Preliminary Evaluation of the Maryland Health Care Commission

Recommendations:	**Waive from full evaluation** **Require the Department of Legislative Services to conduct a separate review of the missions and responsibilities of all three health regulatory commissions by December 1, 2016** **Defer decision on extension of the commission's evaluation date pending receipt of the review**
Date Established:	1999
Most Recent Prior Evaluation:	Full evaluation, 2006 Extended evaluation date by 10 years to July 1, 2017 (enacted by Chapter 627 of 2007); required follow-up report by October 1, 2007 (submitted)
Composition:	15 members (9 individuals who do not have any connection with the management or policy of a health care provider or payer, 2 physicians, 2 payers, 1 nursing home administrator, and 1 nonphysician health care practitioner)
Staff:	61.7 full-time positions
Regulatory Activities:	State Health Plan; health care facilities planning and development (*e.g.*, Certificate of Need); oversight of cardiac surgery, cardiac catheterization, and percutaneous coronary intervention services; statewide health information exchange; certification of electronic health networks; All-Payer Claims Database; consumer publications; approval of ratings examiners to review physician rating systems
Authorizing Statute:	Title 19, Subtitles 1, 1A, and 1B, Health-General Article
Evaluation Completed by:	Jordan More, Department of Legislative Services, 2015

Overview of Regulatory Activity

The Maryland Health Care Commission (MHCC), formed by the 1999 merger of the Health Resources Planning Commission and the Health Care Access and Cost Commission, has the purpose of improving access to affordable health care; reporting information relevant to the availability, cost, and quality of health care statewide; and developing sets of benefits included in the Comprehensive Standard Health Benefit Plan. MHCC is an independent commission in the Department of Health and Mental Hygiene and is organized around four centers based on activity.

Center for Information Services and Analysis: This center is responsible for the major information technology (IT) needs of MHCC, from maintaining large databases such as the All-Payer Claims Database, to producing reports on health expenditures, health insurance, the uninsured, and uncompensated care. This center also focuses on physician services, including cost and quality, and provides for the basic IT needs of the commission, including the website and intranet.

Center for Quality Measurement and Reporting: This center focuses on providing information to consumers about the quality and outcomes of care provided in Maryland. The center publishes the *Hospital Guide*, *Nursing Home Guide*, *Health Maintenance Organization Consumer Guide*, and other reports on the quality of hospital and assisted living care, as well as reports on health disparities as part of the commission's racial and ethnic disparities initiative.

Center for Health Care Facilities Planning and Development: This center focuses on improving hospital care by developing and updating the State Health Plan, collecting information on health care facility service capacity and use, and administering the State's Certificate of Need, Certificate of Conformance, and Certificate of Ongoing Performance programs.

Center for Health Information Technology and Innovative Care Delivery: This center is responsible for the commission's health IT and advanced primary care initiatives, including the planning and implementation of the statewide health information exchange (HIE); promoting the adoption and optimal use of health IT, including electronic health records and other technologies; and harmonizing HIE efforts throughout the State. This center, along with the Center for Information Services and Analysis, also manages the Patient Centered Medical Home Pilot Program.

HIE, the Chesapeake Regional Information System for our Patients (CRISP), has made tremendous strides since its inception, including connecting all 47 acute care hospitals in Maryland and 6 of 8 hospitals in the District of Columbia to its clinical query portal and implementing the Encounter Notification Service, which generates real-time hospitalization notifications to primary care providers, care coordinators, and other responsible parties.

MHCC also manages both the Maryland Trauma Physician Services Fund, which allocated $12.5 million in payments to eligible providers and administrative costs in fiscal 2014, and the subsidy for the University of Maryland Medical System's Shock Trauma Center from the Maryland Emergency Medical System Operations Fund.

Legislative Changes Since the 2006 Sunset Evaluation

Several legislative changes have been enacted relating to MHCC since the last full sunset evaluation in 2007, placing additional responsibilities on the commission. (See **Appendix 1**). Significant new duties include regulating the statewide HIE (also known as CRISP), establishing the Patient Centered Medical Home Pilot Program, conducting comparative evaluations of the quality of care and performance of categories of health benefit plans, implementing a new racial and ethnic disparities initiative, working with payers to establish certain benchmarks, and establishing the Health Care Provider-Carrier Workgroup.

Also notable is the continued use of MHCC as a center of study for various health policies. From 2007 through 2012, a new reporting requirement was placed upon MHCC each year. While most of these reports were of a one-time nature, these reporting requirements were in addition to MHCC's existing workload.

Revenues and Expenditures

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 is $12.0 million. However, commission expenditures have exceeded the fee cap since fiscal 2014. (See **Appendix 2**.) The two main drivers of cost growth within MHCC are personnel costs and the contractual services costs that come with developing and operating large IT projects. While the number of personnel at MHCC has actually decreased since the 2006 sunset evaluation, the commission has experienced the same growth in health insurance costs and pension obligations experienced by other State agencies. Furthermore, contractual expenses have drastically increased as new IT projects, such as the All-Payer Claims Database, have been developed. In order to not deplete its special fund balance, MHCC routinely holds down costs each year by delaying hiring and foregoing certain aspects of IT projects in order to realize savings. In fiscal 2015, approximately $2.1 million of the special fund appropriation was cancelled at the end of the fiscal year due to such activities, and in fiscal 2016, MHCC expects to cancel approximately $1.8 million of the special fund appropriation for a similar reason. Beyond these measures, MHCC notes that the commission has turned to two main alternative sources of funding: federal grants and indirect cost recovery or reimbursable funds from other State agencies. Federal grants allow MHCC to continue its mission without expending user fees or State-supported resources and have ranged between $1.5 million and $3.8 million per year since fiscal 2007.

