Review of the Missions and Responsibilities of the Three Health Care Commissions

Background

In December 2015, the Department of Legislative Services (DLS) completed preliminary sunset evaluations of the Health Services Cost Review Commission (HSCRC) and the Maryland Health Care Commission (MHCC). These evaluations concluded that both commissions function well to fulfill their expanding statutory requirements, meet their respective performance metrics, and provide important policy guidance to the State. Both evaluations noted concerns about MHCC and HSCRC regarding resource constraints due to expansion of the commissions' responsibilities. The evaluations also noted that the landscape of health policy in Maryland has changed significantly. In particular, under the Maryland all-payer model contract, the State is moving to a population-based approach that now impacts both hospitals and community providers. DLS noted that the *three* health care commissions, HSCRC, MHCC, and the Maryland Community Health Resources Commission (MCHRC) may have developed overlapping responsibilities.

Based on these findings, DLS recommended that the Legislative Policy Committee waive HSCRC and MHCC from full evaluation and require DLS to conduct a review of the missions and responsibilities of all three health care commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned. This response presents key observations and two recommendations resulting from this review. All three commissions were provided with a draft of the report for their review and comment. Written comments from HSCRC and MHCC are included as attachments to this review. MCHRC provided corrections but no formal written comments.

The Missions of the Three Health Care Commissions

MHCC is an independent regulatory agency within the Department of Health and Mental Hygiene (DHMH). MHCC's mission is to plan for health system needs, promote informed decision making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policymakers, purchasers, providers, and the public. MHCC is composed of 15 members appointed by the Governor, with the advice and consent of the Senate.

HSCRC is an independent regulatory agency within DHMH whose primary mandates are to review and approve reasonable hospital rates and publicly disclose information on the costs and financial performance of Maryland hospitals. The commission establishes hospital-specific and service-specific rates for all inpatient, hospital-based outpatient and emergency services. HSCRC is composed of seven members appointed by the Governor.

MCHRC is an independent commission. The commission supports the development of community health care resources by awarding grants to expand access in underserved areas and support public health priorities; implementing the Health Enterprise Zone Initiative; and supporting local health improvement coalitions and efforts to promote population health initiatives. MCHRC is composed of 11 members appointed by the Governor.

The All-payer Model

One of the most significant developments in Maryland's health care system in recent years is the all-payer model. Effective January 1, 2014, Maryland entered into a contract with the federal Centers for Medicare and Medicaid Services (CMS) to replace the State's 36-year-old Medicare waiver with the new Maryland all-payer model. Under the waiver, Maryland's success was based solely on the cumulative rate of growth in Medicare inpatient per admission costs. Under the new model, however, the State will:

- limit all-payer per capita inpatient and outpatient cost growth;
- constrain Medicare per beneficiary hospital growth;
- shift hospital revenues to a population-based system and;
- reduce both hospital readmissions and potentially preventable complications.

The model agreement with CMS will be deemed successful if Maryland can meet cost and quality targets without inappropriately shifting costs to nonhospital settings and if there is a measurable improvement in quality of care.

Building on the success of the first phase of the model, HSCRC is developing and implementing changes that will shift the focus from the cost of hospital care to the total cost of care in the State. A plan for phase two of the model is due to CMS by the end of 2016. The key themes of the draft plan circulating in early November are to (1) foster accountability for systemwide and patient-level goals; (2) align measures and incentives for all providers; (3) encourage and develop payment and delivery system transformation approaches; (4) ensure availability of tools to support providers in achieving transformation goals; and (5) increase consumer engagement.

The progression of the existing model to phase two will include integrated care incentives, such as integrated care networks, pay-for-performance programs, and gain-sharing programs to achieve the goals of care coordination and provider alignment. The State has received approval for an amendment to implement specific care redesign strategies, which will allow hospitals to access comprehensive Medicare data, share resources, and offer incentives to nonhospital care partners. Changes will also emphasize the utilization of the Chesapeake Regional Information System for our Patients (CRISP), the State designated health information exchange, and other health information technology (IT) tools.

