750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTH BENEFIT EXCHANGE

Maryland State Reinsurance Program Regulations Hearing

August 9, 2018
Maryland Department of Transportation
7201 Corporate Center Dr.
Hanover MD, 21076

Welcome & Introductions

John-Pierre Cardenas, Director of Policy and Plan Management of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the third hearing of the state reinsurance program. He stated that this hearing is focused on incentives, specifically those related to utilization management and quality improvement. The next hearing will also focus on incentives. He reported that the MHBE submitted an addendum to the section 1332 waiver on August 4 with details regarding the steps the MHBE has taken to address the issues that arose during the state public comment period. The application is now complete and the MHBE is waiting for CMS's response; the MHBE requested that approval be granted by August 22. The Board will have a conference call on August 20 that will cover the issues discussed during the hearings, and the Board will make a decision regarding the interaction of risk adjustment and the reinsurance program.

Mr. Cardenas noted that it is important that these hearings be clearinghouses for information and dispel incorrect information. He asked that insurers come to the hearing with information on existing incentives that are currently in place and the effectiveness of those incentives. He provided an overview of the questions to be addressed during the hearing that were included in the agenda. He noted that respondents should provide justification for the universal attainability of the recommendations, and assume that incentive payments would take effect in 2020. Mr. Cardenas stated that everyone is here to address the rising costs of insurance premium, which has been a problem for the exchange since the beginning. He noted that the reinsurance program could offset premiums by 30 percent for exchange enrollees without access to subsidies.

He acknowledged the presence of Delegate Bonnie Cullison and thanked her for her advocacy of the reinsurance program during the last legislative session. He also acknowledged the presence of Dana Weckesser, MHBE Board of Trustees member and Michele Eberle, Executive Director of the MHBE.

Public Testimony

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Four individuals offered testimony.

Debbie Rivkin, Vice President Government Affairs, CareFirst BlueCross BlueShield offered the following testimony:

> *"For the record, I'm Debbie Rivkin, Vice President of Government Affairs for CareFirst BlueCross Blueshield and with me today is Jennifer Baldwin and she is our Senior Vice President of our PCMH program and all of our care coordination. So I'm sure you're really excited that you won't just hear from me today as has been in the past. So I really do want to start and I think it's in reaction to what JP said and this is something that I've said at every single hearing but that CareFirst, and I want to make sure that I am on the record for this, that CareFirst strongly believes that every penny that the state gets through the state reinsurance program should be used for its intended purpose and for nothing else. And that is to transfer funds to plans that have high claim enrollees in order to exert downward pressure on premiums so that we can start really stabilizing this market. The money should be used for no other purpose so while we're going to talk about all the incentives that we have today in place and what we do, we have no answers for a lot of items you have on the agenda today because we don't think that it's appropriate to use any money from the reinsurance program for incentives, period, so it shouldn't be used for a disincentive or an incentive. That pot of money should be used for its sole purpose and so I just want to make sure that*

everybody's clear about that. We are very opposed to taking any money out for incentives or disincentives because we don't think that will help in the short-term to get the rates down as much as we possibly can. So with that I really do think there has been a disconnect about what's really happening today in practice and what you're trying to do because I really do think after you hear us today that you will believe that we are managing care exactly as you would want us to do and therefore that's another reason that there is no need for another incentive or disincentive.

So what's really important to note is that CareFirst, all of the programs we have designed apply to our entire membership, every single part of our business, so that's really important to remember that we can't just focus on the individual market, all right. People don't stay in the same plan, they don't stay in a PPO or a HMO or a point of service plan, they go back and forth so we have to make sure that our programs apply across all types of products that we sell. The other thing that is really important to note is that people don't stay in any one segment, you can have someone that starts in the individual market, then they get hired by a small employer and they purchase insurance through that small employer then they might go to the state plan then they might go back to the individual market again. So we are agnostic as where for our programs as to where you land in that spectrum of getting your care, that's really important so it's no different than a provider who treats a patient, they don't treat a patient differently based on what insurance they have, they look at the condition of the patient and they treat them appropriately. We do the same thing, we don't care what market segment you're in or what type of product you're in. So we design our programs from young to old, and from healthy to ill. And I think the best way I can describe that if I had to come up with a soundbite—because I've been thinking about this a lot—is that we meet you where you are. Wherever you are in that continuum, whatever product you're in, we are going to find you and make sure you are in the right program for your healthcare needs at that moment and if anything changes we'll move the product, the program for you. We'll meet you where you are.

And I also want to note that when the reinsurance program started, the federal reinsurance program was 2014 to 2016. That money was coming to the state, at that time we were developing our PCMH program, didn't change our course because we said federal money's coming in we don't have to manage that risk anymore for those high-risk enrollees, we were, our goal was to create a PCMH program—patient centered medical home program—for all of our members despite the fact, it had nothing to do with designing our program and we don't think that we're getting money today or in the future is going to have any difference to us. The reason I think that's really important is because I've heard people say we have an unmanaged product, we do not have an unmanaged product, our PPO product is not unmanaged and I think we'll be able to prove that to you today and I think as you've already hear me, say any member in our PPO product is getting the exact same supports as anyone in our HMO product, so that's number one.

The thing that we think is most important I think is that not only are they not unmanaged in our PPO product, we took an actual look at our market segments and said what percentage of our members in the individual market are in care plans or in the programs that we created, what percentage of members in the large group market are in care plans or the programs, the small group market, the self-funded marketplace, we looked across the continuum. And what we found was two things I think are really important, and these are the facts, we have more, higher percentage of CareFirst members in CareFirst plans and programs in the individual market than we do in any other market segment, we are managing their care. Number two, when we look at the individual market, we have a PPO product and a HMO product, we have a higher percentage of members in our PPO product that are in care plans and our programs, we are managing their care. We are actually finding the member that needs the care and getting them the supports that they need.

How do we do this? We do it through our patient centered medical home program and we have something that Jennifer is going to talk to you more about which is our TCCI program, total cost of care improvement programs. We designed a number of, I think it's around 20 support systems around our patient centered medical home program in order to have the very deliberate, coordinated approach to bring the right interventions to the right members so we can get the best outcomes at the lowest possible cost. Each one of those elements is important and each one of our programs has been targeted to do just that. And again as I said it's the entire continuum at all stages of health and illness and there are five components I think for

both behavioral and medical health care for our members that we look at. And those five are keeping the member healthy which is very important obviously, managing a member that has emerging risk, we look at that, we look at a patient's safety, outcomes across settings, where should they be, where's the best place to get that care, and managing members with multiple chronic conditions, which are probably in those highest band, those are our sickest members and that's who you would want us to take care of, those are the members that are in our care plans. And again there are more PPO members in the individual market, or percentage of members who are PPO, is higher than in the HMO. So we're trying to bring the program to the member at the right time for the best possible outcome, so that's the overarching message here and again that is the reason why we don't believe any money needs to be pulled out of the reinsurance program to incentivize any carrier or disincentivize any carrier to manage care because we are doing it today and will continue to do it because it is part of our mission, part of CareFirst's mission, and always will be part of our mission. So with that I will let Jennifer tell you exactly what our programs are and I'm sure you will hear passion in her voice because this is something she has worked on for the past six years and has had tremendous results and she lives and breathes this stuff every day and this is something that is integral to her and to CareFirst.

