
  - Timeliness of data is impacted by claim lag

The advantages of claims data includes:

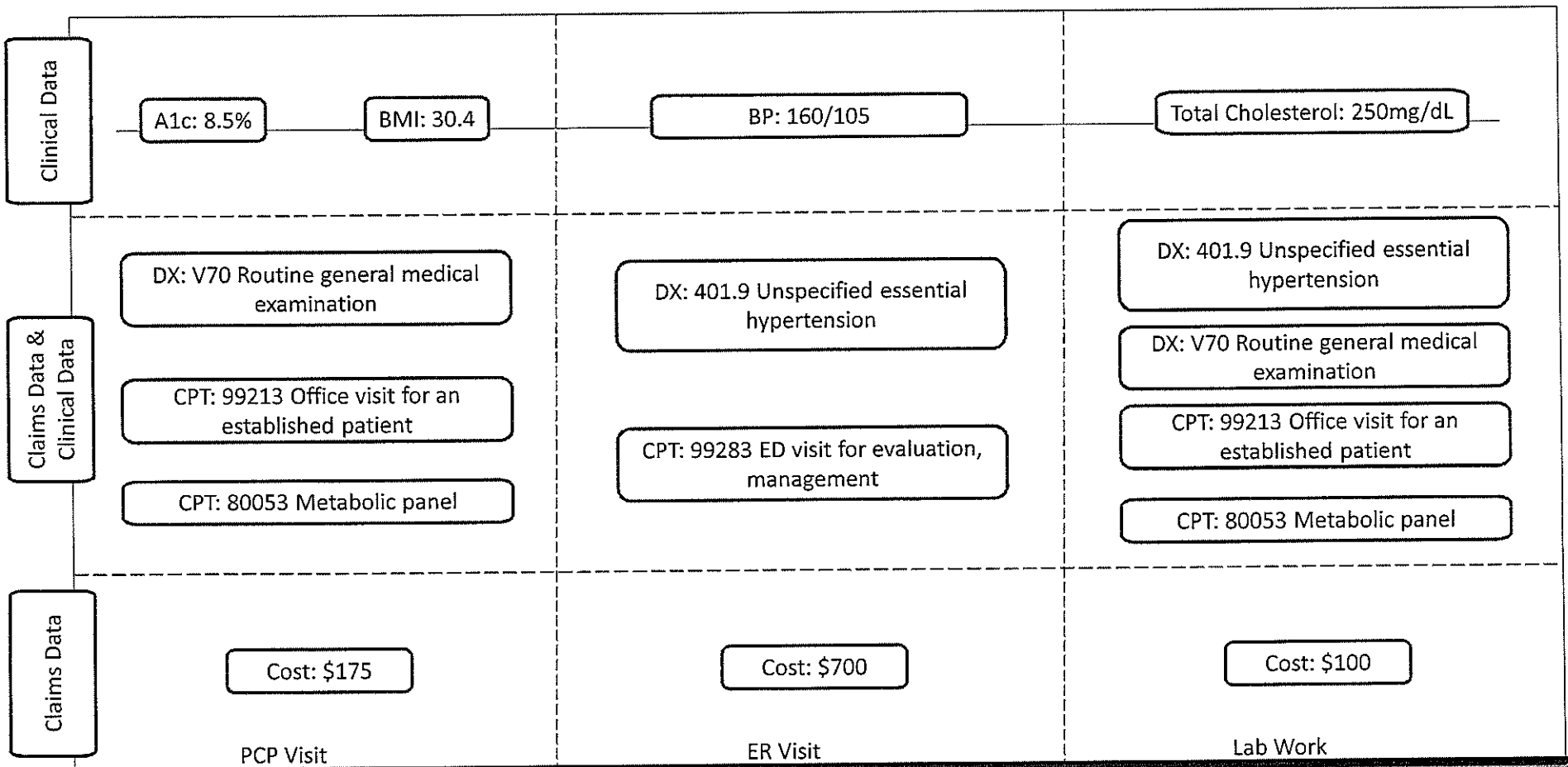
Data are more commonly available and standardized

Data are available for very large populations, allowing for more robust sample sizes.