Resource Constraints for Regulatory Commissions

Both MHCC and HSCRC are special funded using user-fee assessments generated from the entities each commission regulates. MHCC is funded primarily by user fees assessed on health care payers, hospitals, nursing homes, and practitioners. By law, the maximum limit on user fees collected by MHCC is $12 million, and the fees are assessed based on the portion of the commission's workload attributable to each industry. The assessment was last increased to $12 million from $10 million by Chapter 627 of 2007. In the preliminary sunset evaluation, DLS noted that commission expenditures have exceeded the cap since fiscal 2014, mainly due to increases in personnel and contractual services costs related to the development and operation of large IT projects. DLS recommended that the cap be raised to $15 million.

HSCRC is funded through the collection of user fees assessed on all hospitals (including private, psychiatric, and rehabilitation hospitals), with rates approved by the commission. HSCRC's total user fees are also capped by statute at $12 million, which was last increased from $7 million by Chapter 263 of 2014. The significant increase in direct costs incurred by HSCRC over the last two fiscal years is a direct result of contracts related to the implementation of the model contract. In the preliminary sunset evaluation, DLS noted that this amount is likely sufficient to cover expenditures within HSCRC's current scope of activity. However, should HSCRC, in conjunction with CMS, attempt to expand the scope of the model contract, HSCRC's user fee cap may need to be raised.

Substantive Roles and Responsibilities Shared by Multiple Commissions

To complete this review, DLS conducted interviews with representatives of all three commissions, researched the commissions' statutes and regulations, and reviewed inter-commission agreements and memoranda of understanding (MOUs). The most pervasive theme that emerged is that, as the commissions have evolved, some of the most substantive roles and responsibilities are increasingly shared by more than one commission. This creates the potential for tension between the commissions, as well as confusion for entities regulated by or seeking grants from the commissions.

Overlap Between the Health Services Cost Review Commission and the Maryland Health Care Commission

The duties and responsibilities of HSCRC and MHCC increasingly overlap in four main areas: (1) oversight of the Certificate of Need (CON) process; (2) oversight of the statewide health information exchange (HIE); (3) creation of the Integrated Care Network (ICN) project; and (4) use and management of the Medical Care Data Base (MCDB).

Certificate of Need

The CON program, located within MHCC, is one area where HSCRC and MHCC interests and responsibilities significantly overlap. CON is intended to ensure that new health care facilities and services are developed only as needed and that, if determined to be needed:

- are the most cost-effective approach to meeting identified needs;
- are of high quality;
- are geographically and financially accessible;
- are financially viable; and
- will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services.

The CON program requires review and approval of certain types of proposed health care facility and service projects by MHCC. With certain exceptions, a CON is required to:

- build, develop, or establish a new health care facility;
- move an existing health care facility to another site;
- change the bed capacity of a health care facility;
- change the type or scope of any health care service offered by a health care facility; or
- make a health care facility capital expenditure that exceeds a threshold established in Maryland statute.

Overlap between HSCRC and MHCC occurs within the hospital CON process because while MHCC is responsible for determining the size of a hospital facility, HSCRC is responsible for setting its rates. HSCRC's role has expanded under the Maryland all-payer model contract, where hospitals have been transitioned to Global Budget Revenue and Total Patient Revenue agreements. As of October 2016, 96% of all hospital revenue in the State has been transitioned to global budgets; the remaining 4% is excluded out-of-state revenue from three hospitals. Because hospital revenues are so tightly regulated under the model contract, any analysis related to CON necessarily involves a discussion of the revenues of not only an existing hospital's expansion, but also the revenue impact of any expansion or construction of new facilities on other hospitals in the State. Thus, global budgeting under the model contract makes the hospital CON process critical to the model contract, and a significantly more collaborative process between MHCC and HSCRC. Some steps have been taken to address this overlap, for example, an MHCC commissioner currently serves as an *ex-officio* member of HSCRC and an HSCRC commissioner has been invited to serve in the same capacity on MHCC, but has not yet been appointed.