Jennifer Baldwin, Senior Vice President of Care Coordination, CareFirst BlueCross BlueShield offered the following testimony:

"Again my name is Jennifer Baldwin, my title is Senior Vice President of the Patient Centered Medical Home and Care Coordination at CareFirst. I've been a nurse for over thirty years and have been a nurse leader for over twenty and have found to be part of this program has been a privilege, to really focus on I think are the problems are of health care which is a crisis in this country as well as the state. The rigor around this program, I'm so happy to be here to share this with you, I'm asked to speak all over the country about this program and I usually say no because I don't want to take my focus over making this program successful for the members of CareFirst in the state of Maryland. I want to explain the tenants of the program so you can see the resilience of it and how it does really focus on really taking care of patients and making health care accessible. It's across the state as Debbie said whether it's rural eastern shore or western Maryland or Baltimore City, it's every place in the state of Maryland. We work with over 4,400 primary care physicians, they are the real center point of the program, so whether it's a Hopkins or a single practitioner, or an academic center, or in a rural area, it is the exact same program. The tenants, the standards, what we adhere to is the same, we are very focused on doing what's right for the member regardless of what hospital they go to, regardless of what physician or where they live.

As Debbie said, it's across an entire continuum, we want to make sure that we're keeping people healthy, gaps in care, getting their mammograms. We want to make sure those that are very chronically ill, it's overwhelming, I would say you never appreciate your health until you lose it and when you lose it, it is a vulnerable time in your life and you really do need a clinician advocate to come and help you through that so we really do watch the entire continuum and ensure those that are unstable get enormous attention. The program is very high touch we have over 250 nurses, registered nurses, that work in these 4,400 physicians, we have over 50 behavioral health care coordinators, which is incredibly important, we find many of the patients that are medically ill also have behavioral health needs and we know that the access to behavioral health is something we desperately want to make sure that our patients get. So we are also in the hospitals, we have over 60 nurses that are in every hospital and the reason they are in the hospitals because that is a very important part of the journey in health care, it's a transition time that we know that you need support. They are actually in the hospital, 70 percent of hospitals have a person in the hospital to help them. Those that are low admissions also have a dedicated hospital transition coordinator and the work is done telephonically but they track every CareFirst member that's in the hospital and they categorize them, do they need help or not? Do they have a healthy baby and are they going to go home or do they have diabetes, uncontrolled hypertension, or very complicated medications and need a health care coordinator? That hospital transition coordinator transitions that patient back to their primary care physician with the local care coordinator.

So the high touch of the program is, I believe all I've read about telephonic care and virtual care is that there is nothing more important than the relationship you have with your nurse and with your physician to help you really cross that line of health. We want to make sure the care coordination we do is impactful so—that I think the nurses would appreciate me saying this because we do—I want excellence in what they do but I want to measure and monitor it so we select the right members make sure the patients that need us, we find them and we go to physicians and we work with them but we also monitor the care coordination. It's expensive, care coordination, so you want to make sure you're doing the right thing with these limited funds. The physicians are held to a financial issue that we will share savings with them after the care coordination costs so we want them to be very good stewards of the money to make sure they are really focusing on better outcomes for the patients. The best place to get the healthcare where they get, whether it's at the hospital or at the home that the patients really are being cared for in the most cost-effective and clinically effective way.

When we look at, so there's 4,400 physicians in it and 250 nurses, it's very high touch. We also have enormous data to help us, so we have 300 library of Congress' worth of data and that can be overwhelming to our physicians, we have 35 CareFirst associates that are called practice consultants that work with physicians to help them really manage their population, whether again if its gaps in care or whether it's to make sure we're care coordinating the appropriate individual. We know from watching the primary care physicians, they are very busy and they don't have time to assess data much less to take care of the more complicated patients. We also make sure we say to the physicians that we want to work with you, this is a patient that we looked at our information, we look at your EMR, this is one of your patients that really does need—that's how it was in the beginning, now it's really the physicians reaching out to us to say I really need your help with this patient. Just a small comment, when we started this program, seven or eight years ago—we're in the eighth year of the program—behavior change is what is the basis of all this, changing the physicians' behavior, changing really the nurses' behaviors, nurses never really did care coordination, I wasn't taught care coordination in nursing. In fact I went to the University of Maryland and asked them to build a curriculum to teach care coordination because it is really a fairly new science to nursing, which they have done. We found that the trust level with us, the ability to change, the desire to transform, really needed support so the very beginning was us building relationships, really working very closely, making sure that what we said we were going to deliver we delivered.

We do surveys of our physicians and we do surveys of our patients, and we make sure every patient in a care coordination plan, quarterly we do a survey and our goal is a 100 percent we don't do random, we do everybody that will answer the questions, we do get over 85 percent response rate for our patients. We're always pleased with what we hear from these surveys, there are six questions, they're very direct, are you really getting the care, did this matter, did this make a difference? On a scale of 1 to 5 we get a 4.4 to 4.6, very high scores. Along with the same for the physicians, we ask the physicians the question, is this in line with your philosophy, with your desire how to practice medicine—that's one of the most important questions that we ask—are we aligned with how they want to practice medicine and the answer is yes. That we do work together, we are a team, we call the whole coordination team, it's the physicians is what we have as the quarterback or the nurse practitioner and we work very closely each of the practices to make sure they have the data, the resources, that they need to provide outstanding care for the patients.

At this point we do thousands of patients in care plans and I was talking with someone in the audience just about the effectiveness, how do you know outside the satisfied population, how do you know if we're being effective with this, is this the right intervention, what is the right intervention? Because sometimes we go in and it'll be a diabetic that hasn't seen their eye doctor, hasn't gotten their feet checked and we're adding costs although we know it's a better outcome, how do we really show that we're effective. And there's a tool that's internationally used and was nationally created by Judith Hibbert and it's owned by Insignia, and it's called PAM, Patient Activation Measure. It is tool that enables us to and we do it every six to eight weeks with our members, and it's a questionnaire that's fairly straightforward to do. And what it says is that on a scale of 1 to 100 if you are—and it's broken up into 4 levels—if you're level 4, you're really activated, you can have a Fitbit, and a couple websites and you're probably going to go and do the right thing for your healthcare. If you're at a lower level, a one, you're be someone who's I don't want to know my A1C or my blood pressure, it's too overwhelming for me, so we customize our approach to the patient

based on the continuum they are. The second we do is we want to make sure they do move along the continuum, what the data says is that for every one-point increase in PAM equals to two percent decrease in hospital utilization and two percent increase in medication adherence, so we know it's a worthy goal for us to make sure that our patients are moving along the PAM score and if not we know to revisit and we measure that. We looked at our independent market, our individual market, the PAM scores go up just as much everywhere else, they equally go up seven to eight points, which we're really proud of that work. We probably use that tool most than anyone in the country and we find the tool really is extraordinarily helpful for insights. We have another component which the data is in Searchlight reports which is reports that we try to put in consumable, actionable terms for the physicians and their practice, many times they have other people in their office that helps them with the data. So we put these reports together for them so they're enable to look at what should we be doing for our patients whether it's keeping them healthy with the gaps in care or whether it's really focusing on who is their expensive medications or who is on the most medications, we slice and dice the data, again with the whole goal being actionable.

The incentives for the physicians to stay involved are meaningful to the physicians, there's really three levels. One, we pay them more to be in the program, and two, we also compensate them for the time they spend with the patient, we often know that the fee-for-service world creates an environment for the primary care physician to say the more I do the more I do I can't stop even though this patient may need more time of me. We say if the patient really warrants more time we will then compensation in addition to your regular basic code, compensation above that. And at the end of the performance year we do a calculation to see how much savings did your panel save and then we put that prospectively into their fee schedule. It has been incredibly well received from the physicians, its meaningful, there's a quality component to it, they really, they are as competitive on the quality as they are on the cost savings and care desperately on their value and their quality to show they are improving the care of members.