For some types of measures, claims may produce a more accurate picture than even chart reviews.

Source: *Milliman Healthcare Analytics Blog*

The Opportunity



Convening Board Subcommittee on Phase 2 of LD 1740

Charge Developed by Board on September 4, 2014:

- Develop a proposed working definition of clinical data
- Conduct an environmental scan of the current state of who is collecting and using clinical data and determine if there's value in the state collecting clinical data as defined by the subcommittee.
- Develop Use Case rationale.
- Report back to the MHDO board.

Multi-stakeholder Board Subcommittee to Include Representation From: Consumer; Employer; Hospital; Provider; State of Maine

Alternative Payment Models

Review communication to payers & responses received

Next Steps

(Refer to handout)

Message sent to top 10 Payers
Monday April 10, 2017

I am reaching out to you per the direction of the MHDO Board of Directors to gather information on the prevalence of Alternative Payment Models (APMs) in the Maine market. Based on discussions with providers and payers we understand that APMs represent an important and growing category of payments to providers in our State.

The purpose of the MHDO as defined in Title 22, Chapter 1683, is to create and maintain a useful, objective, reliable, and comprehensive health information database that is used to improve the health care quality for Maine people and to promote the transparency of the cost and quality of healthcare in the State.

In order to meet the requirements defined in our law, the MHDO is gathering information to assess the impact on claims data submissions as the system transitions from fee for service payments to alternative payments. As such we are requesting that you complete the information in the table below and return to my attention via e-mail by May 1, 2017.

Type of APM	% APM represents of Total Claims Paid in Maine	Is the payment information for a service covered by the type of APM currently being submitted to the MHDO?	Is the utilization information for a service covered by the APM currently being submitted to the MHDO?
Global Payments			
Limited Budgets			
Bundled Payments			
Pay for performance programs			
Shared savings/risk programs			
Other non-FFS			

MHDO Maine Health Data Organization

Information | Insight | Improvement

PAYER ALTERNATIVE PAYMENT MODELS (APMS)

LAST UPDATED: APRIL 26, 2017

HEALTH PLANS INC.

Type of APM	% APM represents of Total Claims Paid in Maine	Is the payment information for a service covered by the type of APM currently being submitted to the MHDO?	Is the utilization information for a service covered by the APM currently being submitted to the MHDO?
Global Payments	0	n/a	n/a
Limited Budgets	0	n/a	n/a
Bundled Payments	0	n/a	n/a
Pay for performance programs	0	n/a	n/a
Shared savings/risk programs	0	n/a	n/a
Other non-FFS	0	n/a	n/a

UNITED HEALTH CARE

Type of APM	% APM represents of Total Claims Paid in Maine	Is the payment information for a service covered by the type of APM currently being submitted to the MHDO?	Is the utilization information for a service covered by the APM currently being submitted to the MHDO?
Global Payments	0.1%	No	Yes
Limited Budgets			
Bundled Payments			
Pay for performance programs	3.5%	Yes	Yes
Shared savings/risk programs			
Other non-FFS: Transplant program	1.1%	Yes	Yes

E-mail received from Katherine Pelletreau

April 26, 2017

Dear Karynlee,

I am writing on behalf of MeAHP's member plans to raise questions and concerns about your recent request for APM data. The plans are concerned about the request for several reasons.

This data represents competitive business information that the Plans are reluctant to share and want to protect.

MHDO currently compels claims data through Rule Ch. 243 but it is not clear to us that the Agency has the authority to collect the information sought in your recent inquiry.

As you are well aware, there are costs associated with the provision of claims data to MHDO and with responses to requests like these. Plans are being asked to do more with less and resources are very tight to respond to miscellaneous requests like this, especially in a short time frame.

We request that MHDO suspend the request and the due date.

Strategic Focus for the Next 12-18 Months

Data Delivery Model

CompareMaine Enhancements (content & functionality)

Data Quality Enhancements

External Communications on MHDO's Value

Stakeholder Engagement