Statewide Health Information Exchange

Another area where significant overlap is apparent is with the State-designated HIE. An HIE is an infrastructure that provides organizational and technical capabilities for the electronic exchange of health information among entities not under common ownership. Both HSCRC and MHCC took separate actions to designate CRISP as the statewide HIE in 2009, and the

infrastructure became operational in 2010. MHCC redesignated CRISP as the statewide HIE in 2013 and 2016, making significant changes in the designation agreements in each year to reflect CRISP's expanding responsibilities. Since the initial designation, MHCC has been the primary oversight entity for CRISP. MHCC also has authority to adopt regulations for the privacy and security of protected health information obtained from or released through an HIE. State appropriations to support CRISP development, expansion, and operations have flowed through MHCC's budget and MHCC has been the primary entity tasked with promulgating regulations concerning CRISP, particularly regarding protected health information. However, § 19-143 of the Health-General Article assigns the duty of designation to both MHCC and HSCRC, and a substantial portion of State funding for CRISP comes from hospital assessments that are determined by HSCRC, even though they are appropriated through MHCC's budget.

Integrated Care Network

Overlap between HSCRC and MHCC has progressed with the advent of the ICN project. The project, which began in fiscal 2016, is intended to create a system where multiple providers can coordinate care and integrate their efforts to better meet the needs of patients and the goals of the all-payer model contract. Both MHCC and HSCRC have engaged CRISP to begin the buildout of the software and other IT infrastructure for the ICN, with expenditures totaling approximately $18.0 million in fiscal 2016 and an appropriation of $25.0 million in fiscal 2017. However, funding for the ICN project flows through HSCRC even though MHCC has the infrastructure in place to oversee CRISP. There are also competing ideas between the two commissions on what the goals of the ICN project should be and whether or not the project is meeting those goals. To date, the ICN project has been run by HSCRC, as HSCRC was responsible for the project's initial design. However, MHCC has been given a partial oversight role, primarily due to MHCC's historical oversight of CRISP. The problem with this arrangement is that, while both commissions are charged with oversight, HSCRC has greater authority over this particular project than MHCC, creating tension in light of the conflicting visions for the project.

Medical Care Data Base

MCDB is Maryland's All Payer Claims Database comprising enrollment, provider, and claims data for Maryland residents enrolled in private insurance, Medicare, and Medicaid. Five separate files containing eligibility information, professional services claims, institutional claims, pharmacy claims, and a provider directory are available for each year. MCDB supports estimates of cost and utilization, as well as policy analysis and evaluation and has continued to evolve in both its substance and relevance to the State.

MCDB, which is maintained by MHCC, has grown more sophisticated over the years as different stakeholders have sought to utilize it. Most recently, HSCRC began using MCDB to monitor total cost of care metrics that are key performance measures for the all-payer model contract, and are assumed to be an even larger component of the next phase on the model contract agreement that is currently under negotiation. In order to ensure MCDB is useful for this purpose,

additional functionalities were added in the most recent contract procurement signed by MHCC. The most notable increase in cost involved the acceleration of reporting timelines from annually to quarterly. As such, HSCRC recently agreed to begin paying $500,000 annually to MHCC, beginning in fiscal 2018, to cover the increased costs of operating MCDB. However, in order to get to such an arrangement, a fully executed MOU had to be negotiated between the two commissions concerning both the costs of MCDB and what functionalities would be involved in any new project. Negotiation of MOUs between the commissions is a drain on resources as they require an extensive amount of commission leadership's time and effort.

Other agencies, including the Maryland Insurance Administration (MIA) and the Maryland Health Benefit Exchange (MHBE) have sought access to MCDB. Thus, MHCC is reconsidering its role concerning the oversight and management of MCDB. MHCC has four management functions regarding MCBD: (1) collecting the data; (2) editing the data; (3) maintaining the data; and (4) analyzing the data. MHCC has focused on collecting, editing, and maintaining the data in order to make the data more useful to other agencies. In addition, MHCC continues to analyze the data for statewide cost reporting as required under statute.