The score card is a 100 points and this is important from a change management perspective knowing that we are trying to change how people deliver health care, how physicians transform their offices, and then how patients respond. 50 points of the score card is for engagement, I will tell you eight years ago I think it should be much more in clinical but what we found is that when you are engaged, people don't want to change, if you understand something, if you get a comfort with it you are more adept to change, you are more going to do that. So 50 points out of a hundred are engagement if you do not achieve 35 out of 50 we don't share the savings with you it is extremely important for the primary care physicians, they want to make sure that they are doing the right thing in the program for obviously the outcome incentive award, for the financial award but imbedded in that is working very closely with us to transform. The points are, are you working with your nurses, are you working with the data, are you transforming your practice? The examples we've had across the whole state have been just very impressive for what physicians and practices have done to make sure that members are getting the right medication, the members are not going unnecessarily to the hospital. Access, access, access; if a patient can go to their physician then they won't go to the ER so we talk often about you have to be accessible, does that mean evening hours, does that mean Saturday, does that mean all of it? But the idea is to make sure that when your patient goes outside of your practice you lose sight of it.

What Debbie talked about was wrap around services, our TCCI, total care and cost initiative. A solo practitioner, 70 percent of our physicians are solo practitioners not with academic centers, they don't have the wherewithal to put together entire support services for them, if they need home care they tell the member you can get some home care or maybe the front desk can help you find an agency. What we did is we went through all the different components we think help stabilize a patient, one is home care, two would be enhanced monitoring, home monitoring, see a pharmacist to review your medications. But we went one step further, not only did we create all these programs and went out to all the agencies and we said we want the best of the best to really serve these patients and we want that to include everybody. And now we said to the nurses we want you to send the patients when they need home based services, we want you to do that. But because some things are so difficult, it's they have to follow up see if they attend. We created this service request hub and what this I call the Zappos of PCMH it doesn't get you shoes but it can get you home care. And you go and the nurse will say I live in Montgomery County, my patient's in Montgomery County and she needs home care, she puts it she clicks clicks, a couple clicks and she walks away. And that

we have an entire system that monitors did home care get delivered, was it fair, and they're notified, which it rarely happens that we don't get the services right away. Same with the comprehensive medication review, we realize the patient is on 8, 9, 10 medications, we have patients on 20, 30 medications. How could you possibly keep track of that, no offense to nurses I have very high regard for nurses, they've had one or two semesters of pharmacology and many of my nurses are very experienced and they've been out of school for a while. We know you need a Pharm. D. to review medications so that is again you go to the service request hub and you say my patient Jennifer Baldwin needs a comprehensive medication review and that again is all the administrative component is done behind the scenes and the patient gets that comprehensive medication review with the primary care physician getting the information back. One other component about the program is that all of the nurses are local. All the behavioral health coordinators are local. Healthcare is local, when you need an orthopedic surgeon or you need care you don't often say I'd like to leave western Maryland and go to the Eastern Shore for care, you just don't do it, you want it very close to where you are, you want it convenient. So all of our nurses, even in the days with a nursing shortage we do not hire anyone that's not, one, experienced and, two, lives in that community, you're familiar with the culture of that community, you know that the referral patterns, you know the hospitals, you know all of the things that are there. Our nurses work very hard to make sure the community services are offered to the patients. Behavioral health coordinators do the same, they all live in the communities and that improves the ability for our members to get access to behavioral health which we know is an incredibly important component.

We also have another one I'd like to share with you, it's the cost share waiver, what that is, is we found it was a past program and we brought it back. I have to say much of what we've learned and improved on has been from the voice of the physician, or the voice of the nurse, or the voice in the member satisfaction survey that we hear loud and clear; 5,000 patients answered that survey and over half, 3,000, will give us comments and we read every single one. And every quarter we get that survey to make sure we are meeting the patient's need and we come out of that with great suggestions. One was I know I need home care but I can't afford the $20 co-pay, with that's just—are you sure you really can't—so what we have is the cost share waiver. If you're in a care plan and you're compliant, meaning you're talking to your caregiver every week, we want to make sure that you're talking to your behavioral health coordinator or your local care coordinator weekly, you're adhering to the plan that's been set by you and the physician. If you are compliant with that we will waive your cost-share, and your co-pays, or your co-insurance or your deductibles to see your specialist or for your physical therapy or your home care. That has been extremely well received for those that are economically compromised, it has been a reason that they will get their home healthcare, which they wouldn't have done before.

We also, the care plan I just want to share just a little bit, I'm sure that maybe I'll get the hook, I'll be happy to answer questions. The care plan has nine components to it so it's a, we want to streamline the work for the nurses but we also want to be very thoughtful and methodical in what they do. So there are nine components of it and one very important component is social barriers. We have five sections on what are the things that are preventing you, we often used to think there was an illness burden, how sick you are and that's it. We finally know now it's how sick you and how difficult things are for you, do you have transportation? Do you live alone? We find living alone in the literature says that you have a greater chance of being admitted than if you live with somebody. All these pieces of data we collect on every single one of our members to make sure again, are you healthcare literate? Are you able to understand your medications? We have found that has been extremely helpful for us to be successful for those that are in care coordination. It's also taught us a lot about our community and what the needs are for the different physicians to share whether or not they are in a care plan they still need to benefit from other components of it. We do a medication reconciliation with every patient, we ask a question of the patient, why are you on this medication? And we are always profoundly somewhat sad that we know that they don't know why they are on the medication, I've been told to be on this medication. So I always say that first time when you go through all those medications with your patient, our nurses need our patients in the office, they do video visits so we can still show the pill bottle over on the video if they can't get to the office, but we make sure we go through every single one of their medications to make sure they know why they are on it. And that's often when they go, I think we should have a pharmacist come, but the clarity, the education, the care coordinators provide in connection with their primary care physicians so it's not out of—it's really very

connected with mainstream medicine, really focused on what they believe. The primary care physicians when we first started the program, they were like I can't influence the whole medical dollar, I'm only 6 cents on the dollar, how am I going to influence the other 94 percent. We kept saying you are influential and you are a leader in this and we want you to embrace this opportunity and lead. You don't necessarily went to medical school to be a primary care physician to lead—I used to say when I went to the hospital cafeteria, which I spent 17 years in the hospital, I could know who just by their practices, of whose outspoken, and I always see that the people at the tables eating with the families are usually the primary care physicians. This was a behavior change for them, we wanted them to say to call specialists and say this patient is on a cardiac drug that has efficacy for two years and this is the third year and its 20,000 dollars, we don't think that patient needs that medication. So we want to give the data to do that and empower them as we're working with all the panels, the group of specialists they work with so that fragmentation between a primary care physicians and specialists go away. And the nurse often is the link to that, the nurse will go to the specialist's office with the patient to make sure that connection with the primary care and what the specialist is doing happens.

And the final thing I would say is that there is no administrative burden to these physicians. This is an incredibly important point. Because the insurance world isn't where the highest level of love and trust with the primary care physicians, it was important for us to make sure that we did not bring a burden to them. That we do all the heavy lifting as the nurses do the work, the data is put into very streamline fashion for them, and we do have the practice consultants help them with the data. Then what we ask them to do is meet, collaborate, talk with us, think about how you can be a better practitioner, how can you be a better practice. Are we taking care of your members in the best way to make sure that what we do is sustainable? We always want to make sure that the care we give the patient doesn't fall apart after we close the care plan. Since the care plan is expensive, we want to make sure that it's a lasting change, sustainable change that you make with the patients. We often talk to the nurses about when you first meet the patient you talk about the end, and you say we're going to be together for about six months because we do know that they love their nurses. We also connect them with the CareFirst customer service advocate so they understand their benefits really well; at times you can say I get this part but what are the benefits. So these sustainable changes are very important and we measure them after they're out of care plans, 3, 6, 9, 12 months and then longitudinally to make sure the changes that we've made are sustained and if not, why not.

We do monitor, so what, what happened, was there any impact to it? We have, we do two things, one we measure each panel on did they beat their budget. Here's the budget we don't lower the number, we say that this is what you spent last year, we escalate it for acuity and for inflation and then we say we want you to stay within that. So reduce your unnecessary admissions, reduce your unnecessary use of the ER, make sure that your patients are adherent to their medications, and I could go onto all of the different transformational activities they do. So one way we measure the effects of the program is, did the panels, and we have 450, reduce their expected cost? Year over year more than average, more than about 70 percent do have a decrease in their costs and they win an outcome incentive award if they met the engagement measures which often many of them do. On a whole book of business this year we had 13.7 percent fewer admissions, 19.4 percent fewer days in the hospital, 41 percent fewer readmissions which is really very important to us, and 7.3 fewer emergency room visits. So one watch is that a—are the patients satisfied? Are we seeing better outcomes on their pat with the PAM score? Are the practices joining, working on transformation, are they seeing a benefit from that? And then globally are we making a difference with our… with the access to care and reducing hospitalizations and readmissions? I think I'll stop. If there's any question, I'll be happy to answer any questions."

Mr. Cardenas thanked Ms. Rivkin and Ms. Baldwin for their testimony and asked how many CareFirst members are part of the PCMH program.

Ms. Rivkin replied:

"You can, but I just… before… there's much more… we talk about PCMH but there's all those supports around it… so, I don't know… so just know, if we're talking about care plans, that's one element and then we've put all these programs around them so, yeah."

Ms. Baldwin continued:

"So about 85 percent of the primary care physicians are in the program. So, patients don't enroll. They go to the primary care physician. So we have a majority of primary care physicians in the program. For those that don't go to a primary care physician, we still reach out to them. We still have information. We have what we call a core target list. And every month we put together, with about—there's about nine variables. You have a high LACE score, meaning you're discharged from the hospital and you have a good chance of being readmitted, or you have a five thousand dollar spend over six months. All these different indicators that say oh we should watch you. If you are in the program and work with a primary care physician if you're not we reach out to you. You may be seeing an oncologist, you may be seeing a cardiologist, so although we really believe in the primary care, the patient centered medical home being very focused on primary care, we do know that there's members that see specialists as their primary care and we completely address that."

Ms. Eberle asked if the 4,400 PCPs participating in the PCHM program represents 85 percent of the PCP network.

Ms. Baldwin replied:

"Yes, that's correct. Eligible PCPs that's correct."

Mr. Cardenas asked about the percent of the population base affected by these programs and how it compares between the individual market and broader enrollment.

Ms. Baldwin replied:

"So most are in the program, so about a million members are in the program, I can get you the exact numbers to be sure. So what I will share with you on care coordination although Debbie's right, if you are not unstable but are on 30 medications, we make sure that you get a comprehensive medication review. So you don't have to be one of these sick members, because 2 percent are really the sickest members that are 30 percent of the cost. So although we focus heavily on those 2 percent of the members for the 30 percent of the cost, we know that again keeping people healthy, making sure that they're getting mammograms and their colonoscopies so they don't become part of this 2 percent is just as important for us. We really have three levels of patients that we track, those that are very unstable and chronically and acutely ill. Those that are emerging—we're worried about you, you have climbing A1C, you have chronic kidney disease, and we want to stop the progression of it or you're healthy and we want to keep you healthy. We really do have different initiatives on every single of those levels, whether you go to primary care physician or you don't we make sure that we address that."

Mr. Cardenas whether these wrap around programs are more impactful for HMO or PPO products.

Ms. Baldwin replied:

"No."

Ms. Rivkin added:

"I want to be really clear with that because I think it's really important because I'm a little concerned that you even asked that question that it didn't come across, it's is the member that matters not where they are. So we are completely agnostic to what type of product they're in, if they're in a PPO or a HMO, we look at

the member and we treat them based on their health status at the time, so it has nothing to do with the type of product they're in."

Mr. Cardenas about the savings compared to the investment of these programs.

Ms. Baldwin replied:

"So what we look at is the total trend, are we keeping the trend down. Before we started the program the trend was 7.5, 7.5, 7.5, our desire was to bring that down, maybe 6.5, it's to really stop the escalation of the trend and we've shown that we've been able to do that, we kept it under 5. That's been our goal to really make sure that the cost of care doesn't go any higher, we'll love for it to go lower, our goals are always to have it go . . . continue to strive to have costs go down."

Ms. Rivkin added:

"I just wanted to add one thing to that. I think it's also really important to note and I think this has been, people have confused this in the past. When we say that we have savings, it's savings to a number that would have been higher, right. So we've always had an increase in our rates unfortunately, but the rates would have been higher if we had not been able to avert this amount of . . . the trajectory of where it was going."

Mr. Cardenas asked if it is a rate off-set similar to the reinsurance program.

Ms. Rivkin replied:

"Correct, we are averting that amount. Exactly, just like reinsurance."

Mr. Cardenas asked about whether these programs have maintained or improved morbidity or improved the management of chronic diseases.

Ms. Baldwin replied:

"So we have, the data we have is all those in care plans, and so a couple of questions. We probably haven't had it long enough to really see the ultimate outcomes of morbidity . . . or mortality that would be. What we track A1Cs, we track different clinical measures on the patients that are in care plans, so the whole population we track more of the gaps in care, the immunizations, the colonoscopies, and the screenings to make sure to ensure. And our measurements have gotten better with people being more adherent, that they care desperately about because it's in the quality score cards I shared with you. The CKD program is probably where we have the best of line of sight to—are we really preventing the further deterioration of somebody's kidneys by watching their hypertension and their diabetes and making sure they're stabilized. So we have a really specific program that we look at everybody with either hypertension or diabetes or both, and every month we track them, where are they, have they gotten the right screening. There's two screenings that you have to get for lab tests to make sure. We watch them and we feel very promised about the data, only doing it for two years so we really want to keep watching it to make sure we are stopping the advance of CKD, which you know if extremely expensive, and it can be very terrible for someone's quality of life."

Mr. Cardenas asked about CareFirst's future plans for maximizing member and physician participation in the program and the downstream impacts of such participation on premiums.

Ms. Baldwin replied:

"Well, the hope is . . . the goal is probably the same as you're talking about. We . . . the good news about this program is that there's not any artificial limits, I will hire as many nurses as we need to treat patients, every physician is welcome in this program. Next steps are really to engage with the specialists, to make sure that the primary care and specialty world work closely with hospitals, I think there's been, I don't know which hospitals I haven't been to . . . to ensure that our hospital transition coordinators, it's a whole FTE that's in the hospital that's totally focused on discharge planning and making sure. So it only will grow there's not limit to it, there's not an artificial goal to stop here, we want every panel to have savings, we want every panel to achieve savings. There's not like a component that, oh we can only afford to do this, it is really if you think about the way the program is so sustainable, is we share the savings based on your actual savings so it's not that it's from a pot of money or grant that could ever dry up. It really is focused on the better we take care of the CareFirst members, the less they use in unnecessary ER, unnecessary hospitalizations, they really adhere to their medications. So their quality of life is incredibly important to our employers, they want the presentism, they want the kids in school so the parents work and they want the parents healthy. We work very closely with pediatrics to make sure the BMI issues and all the issues that keep children, that later on will affect our adult panels, they work very closely together to really focus on the entire picture. So the hope is that we just keep getting better and better and better at care coordination, at what else is needed besides care coordination, as Deb said we got 20 programs that surround it. With behavioral health, we've been doing for probably, we brought it internal in January or April, but we would love to get much more closer with patients that access for behavioral health. So it's just meeting the needs, it's constantly assessing the needs of the community and our patients and our members and making sure we're meeting those needs to stabilize them and decrease their costs and improve their outcomes. Nothing is really off the table, it's really very important that we're innovative with this program, it's a wonderful platform, I'm extraordinarily proud of CareFirst, I'm proud to be part of it. It is really focused on improving outcomes the right way, decreasing costs for the right reasons to really make sure people are healthier. We care desperately about our members."