In order to keep the cost of MCDB low due to the statutory assessment cap on MHCC's user fees, MHCC has decided that it will only be *maintaining* the database for other State agencies. As a result, each State entity seeking to use MCDB must pay MHCC any fees associated with accessing data from MCDB, as well as procure and absorb the cost of any analytical tools that it may seek to analyze that data. As a result, the State could be paying for up to four different types of software used by separate State entities to utilize the same database. As far as the payment for access to the database, only HSCRC has agreed to contribute toward the cost of MCDB. However, HSCRC as well as MIA and MHBE will all have to procure their own data analytics vendor to analyze the same basic information. As a result, it is questionable whether this arrangement allows for the most efficient use of MCDB and raises questions as to whether redundancies in the contracting to interpret MCDB information will result in unnecessary expenditures.

Overlap Between the Health Services Cost Review Commission and the Maryland Community Health Resources Commission

MCHRC was created by the Maryland General Assembly in 2005 to expand access to health care services in underserved communities in the State. Unlike MHCC and HSCRC, MCHRC is not a regulatory agency. Instead, MCHRC's primary function is to award grants. Since its inception, MCHRC has awarded 169 grants totaling $55.8 million. MCHRC reports that the grants awarded have enabled grantees to leverage $19.1 million in additional federal and private/nonprofit resources. DLS found that, with respect to its mandate to provide funding to innovative community-based health providers for projects that otherwise would have no way of functioning, MCHRC performs adequately, with ever increasing improvement in its oversight functions and grant requirements in recent years, following negative audit findings by the Office of Legislative Audits regarding these functions.

The roles of MCHRC and HSCRC overlap, in large part due to the model contract, which focuses each commission on encouraging partnerships between community providers and hospitals in order to fulfill the goals of the next phase of the model contract. For example, MCHRC recently concluded a study of hospital and community-based health entities where it funded five different pilot projects in order to see if these partnerships could lead to a reduction in potentially avoidable hospital utilization, which is a major goal of the model contract. This is very similar to the community-based regional partnership grants that HSCRC has been pursuing in recent years, which are designed around the premise that partnership agreements between hospitals and community-based providers could lead to a decline in potentially avoidable utilization. While it is too early to evaluate the results of each commission's efforts, there is the potential that the goals and strategies of the two bodies will diverge which heightens the need for increased communication and collaboration.

Caution Warranted For Potential Realignment of Commission Functions

Despite the issues with overlapping roles noted above, there is significant reason to be cautious about proceeding with any effort to realign or condense commission functions. As noted earlier, HSCRC is developing and implementing changes that will shift the focus of the model contract from the cost of hospital care to the *total cost of health care* in the State. A plan for phase two of the model contract is due to CMS by the end of calendar 2016. The key themes of the draft plan circulating in early November are to (1) foster accountability for systemwide and patient-level goals; (2) align measures and incentives for all providers; (3) encourage and develop payment and delivery system transformation approaches; (4) ensure availability of tools to support providers in achieving transformation goals; and (5) increase consumer engagement.

The progression of the existing model to phase two will include integrated care incentives, such as integrated care networks, pay-for-performance, and gain-sharing programs to achieve the goals of care coordination and provider alignment. The State has received approval for an amendment to implement specific care redesign strategies, which will allow hospitals to access comprehensive Medicare data, share resources, and offer incentives to nonhospital care partners. In addition, the State is developing initiatives for accountable care organizations serving individuals eligible for both Medicare and Medicaid in certain regions and for a Maryland CPC+ Primary Care Home for Medicare beneficiaries that will allow participating providers to qualify for Medicare bonus payments. Changes will also emphasize the utilization of CRISP and other health IT tools. HSCRC asserts that any changes to the structure or mission of the three commissions, in particular to the structure and missions of HSCRC and MHCC, would be a distraction to their efforts to develop and implement phase two of the model contract.