Mr. Cardenas asked about the impact of the cost-sharing waiver on members and the backend savings for CareFirst.

Ms. Baldwin replied:

"So we started in 2015, so again I'll say that I really still want to watch the impact of the cost sharing waiver. The idea is we prevented a hospitalization because we treated you at home and you didn't have to go to the hospitalization. As you, I know that you are in this world too is, did I really prevent a hospitalization so it is a little bit of, yes we stabilized you which if we didn't do this you would have had to go to the hospital. And that's really what we've seen, that the cost-share waiver especially for those that are economically challenged, it's not as beneficial to those that say oh great thanks for the 20 dollars. But for those that say I wouldn't have if you didn't do the cost-sharing waiver. So the impact really is that we give care which is home monitoring or the comprehensive medication review, that all those benefits are covered benefits so there is not an out-of-pocket cost for them. We do think it creates an environment to improve their health care. Now did they avoid the hospitalization? Well, I'll tell you yes I believe so, the data shows that we decreased hospitalization readmissions."

Ms. Rivkin added:

"So if I can just add to that for a second because this is something I'm so proud about our company. I believe we're the only company, the only insurance company in the country that's ever thought about this, And you know when you looked at what happened through the ACA the philosophy was let's take away the member's barrier of cost for preventive care. And we thought about it, Jennifer and her team and Chet, and said wait a minute who's actually accessing care all the time, who's the one that's actually putting out money week after week, the one that the people we want to get healthier, right, that are really sick. So we were that novel I think, and focused on our members to say let's take away that barrier and that's why it's one of the perfect reasons when I say we're doing the right thing now we don't need to be incentived more. We created it on our own, no one told us to do that and no one and we didn't follow anyone else, we're leading in this space. And I would ask and I'm sure Kaiser would be the same and any other carrier that

comes into the individual market hopefully, that we sit down with you and can have a long conversation but what we're doing might beyond what we're doing today that you're get that comfort that we're really doing a lot for the member today and don't need that incentive to do more because we are constantly moving, think changing our ideas, expanding on things that we need to, and pulling back on things that aren't work. I mean it is really an elastic program and we learn every day from what we did and we learn what works and what didn't."

Ms. Baldwin added:

"I would like to add, we added a really innovative program recently. It's called the IAA, the intake assessment and appointment team. We found one of the barriers to care for behavioral health was an appointment, and I don't know who to go to or where to go. So we have . . . what we have behavioral health care coordinators manning a phone that people call, the number is on the back of their card, they call all day and we get them appointments and we do either warm transfers and then we make sure they went to their appointment. We also have a hotline you can call and there's been things that have just taken me back, there was a dad that went to pick up his child at school and was told that they could not release the child to them unless they knew he had an appointment with a psychiatrist and he called us and again not sure why he called CareFirst but I'm so happy he did. And we were able to make sure that appointment was not only did we find the right practitioner in their community but then also made sure he had the appointment to be able to go to. That's been around since April 1, the amount of the calls that come through the IAA, that's the acronym that we use obviously, the intake assessment and appointment team, and the care that they're giving to individuals, making sure they get the right place and the right service has really has been remarkable and I'm very proud of it."

Mr. Cardenas asked for a description of the extent of supports provided by CareFirst to address social determinants of health among their members.

Ms. Baldwin replied.

"So we don't have any transportation issues. What we do have—so our care coordinators do find out what's in the community, so we build a clearing house that's county, state, federal, and we find that we get our expertise and we have a thing that's online that really says put in the county. Do you need transportation, and then where is it? We're just building out the behavioral health component too, as well. Guides to make sure you have those resources. CareFirst itself doesn't have a bus as of yet, but it is the idea to make sure that we do leverage other resources and get members to them. And, obviously, from the beginning that, when people are unhealthy, they don't have the energy, the time, or the wherewithal, really, to figure all that out. And that's what the care coordinator really does."

Ms. Eberle asked how the PCMH program at CareFirst has affected hospital costs in its lifetime.

Ms. Baldwin replied.

"So I think, with the waiver, you know, it does… if… it's a little bit different answer in Maryland because it's days that you look at. It's utilization that you look versus the cost because the waiver does that. So the days that I shared with you is what we measured before, which was a… 19 percent fewer days in the hospital for 2017."

Ms. Eberle asked Ms. Baldwin to clarify whether that decrease was year-over-year or over the life of the program.

Ms. Baldwin replied.

"That's the one year. From the beginning of the program, from its inception in 2011, it was 21.3 percent fewer hospital admissions and 7.8 fewer days in the hospital. We measure from the beginning of the program and we measure annually."

Ms. Eberle asked whether the figures cited earlier regarding the number of members receiving care assistance and the number of surveys taken covered only the PCMH members.

> *"Everybody's in the program when you go to a primary care physician. A physician is in the program. So, we have 4,400 physicians in the program. All CareFirst members that go to that physician or that nurse practitioner is considered—attributed to the program."*

Ms. Rivkin added.

> *"So they're eligible for those supports, right?"*

Ms. Baldwin continued.

> *"What we do—we proactively make sure that… So, as I said before about we look at this core target list to make sure those that—or the CKD list—to make sure those that have needs, that we are reaching out to them. The primary care physicians do exactly the same thing with their EMRs to make sure those patients—they'll often have a patient come in and they'll call us right there and say, 'I need the LCC here.' That's another reason why the local care coordinator has to live in that region, because she will get a call to say, 'Can you come? A patient at noon today who'd really like to meet you.' So, the 5,000 was those in care plans."*

Ms. Eberle asked how many of CareFirst's 12,000 PPO members are engaging with the supports available through the PCMH program.

Ms. Baldwin replied.

> *"I don't know that exact number. We do know that… Again, we don't do anything by pro—Everybody that's in it, whether… okay."*

Ms. Eberle, noting the requested 91 percent rate increase for the PPO product next year and the fact that all risk adjustment money paid in Maryland offset the claims of PPO members, clarified that she wished to know how the supports available through the PCMH program affect premium rates for the CareFirst PPO product.

Ms. Rivkin replied.

> *"So, let me… I don't know if I really understand the question, but the PCMH program… We're talking about today about, for next year, getting the rates down is going to be based on the reinsurance dollar, right? I mean, so, what we do across the board—and we can talk to our actuaries and get better numbers. I really don't know how to… It's in our rate filings, right? But how we actually pull out for each market segment based on a PCMH program is a piece of what our rate filings are. Right? But the hope is, then, through the reinsurance mechanism, if you're taking money, and you're putting to wherever the sick members are, that will have a direct impact."*

Ms. Eberle asked again how the PCMH program is affecting rates among the PPO members.

Ms. Rivkin replied.

> *"Which is why I think I started by saying there are more PPO member—there's more care plans… there's a higher percentage of care plans in the individual market than in the small group market, the large group market, or self-funded business."*

Ms. Eberle asked how many people Ms. Rivkin described.

Ms. Rivkin replied.

"I can pull that. I just came in—so… There's a higher percentage of CareFirst members in care plans in the individual market. If you break out the individual market into the HMO and the PPO, we have a higher percentage of our PPO members… So, we've always said to you—Chet has said, over the years, and we repeatedly say we have a sicker membership in our individual market. They're older than the… They are sicker and older than they are in the small group market, the large group market, and self-funded business. And our PPO is sicker and older than the HMO, right? So, it's really, to me, it's working. We're finding the members where they are, and we have more members in care plans than are not in care plans in the PPO to make sure that we are working with those members who are the sickest."