Additionally, DLS notes that it is likely that phase two will require additional changes to the CON process; the duties, funding, and oversight of CRISP; the duties of HSCRC and MHCC; and how HSCRC utilizes MCDB to evaluate waiver performance. As a result, any attempts to

modify CON, CRISP, or MCDB may interfere with the complex negotiations HSCRC is currently engaged in with CMS.

Recommendations

Due in substantial part to the development of phase two of the model contract and the potential for important changes to result from any negotiations with CMS, as well as the general uncertainty as to the health care landscape following the congressional and presidential elections, DLS concurs with HSCRC's position that any substantial modifications to the mission or structure of the three commissions should wait until phase two of the model contract has been at least partially implemented.

Recommendation 1: Statute should be amended to extend the evaluation dates of both HSCRC and MHCC by three years to July 1, 2020, and require another special evaluation of all three health care commissions in 2019. This evaluation should focus on areas of overlap identified in this review, as well as any new structures that have been developed or are developing due to the implementation of phase two of the model contract.

Recommendation 2: While not currently subject to sunset review, MCHRC should remain part of any future evaluation, as it is likely that changes to the waiver will only increase the relationships between community providers and hospitals.

By providing time for phase two of the model contract to take shape, DLS hopes to avoid distracting the commissions from the sensitive negotiations already underway and the initial implementation of phase two, while balancing the compelling interests to consider realigning the missions and duties of the three commissions, in an effort to achieve greater efficiency and potential cost savings.

Beyond the missions and responsibilities of the three commissions, **DLS reiterates its previous recommendations that the user-fee assessment caps of both MHCC and HSCRC be reviewed to ensure that both commissions have sufficient resources to carry out their current missions and responsibilities.**

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December 1, 2016

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Executive Director
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Dear Mr. Deschenaux:

Thank you for the opportunity to comment on the sunset review of the Health Services Cost Review Commission (HSCRC). We appreciate the hard work that your staff conducted to review the mission and operations of the three health regulatory commissions and how they work collaboratively to advance health care in Maryland. While some of the focus of the three commissions have converged in recent years, they do so in a complementary fashion. The HSCRC and the Maryland Health Care Commission have a history of collaboration where each commission brings their own expertise and capabilities to health care challenges.

In light of the tremendous amount of work and change in our health care delivery system brought about by the Maryland All-Payer Model, which began in 2014 and continues to progress and mature, **we concur with the recommendations contained in the sunset report to extend the evaluation dates of the commissions and to include a review of the appropriate user-fee assessment of the commissions in order to ensure sufficient resources to carry out each commission's mission and operations.**

In response to this sunset report, we would like to focus our comments on the importance of the work to meet the goals of the All-payer model and the initiatives and collaborations that we are focusing on such as integrated care networks to ensure success under that model.

<u>All-Payer Model</u>

Maryland, under an agreement with the Centers for Medicare and Medicaid Services (CMS), launched the All-Payer Model in 2014 to transform the health care delivery system and improve care while moderating cost growth on a statewide, all-payer basis for the 800,000 Medicare beneficiaries and 6 million Marylanders that receive care through the hospital system.

The All-Payer Model changed the way Maryland hospitals provide care, shifting away from a financing system based on volume of services to a system based on hospital-specific global revenues with overlying value-based incentives. While still in the early stages of transformation, Maryland is already demonstrating that an all-payer system accountable for the total cost of hospital care on a per capita basis is an effective model for advancing the goals of delivering better care, better health, and lower cost. In the first two and a half years of implementation, Maryland has met or exceeded the key agreement measures for limiting hospital cost growth, providing savings to Medicare, and improving quality.

Looking towards the progression of the All-Payer Model, Maryland's vision is to achieve person-centered care, foster clinical innovation and excellence in care, improve population health, and moderate the growth in costs, on a statewide basis and in the all-payer environment through the transformation of the health care delivery system. Per the contractual agreement with CMS, the State, under the leadership of the Department of Health and Mental Hygiene (DHMH) and HSCRC, is preparing a "Progression Plan" to outline its proposal to accomplish the expanded All-Payer System goals. We have worked with a robust group of stakeholders including hospitals, payers, hospital-based providers, nonhospital-based providers, specialists, and consumers to ensure coordinated success of the progression to take accountability for containing costs and improving quality in all settings.

The lofty and far-reaching goals identified in the Progression Plan that extends and expands the existing All-Payer Model will require intensive and focused State resources. The DLS report recognizes the importance of this work and the need for additional State resources or an increase in the user-fee assessment to accomplish these goals.

Integrated Care Networks

Cited as one of the areas of joint responsibilities, the DLS report focused on the integrated care networks project, which has the purpose of putting the infrastructure in place to connect multiple providers to coordinate care and deliver better care for patients. The ICN project is indeed an important supporting tool to enable the All-Payer Model to align with the goals of other providers and also contain cost growth and improve quality across the care continuum.

There is unanimity among the commissions on the need to share data for better care coordination and health care delivery. However, CRISP and the commissions are still working through how CRISP can best participate in providing some of the back-end care transformation tools for hospitals and other providers to achieve best practices. Continued collaborations between HSCRC and MHCC is necessary to ensure that the use of CRISP tools are most efficacious to providers.

Conclusion

The development of the second phase of the All-Payer Model to extend and expand care coordination across both hospital and nonhospital providers will transform the health care delivery system in Maryland. Continued collaboration between state partners, including DHMH, HSCRC, and MHCC is critical to the success of care transformation in Maryland. In fact, the staff of DHMH, HSCRC, and MHCC are currently conducting bi-weekly coordinating meetings to maintain a common focus and avoid duplication of efforts.

We appreciate the opportunity to respond to the DLS report on the mission and operations of the three health care commissions. We believe there is great opportunity and need to work collaboratively on the

health care challenges facing the State. While there is increasing overlap in the focus of the work of the health care commissions, the work is done in a complementary fashion.

If you have any questions regarding this response, please contact Steve Ports or Katie Wunderlich at 410-764-2591.

Sincerely,

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December 1, 2016

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Dear Mr. Deschenaux:

Thank you for the opportunity to comment on the sunset review of the Maryland Health Care Commission (MHCC). Your staff have done an outstanding job summarizing the structure, financing, and performance of all three health regulatory commissions. The MHCC and the Health Services Cost Review Commission (HSCRC) have a tradition of working together on common initiatives and we appreciate your staff emphasizing those collaborations in the review. That tradition is enshrined in Maryland law and, equally important, is a part of the DNA of the two organizations. MHCC agrees that there is overlap in responsibility in a few areas, but is confident there is little duplication of effort.

There are numerous opportunities for cooperation in the few areas where the two Commissions' responsibilities overlap and in many other areas where the MHCC and HSCRC perform complementary functions. These partnerships occur in budget management, information technology, personnel management, vendor financial audit, government relations, policy analysis, and provider quality reporting. MHCC is committed to working with HSCRC to streamline further shared activities consistent with current Maryland law and any changes adopted by the General Assembly. The MHCC Chair and I would be pleased to discuss existing collaborative efforts and streamlining proposals at your convenience.

The Department of Legislative Services (DLS) notes that the negotiation of Phase 2 of the new hospital agreement will be a prime focus for Maryland government over the next two years. When implemented, Phase 2 will engage a wider range of providers in our $65 billion health care economy under the new model. As important, broader consumer and purchaser engagement will be essential to Phase 2 success. The functions of the organizations that oversee Phase 2 will likely encompass responsibilities beyond the authorities of both MHCC and HSCRC. A prudent approach when considering any alignment is to wait until the Phase 2 agreement has been finalized with the Centers for Medicare & Medicaid Services (CMS) and then conduct a careful assessment of the functions needed in the powerful organization that will have responsibility for overseeing Phase 2.