Ms. Eberle repeated her request for details as to how the programs and supports drive down premium rates for the sickest members.

Ms. Rivkin replied.

"We'll see if we can get our analytics to pull that out."

Andy Ratner, Chief of Staff at the MHBE, repeating CareFirst's assertion that their programs are working as intended and noting that premium rate increases in Maryland remain quite high, asked what other actions might be taken in order to achieve reductions in premium.

Ms. Rivkin replied.

"So, I will tell you that I—we don't have—if we knew the answer, we would have already been saying it years ago. There's no doubt about it. Anyone could tell you that it's sobering that we've lost over 500 million dollars since 2014, and so if we had a magic bullet, we would have already told you. This is step one, and that's why we came to the legislature last year and we talked about this. The legislature, as you know, has created a commission (I forget the whole name of it… Health Care Access Commission or something to that effect) which will be looking, starting in September, at the next steps. What do we need to do? Not really sure yet. I don't have that answer. I hope to have some by the time—as we start discussing this, but they're going to be looking at things like—and this was all part of the legislation—should we merge the individual and small group market? I don't know if that's a good idea. Do we have to do an individual mandate? I mean, so, there's a lot of things that we're going to look at. Now, I will tell you… I know you said, and I think I heard you right, that Maryland's rates were higher than other states. So, that question was raised, and don't quote me perfectly on this, but I'm going to summarize. That question was asked at the rate hearing. I think you may have been there. And, one of the answers that our chief actuary said as possible reasons why the rates have not—while the rates are stabilized better this year, they weren't as high, like for example, in our HMO than they have been in previous years, he gave a couple possibilities.

One is our All-Payer system, right? We cannot negotiate with hospitals at all. So, we don't have the ability to take our market share and drive down rates in hospitals, so, and our members go to Hopkins. Our members go to Maryland. They're expensive academic centers and we have to pay what the state tells us we have to pay. So, no other state has that as a barrier to try to bring rates down. And there's great things about, obviously, the All-Payer system, but that is something that impacts our ability to cut rates down.

The other thing that he noted was that a lot of the states that have been very successful in getting rates down compared to Maryland is we look at our brothers and sisters in blues plans or, I guess, throughout the state, is that they have had the ability to narrow networks and they have seen, over the years, that, because of the ability to narrow networks, their rates have gone down. So, they have adjusted based on what's happened in the marketplace. That has not happened here in Maryland.

Um, and so those were two theories that were raised how we're different than the rest of the country."

Dana Weckesser, member of the MHBE Board of Trustees, asked what CareFirst is doing to prevent morbidity among their members.

Ms. Rivkin replied.

> *"So, let me—I'm going to hand it over, but we focused on what we're doing for the sickest because that's what the discussion has been about the reinsurance program, right? Keeping the high-risk enrollees. That's specifically what it was about, and are we managing the care of high-risk enrollees and that's why we focused on that but we certainly are doing things across the spectrum."*

Ms. Baldwin added.

> *"There is an entire wellness—there could be another hour of the presentation to make sure that we have access of wellness programs for our members. But, you asked more for the primary care physicians. You can't listen to the radio or the television and not realize lifestyle is a huge impact. Many of the offices have embraced transformational things specific to exercise or diet or nutrition. For those that are sicker, like our chronic kidney disease patients, nutrition is critical for them to have that. Like the yoga, the hyperten—all those things are very important and primary care has embraced many of that. Many have different programs that they have to their practices and have gotten very much into that. Just because I think the evidence-based practice has shown that's where so much of the work should be. Especially pediatricians, I mean, they've done a lot. Pediatricians."*

Wayne Wilson, Vice President of Government Programs and External Affairs, Kaiser Permanente, offered the following testimony:

> *"Once again I'm Wayne Wilson, Vice President of Government Programs and External Affairs at Kaiser Permanente, and I'm going to do a little more reading but hopefully that will keep me on course because I have a lot of passion around this particular discussion. In fact one of the things I'll open with is a little bit of what Andy just asked which was gosh with all the programs that are in place, it's still being this struggle to stabilize the market and create some level of affordability. What is the structural challenge? At Kaiser Permanente we firmly believe that a huge part is the fact that there no incentives to drive the kind of performance across both provider behavior, and to help members that have been proven to actually make a difference when it comes to both managing costs and outcomes to members. I'll probably to go back to this but let me give you one—a couple quick examples. You think about the federal program, Medicare Advantage, what is probably one of the most celebrated in terms of its ability to both improve health outcomes and manage costs, has a program called the Medicaid five star program, which is designed to address things that have to do with incenting providers and members around their care. The state of Maryland's Medicaid program has 13 value-based purchasing incentives that Medicaid health plans have the opportunity to benefit from provided they are able to demonstrate, once again designed to target both clinical outcomes and member experiences so we're get into that a little further.*
>
> *One of things that we didn't do, else I would have brought one of the clinical leaders from Kaiser Permanente, is address deeply population health because we knew that was coming up, we really wanted to give you a sense of programs that make sense for them, the individual market. So I guess I should take a moment and say thank you once more because you heave both the Maryland Health Exchange Board and the MIA have really devoted a tremendous amount of time around, one, instituting reinsurance but also recognizing the necessity to take a look at—are there incentives that actually make a difference in as opposed to just instituting a reinsurance program. And I would even mention or remind folks that as the CMS checklist for the 1332 state waiver states that CMS requires states to address whether reinsurance programs include incentives for providers, enrollees, and plans to continue managing care costs and utilizations for individuals for the described reinsurance program. So this is really about how do we close that complete loop because to your point Andy, just the reinsurance program by itself, really oddly enough does not address the opportunity to. This is a little bit of an old-fashion statement but I think we all agree, entities tend to follow the dollar so having a lot of programs are one thing, but it's different when there's*

an incentive that if they don't perform to it that there's then a consequence that's associated with it. It's one of reasons again, why the Medicare Advantage program and state Medicaid programs have made a difference.

So having said that let's talk a little bit further. As I said the Maryland HealthChoice value-based purchasing initiative, every Medicaid program that participates in it has the opportunity to take advantage of the 13 value-based purchasing measures. And one of the things that's really instrumental in that is that the incentive has a de-incentive, a neutral, and a gain to it. And so based on budget, it can't be paid above what is in the total budget but also if one exceeds the value-based purchasing performance they have the opportunity to receive the positive element of that consequence. Within the Medicaid Advantage program the state it gives the Medicare star quality system and it is designed to address the categories around quality and customer service. Forty-something measures under five categories, staying health which includes through the question that was asked earlier around screening, tests, preventive things that not only are designed to identify conditions but really help in, help perform that platform to manage that care as well. Managing chronic conditions, plan responsiveness to care, member complaints is one thing to need a service this is another thing to be able to get that service efficiently, and then just plain old customer service. So these elements have made some defining differences and the insurers that participate in Medicare Advantage and at Kaiser Permanente and even beyond that there is a host of data that really celebrates the success that's occurred in being able to maintain a trust fund as a result of this type of program.