MHCC concurs fully with the recommendation including the increase in MHCC assessment cap. Since we are in agreement with the Recommendation, we will focus our response on the four areas of overlap between the MHCC and the HSCRC that DLS identified.

Oversight of the Certificate of Need (CON) Process

MHCC's health facility planning and certificate of need program encompasses health facilities, including hospitals, ambulatory surgical facilities, comprehensive care facilities, hospices, and home health agencies. MHCC also has planning authority and regulatory oversight for certain specialized services, including cardiac surgery and angioplasty. Over the past three years, MHCC has successfully modernized a number of the state health plan chapters by streamlining some administrative requirements for applicants but adding provisions that establish quality performance threshold that applicants must meet or, in the case of specialized services, maintain in order to continue providing the service.

MHCC recognizes that the current hospital CON regulatory model is not optimally aligned with the new hospital payment model based on revenue caps and mandatory savings objectives. As the Maryland hospital model evolves toward Phase 2, the Commission will modify hospital facility planning requirements to reflect the reality that the new hospital payment model does not incentivize hospitals to pursue financial success through growth in the volume of services. MHCC believes that it is prudent to consider providing hospitals with more flexibility in planning and developing capital projects that do not involve the creation of new hospital capacity or expansion of services or require modifications to the hospital's global budget. Health systems and hospitals indicate they could consider this idea in principle, but will seek commitments that the expanded global budget will provide sufficient fiscal and debt capacity for maintenance and ordinary replacement and modernization of physical plants and equipment. MHCC has initiated discussions with the Maryland Hospital Association and the HSCRC on how to set capital spending under the overall global budget. The appropriate level of capital spending to be built into a global budget, the degree to which hospitals assume risk for projects under the budget, and the mechanism for retaining unused capital budget funds are key issues to be resolved. The State also will need to consider this model carefully, because increasing GBR by an amount necessary to account for predictable capital projects could present additional challenges for meeting financial performance metrics in the State's agreement with CMS.

Statewide Health Information Exchange

MHCC is responsible for advancing the adoption and meaningful use of health information technology (health IT) in the State to improve the experience of care, the health of the population, and reduce the costs of health care. Key aspects of health IT include electronic health records, health information exchange (HIE), mobile health, and telehealth. MHCC's initiatives focus on balancing the need for information sharing with the need for strong privacy and security policies, and transforming care delivery.

CRISP is one of the strongest HIEs in the country. Maryland's current framework for oversight and development of health information technology has contributed to the increased adoption of electronic health records and use of CRISP by providers. MHCC and HSCRC share responsibility for the development of the HIE. MHCC does not believe there is significant duplication because duties are appropriately segmented. The MHCC provides technical oversight of CRISP's efforts and works with stakeholders to promote the broadest use of CRISP while protecting the privacy and the security of protected health information. HSCRC plays the lead role in determining health information technology applications that will be supportive of the new hospital payment model. In that capacity, HSCRC is also a significant funder of CRISP.

About 94 percent of the 2017 CRISP budget comes from hospital assessments that are determined by HSCRC. Funding through the Budget Reconciliation and Financing Act of 2014 specifically dedicated to ICN deployment represents another important source of funding for CRISP. Other substantial sources of funds include the Medicaid Implementation Advance Planning Development and monies from the Prescription Drug Monitoring Program. The HSCRC dollars fund development of specific functions that support the new hospital model agreement with CMS. Other organizations use CRISP to meet their own specific HIE

objectives. For example, CRISP has invested significant funds in developing a provider directory, including providers' participation in payer networks. This information can be used by consumers when they are considering enrollment in health plans through the Maryland Health Connection. MHCC has worked with the Maryland Health Benefit Exchange to enable the use of the CRISP directory rather than develop duplicative technology.

As Maryland government becomes the key customer of CRISP, MHCC's oversight functions are essential in reaching consensus among agencies on CRISP priorities, identifying areas for alignment in software development, and flagging performance bottlenecks in the CRISP technical infrastructure. MHCC works collaboratively with HSCRC colleagues, MHBE leadership, DHMH staff, and CRISP personnel, in identifying common initiatives and resolving system performance bottlenecks across multiple applications supporting State agencies. Requiring all State funds for CRISP to pass through MHCC's budget enables the Department of Budget and Management, DLS, and the oversight committees to better monitor the total level of State funding to CRISP and is consistent with MHCC's longstanding oversight function.