So I want to shift a little bit and talk about the individual market specifically and your question around utilization management. We believe, Kaiser Permanente believes that the stated based reinsurance program designed should be designed to incentivize the individual market to manage care and provide efficiencies. And it's not uncommon as was kind of mentioned earlier to recognize that highly managed HMOs are considerably less expensive than PPOs. Let's talk a little bit about what that really translate to. So Millerman recently conducted a study that looked at the difference between highly managed HMOs versus loosely managed PPOs, and found that there is a 27 percent advantage in terms of efficiencies over, in a highly managed HMO versus a loosely managed PPO; they looked specifically at the state of Maryland. And so I want to talk a little bit about how they sorta set that up, they looked at a loosely managed again PPO versus a well-managed HMO but the factors were essentially a $1,500 co-pay with a $20 PCP cost and a $30 specialty so the payment to the member was sorta neutralized. But what came out of it were the factors that demonstrated why a highly managed HMO performed better. There was a host of things, and I'm just going to read a few of them. One was active use of evidence based treatment guidelines, another was programs that educate physicians on ways to provide care and efficiency, financial incentives for providers for efficient utilization, on-site utilization management. For in-patient services there's actually a pretty healthy list of, I'll just address a couple others here, disease management programs targeting persons with particular disease states, active use of case managers to facilitate treatment and acute and chronically ill patients. What is interesting is we heard a lot of these things, however when there is incentives attached to it, for example I'm going to go back to the Medicare Advantage example again. The same providers that see individual market members and that see Medicaid members are the same providers that see Medicare Advantage members, but there is an incentive by those Medicare Advantage plans to really drive performance through those providers and assist those members, and that ultimately helps to, through those incentives to address the overall cost challenge. And so it's not that programs themselves don't have a genuine capability but I go back to the statement I made earlier it's been absolutely proven that when there is a financial motivation that there tends to be a better outcome, so that's really the point I wanted to make there.

Talk a little bit about quality, so carriers in the individual market should be incentivized to improve quality. And CMS was interesting in the individual market, CMS actually has a quality rating score, it's based on HEDIS, and I think everyone is familiar with HEDIS as the Healthcare Effectiveness Data and Information Set, and which are, you know, clinical quality areas and caps, the customer assessment of the health plan. So it goes back to, you know, the types of things that we were just mentioning regarding preventive care and things of that sort but also how the member experienced things. So there is a score, it's a five star rating but there is no incentive to it, there's no if you do well you receive a certain gain and if you don't

with regards to that you do not. So one of the things to consider as you think about, you know, how to implement something like this there are easily two or three templates that are available, one you can utilize wrapping incentives around the current ratings that are associated with the individual products that are on the exchange. The second is there is a lot that can be mimicked directly from how the Medicare Advantage five-star plan works, and in fact I would even go as far as to say the learnings from that program were part of what helped to create the original quality ratings scores that are associated with the individual market. However there was no financial incentive to it, it was a way to attract people but not really direct providers around really improving cost.

So again one of the questions that you had that I think is really a big one which is around funding, you know, how should the funding mechanism be and that sort of thing. And so first and foremost we think it should be straightforward that there should be an annual percent that is allotted to the incentive program, and that for example and this is just an example remember, if it there were 10 percent, we think it needs to be something that is meaningful and material or else it probably won't be enough to move the needle. But that the payment would essentially be a multiplier so that if someone achieved the target or goal amount of performance then that multiplier would be provided, it would be retroactive obviously, looking back over a period of time. We think this kind of approach is really simple because I think one of the challenges is really around just ensuring implementation makes sense but because of the factors state and federal programs that actually do this today, it's not a new start. And I would also say I know that the—JP as you mentioned earlier the idea is to have incentives implemented for 2020 and I would also say take a look at 2019 because the benefits of both if you think about it from the perspective of really being able to lower premiums then the sooner that can occur then the sooner Marylanders can really benefit from the fact that incentive programs will be a part of that vehicle that will help to stabilize the market and ultimately drive down costs for members. So I guess I will move a little bit on to conclusion and simply say that Kaiser Permanente absolutely agrees with reinsurance as a vehicle that will make a difference but equally we believe that offering incentives to actually impact the our providers and our members in a way which the behaviors will drive down costs similar to the way it's occurred in Medicare Advantage and in some Medicaid programs, is that additional instrument that is lacking. And so we absolutely, I did not bring, you know, our performance against quality and this, that, and the other, but I would certainly if you need any of that kind of information to get a sense about why we so strongly about this, it is an absolute area that we would be more than happy to provide the types of programs in particular, we'll document it locally, nationally, etc. So let's see, so with that I think I'll just take a pause and ask if there are any questions that I can answer and thank you again for allowing me to share some thoughts here."

Mr. Cardenas thanked Mr. Wilson for his testimony and asked whether Kaiser Permanente has ever modified their business practices in response to performance incentives provided by Maryland Medicaid and whether such changes have materially affected patient outcomes.

Mr. Wilson replied.

"So, it's… It's almost like a… It's a great question because Kaiser Permanente's foundation, really, is built on doing the kind of things that—well, first of all, Kaiser Permanente participates in all the markets, so sort of like it was stated with CareFirst, at Kaiser Permanente, all members truly do get the programs that are designed around preventative care, that are designed around screenings, that are designed to pull the member in so that we quickly understand what their needs are and can ensure that they get to the settings of care that are most appropriate for that member. One of the comments, as an example, that was described around network, which is really interesting. We have members that certainly go to University of Maryland, Johns Hopkins, etc. We also recognize that there's efficiencies and that they're important. So, it's important that the member who goes to one facility, it's the best facility for that member's needs versus another facility. So we, intentionally, really, work towards identifying where is the best site of care for that member to get the kind of outcomes that the member needs but that is also very efficient so that we don't just sort of leave that to occur just by the member's knowledge."

Mr. Cardenas asked, given Kaiser Permanente's staff model, how incentives would pass through to providers in such

a way as to effect a material change in care administration.

Mr. Wilson replied.

> *"So, you're right. Kaiser Permanente is a staff model. There are some providers that are not Kaiser Permanente-employed providers that we have individual provider agreements with and we really apply the same expectations with them. We certainly look towards having our members utilize the Kaiser staff model facilities as much as possible, but within those that tend to have needs that are outside of that, they have… you know, we have contracts that are designed to affect the same kinds of behaviors because, again, I know we're talking about the individual market, but we apply the same rules in the markets that have utilization and quality incentive programs tied into them today, so we take that same framework into those relationships."*

Mr. Cardenas asked to what extent Kaiser Permanente's performance on quality indicators is a result of their captive population who cannot go to another provider when they choose.

Mr. Wilson replied.

> *"I want to make sure I'm answering that the right way, so to what extent does the performance of our programs impact the member? Is that what you're..?"*

Mr. Cardenas clarified his question. He asked to what extent the performance of Kaiser Permanente of those indicators is a direct result of members not necessarily being able to go elsewhere.

> *"I got you. So, that's a very interesting question, there. Again, if we were to look at the fact that our members… When we… So, some of the things that we do. We measure the absolute ratings that are provided by third—what I would call third and neutral party entities. Whether it is NCQA, whether it is Medicare's five-star, or it is the Medicaid programs. And because they directly influence our—they directly reflect, in part, that member experience. We look at that greatly. And, needless to say, across each of those programs, Kaiser Permanente has been a leader. So, we know that the impact that the fact that those members come to Kaiser Permanente facilities have a great influence. Where I, candidly, can't give you a specific answer is if members that go outside of the Kaiser Permanente network—those members' influence on our performance is much less because we put the same expectation in a contractual relationship with those providers. The same framework, the same education, those sorts of things. We do recognize that if a member goes to a Kaiser Permanente facility they—it's a one-stop shop, so they kind of get everything, but when you're outside—which is one of the major conveniences, one of the reasons that members choose Kaiser—but the fact of the matter is that our sort of holistic approach of how we manage care across the continuum is extended to those providers that sit outside the network. But, candidly, our goal is to have them within our system and be able to perform this. I don't want to lose sight of the fact, though, that, because I really felt like a big part of what you wanted to gain from today's discussion is, essentially, do these incentives move the needle? The fact of the matter is it's proven. I mean, you can google any article that says, 'Does Medicare Advantage make a difference in Medicare?' and I'll tell you, savings is down. Member outcomes are better. And those programs are designed based on incentives to providers."*

Ms. Eberle asked for details on what programs Kaiser Permanente has in place and how those programs impact premium rates.

Mr. Wilson replied.

> *"So, let me just start by saying I probably should have brought a clinical leader here for you to really kind of give you some similance [sic] around the broader programs. What I would say is that from the moment a person becomes a member of Kaiser Permanente the first goal is to get the member engaged into the system so we can help them understand how to fully take advantage. Though I wouldn't call that a clinical program, but it really is an orientation to the fact that they have care in abundance and perhaps in ways*

which they aren't very familiar with. Through that, we get a lot of the diagnostic stuff done. We actually begin to engage the members then that are identified for specific types of needs because there is typically an assessment of their health that's done, and out of that we can then determine immediately if they need things like case management which they would be, then, provided or other types of services, for example a member could come in in that engagement and it be determined that, you know, perhaps they need to have their eyes checked. We could send them right down the hall and they have that kind of service done, and that all gets incorporated into a way to more holistically, constantly be managing that member's care.

To the extent that the second part of, kind of, how is that…? I just want to say what are the implications of that? You know, candidly, we think it's… that's the reason why Kaiser Permanente gets the marks that it does in terms of overall quality, and that's both in clinical quality, that's in member satisfaction. So, again, I probably would have been best served to have one of our physicians or one of them to come in and really walk through those programs, but what I thought we really wanted to address as well is do these incentive programs make a difference or if you don't incent and just leave it up to the insurer to just do their thing, are you going to see a change? The fact of the matter, other programs have proven that, if you don't do anything, you get the same. It's not that, obviously… we're ecstatic that reinsurance is here, but we strongly believe that managing care without an incentive to manage that care doesn't fully meet the need or the opportunity."

Ms. Eberle noted that the MHBE would appreciate Kaiser Permanente's clinical expert being present at the next hearing.

Mr. Wilson replied.

"Sure, okay. Yeah, because we'll get population health and that's exactly how we had it planned."

Ms. Eberle asked, noting that Kaiser Permanente has experienced high levels of membership growth in the last 4 years, how the cost containment and utilization control programs have affected premium rates.

Mr. Wilson replied.

"Yeah, I think both of our organizations would say that maintaining them is not—that has not happened, right? So we both—I think we've seen a 28 percent loss over the course of the past 3, 4 years overall. In terms of… We… Kaiser looks at it like, without these types of programs, where would Kaiser Permanente be in terms of the degree of loss in this market? I can't give you the factual number. I'll make sure I get to you. 'Drastic,' though, is the word I'd like you to capture with that. There's no question the fact that we go the additional miles to engage the member to get in for service and those kinds of things make a difference. But I think it would be helpful to your question, Michele, to give you a specific number that says how we see the value of those programs, I think, impacting the cost change or the expense change."

Mr. Ratner noted that only two carriers exist in Maryland's individual market and that only CareFirst operates statewide including in rural areas that have older populations. He noted, further, that Kaiser Permanente's market share has grown nine fold since the ACA reforms. He then asked whether Kaiser Permanente's membership among the older, sicker residents of Maryland has increased to the same degree.

Mr. Wilson replied.

"I'll make sure that we get that captured. I would go to say we probably haven't seen a disproportionate share. We—at Kaiser, we do have certain conditions that we tend to have a higher percentage in. For example, HIV and AIDS we have a higher percentage in. And that may be… that may be, in part, because of the fact that Kaiser services are, you know, pretty broad and those kind of members can really get coordination across every element. But I'll make sure that we can answer that question more specifically for you."

David Stewart with AHEC West offered the following testimony:

> *"I wasn't planning on talking but I got inspired. What's missing for me is context a little bit. What I think I'm agnostic about incentives, my real concern is social determinants of health, it's what I talked about last week. It's would be really interesting, I think what's missing is a measure of those risk factors that can be used to put the data in context, right. So all the numbers that we've heard, particularly from CareFirst, I don't know how that relates to people who have high social risk factors. And I think that's just something at this stage of the game if we really want to move the dial on health, we have to start tracking that. We have to start matching where did people fall on the scale of social risk, right, look at it according to it to their regions because we know that rural and urban areas have different, have higher social risk factors in many cases than suburban areas, more affluent areas. So I really don't have a whole lot to say but I just feel like there really needs to be some kind of a measure to put this in context for us, because are these increases and decreases and bad outcomes is that with affluent people that live in the suburbs, is it with people who live in Allegany county, is it people who live in West Baltimore, I'm not sure. And I just can't help but believe that given what I just see in my neighborhoods and where I live that some of these programs aren't as effective in the areas with high social risk factors as they might be in other. So that's all."*

Mr. Cardenas thanked Mr. Stewart for his testimony.

Barbra Banks-Wiggins with Prince George's Health Care Alliance offered the following testimony:

> *"Hi, I'm Barbra Banks-Wiggins with the Prince George's Health Care Alliance. Thank you for giving me the incentive to come up and speak. The Prince George's Health Care Alliance is a non-profit organization formed from a four year grant from the state focusing on the impact of addressing social determinants of health on utilization and hospital spending. So we had a four year grant where we created a care coordination community health workgroup program among other things. Focusing on what the social issues are that are keeping patients who turn to the hospital utilizing the emergency department. And the community health workers would connect and develop pathways on how to address all of the needs that these high risk, high frequent utilizers had, identifying what the whole challenges are and helping them to address those challenges. My community health workers, some of whom are here with me, this was a very passionate topic for us. We actually go where a lot of insurance companies don't go, and that's into the home and connect with the patient and their family and find out what is your challenge, how can we help you. So we establish the social determinant, assessment, developing care plans and goals to help them get the services that they need, connect them to the resources. And our grant partnered with Prince George's Hospital center and we were able to reduce for the patients admitted to our program—we were able to reduce their hospital utilization by over 54 percent during an 18 month period. That's important and—but community health worker services, addressing social determinants of health are currently not a reimbursable, recognized—billable, you know, charge. So therefore we are funded by health department, we're funded by hospitals that support this effort but—and assisting with utilizing management and outcome., I would recommend part of the state reinsurance program or other programs from the state recognize the impact from deliberate social—deliberate focus on reimbursing providers who address social determinants of health."*

Mr. Cardenas thanked Ms. Banks-Wiggins all of the important work that they do. He noted that it important to consider how insurers and community health address social determinants of health and they could potentially work together.

Mr. Cardenas then invited any attendee on the phone or in the room who so desired to offer testimony for the record. No one offered testimony.

Closing

Mr. Cardenas closed the hearing and thanked everyone who attended.

Participants

Maryland Health Benefit Exchange
Dana Weckesser, Member, Board of Trustees
Michele Eberle, Executive Director
John-Pierre Cardenas, Director of Policy and Plan Management
Andy Ratner, Chief of Staff

Maryland Department of Health
Jinlene Chan, Assistant Secretary Public Health Services Chronic Hospitals

Members of the Public
Lisa Skipper
David Stewart
Julie McQuie
Emily Ewing
Karen Millison
Wayne Wilson
Beth Mays
Sean Gibson
Debbie Rivkin
Jennifer Baldwin
Natasha Murphy
Somany Benaave
Jared Sussman
Barbara Banks-Wiggins
Matt Celentano
Monica Spunn
Maria Elena Analuise
Angie Chappell
Janell Bunamy
Laurie Kuiper
Ken Brannan
Dourakine Rosarion