Creation of the Integrated Care Network (ICN) Project

The overall objective of the ICN is to development a technology infrastructure that will support a health system aligned with the triple aim and operationally support the deployment of the new Maryland hospital model. The ICN project is best visualized through the overall objective: create a system where multiple providers can coordinate care and integrate their efforts to better meet the needs of patients and the goals of the all-payer model agreement. Progress on the ICN is best monitored by tracking CRISP's progress in building seven specific workflows from foundational activities of expanding ambulatory integration and deploying a 'smart' data router to core HIE functions, including provider notifications and analytic support and then to the most expansive efforts of developing care management software and facilitating practice transformation.

MHCC believes that HSCRC and MHCC are in alignment on the overall goals of the project. MHCC provides technical guidance to CRISP in developing the ICN infrastructure, input on the goals of the project, and feedback to the HSCRC on whether CRISP is meeting those goals. While HSCRC has the authority over the direction of this particular project, involvement of the MHCC enables the alignment of the ICN with the broader goals of health IT.

DLS is correct in the assertion that some stakeholders are not in alignment with all of the methods for achieving goals of the ICN. As a generalization, everyone agrees that connecting stakeholders and routing data are important CRISP roles. Most agree that improvements to information flow at the point-of-care are important. Many, but with a sizeable minority, agree that CRISP should be creating basic reports and not just forwarding raw data. The opinions on cooperation for care plans and health risk assessment are divided. And, only a minority believe CRISP should be fostering cooperation on the software applications necessary to manage care. MHCC and HSCRC are working together to ensure that the visions for the project are achieved.

Medical Care Database

Maryland is one of 17 states to collect and maintain data on health spending through an All Payer Claims Database, called the MCDB. DLS is correct that the MCDB has expanded over the years, most recently with the inclusion of data from Pharmacy Benefits Managers and third party administrators. Multiple State agencies and other stakeholders have sought to use the data, which is collected, edited, and maintained by the MHCC, for purposes unique to the individual organization. Over the past few years MHCC has focused on creating a system for data sharing that will allow organizations to conduct their distinct data analysis needs.

The MCDB is a rich data source and the scope of applications is expanding. It is not possible for a single agency to conduct all analyses that other agencies now envision. Given limited resources, focusing on the accuracy and timeliness of that data benefits all users. This approach is consistent with approaches followed by organizations administering APCDs in other states.

DLS correctly notes that different agencies could use different data analysis software, these are decisions specific to the agency and its analysis needs. Generally agencies select analytic software based on the utility of a software product to support multiple applications. MHCC uses Microsoft SQL server for data management and SAS, Tableau, and Microsoft Excel for analysis of many MHCC data systems. These products are purchased under State contracts and licensed to specific servers (server licenses) or for a specific number of users (seat licenses). Most other state agencies have similar 'software stacks'. Because State agencies conduct different analyses and use software purchased under State contracts, MHCC does not believe cost saving or programming efficiencies could be generated by requiring MHCC to conduct all analyses. MHCC regularly consults with any organization that is using the MCDB. We pursue an "open source" approach to sharing computer code as does HSCRC and other State partners. Finally, MHCC believes the MOU process should continue to be used to define agreed upon services between State agencies and does not believe the amount of time and effort required by Commission leadership is burdensome.

Again, I would like to thank DLS staff for their thorough analysis of the three health regulatory commissions. A careful, well-conceived external review like the one the MHCC has just experienced provides an invaluable third-party perspective on our performance. Please feel free to contact me with any additional questions.

Sincerely,

Craig Tanio, M.D.
Chairman
Maryland Health Care Commission

Ben Steffen
Executive Director
Maryland Health Care Commission