The utilization of other special and reimbursable funds has also increased as MHCC has been more aggressive in requiring other State actors that utilize MHCC resources to subsequently pay for those resources. The largest sources of such funding are the Health Services Cost Review Commission (HSCRC), the Maryland Health Benefit Exchange, and the Maryland Trauma Physician Services Fund. However, even with these alternative resources, MHCC can no longer keep expenditures below the assessment cap, given the additional responsibilities it maintains.

Conclusion and Recommendations

Overall, MHCC continues to meet its performance metrics and provide the State with important policy guidance. The commission fulfills its statutory responsibilities in a timely manner and has continued to successfully implement new programs and policy directives of the General Assembly.

However, the landscape of health policy in Maryland has changed significantly under the all-payer model contract, moving to a population-based approach that now impacts both hospitals and community providers. The activities of *all three* health care regulatory commissions (MHCC, HSCRC, and the Maryland Community Health Resources Commission), which each have varying policy and funding roles, may have overlapping responsibilities in light of these changes. As such, **the Department of Legislative Services (DLS) recommends that the Legislative Policy Committee (LPC) waive MHCC from full evaluation at this time. DLS further recommends that LPC require DLS, by December 1, 2016, to conduct a review of the missions and responsibilities of all three health care regulatory commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned. This review should include recommendations regarding the relationship between State agencies and major health IT efforts, such as CRISP. The decision on the length of time for which HSCRC's evaluation date should be extended should be deferred pending receipt of the review.**

Policy Issues for Consideration

Assessment Cap

Commission expenditures are estimated to exceed the cap by more than $700,000 in fiscal 2016, forcing the commission to draw funds from its special fund balance despite cost saving measures discussed earlier in this report. While DLS encourages MHCC to continue to seek alternative sources of revenue in addition to user fee assessments, given that the fiscal 2016 appropriation is $14.7 million, **DLS recommends that the assessment cap be raised to $15.0 million.** If the assessment is increased by this amount, MHCC should not seek an additional increase for another three years.

Calculation of Workload Distribution

MHCC user fees are assessed based on the portion of the commission's workload attributable to each industry. Workload distribution is recalculated every four years. (See **Appendix 3**.) One disadvantage of the calculation is that it is done on a retrospective basis. As such, potentially major changes that MHCC knows will impact its workload in the near future, (such as increased efforts with the new Maryland All-payer Model Contract that governs hospital rate setting or increasing work on the All-Payer Claims Database) cannot be taken into consideration at the time the commission conducts the calculation. Thus, **DLS recommends that MHCC explore how the workload distribution calculation might, at least in part, consider *future* workload requirements.**

Appendix 1.
Major Legislative Changes Since the 2006 Sunset Evaluation

Year	Chapter(s)	Change
2007	627	Extends the evaluation date for the Maryland Health Care Commission (MHCC) by 10 years to July 1, 2017. Increases MHCC's user fee cap from $8 million to $10 million. Makes several operational changes, including standardizing quorum and voting requirements.
2008	238	Expands and specifies eligibility for reimbursement from the Maryland Trauma Physician Services Fund. Requires MHCC to develop a grant process for equipment for Level II and III trauma centers and allows up to 10% of fund balances to be used for such grants. Prohibits expenditures from the fund from exceeding revenues in any given year. Increases by $25,000 the cap on annual reimbursement to emergency physicians from the fund and increases a specified annual grant.
	692	Requires MHCC and the Comptroller to annually study and report on the number of families claiming exemptions for dependent children, the value of the exemption, and the effect of requiring claimed dependents to have health insurance.
2009	546/547	Expand eligibility for reimbursement for Level III trauma centers from the Maryland Trauma Physician Services Fund, contingent on funding.
	577/578	Alter the Comprehensive Standard Health Benefit Plan (CSHBP). Require MHCC to specify the deductibles and cost-sharing associated with the benefits in CSHBP. Require MHCC to maintain a website tool that small businesses may use to compare CSHBP products.
	585/586	Establish requirements for MHCC to approve ratings examiners to review physician rating systems.
	664	Requires MHCC to annually review payments to providers to determine compliance with statutory requirements regarding payments to noncontracting providers.

Year	Chapter(s)	Change
	689	Requires MHCC and the Health Services Cost Review Commission to designate a statewide health information exchange (HIE).
2010	5/6	Require MHCC to establish a Patient Centered Medical Home Pilot Program.
	505/506	Require MHCC to conduct a study of the effect of the rates established for freestanding medical facility pilot projects.
2011	11	Requires MHCC to comparatively evaluate the quality of care and performance of categories of health benefit plans.
	176	Aligns statutory requirements for the closure of specified health care facilities with those required for the closure or partial closure of hospitals.
	534/535	Require MHCC to adopt regulations for the privacy and security of protected health information obtained or released through an HIE.
	616	Prohibits hospitals from performing nonprimary percutaneous coronary intervention services without a Certificate of Need (CON) or waiver.
2012	3	Requires MHCC to implement a standard set of measures regarding racial and ethnic variations in quality and outcomes and provide information on carriers' actions to reduce health disparities.
	418	Specifically requires a CON for the establishment of percutaneous coronary intervention services.
	534/535	Require MHCC to work with specified payers and providers to attain benchmarks for standardizing and automating the process required by payers for preauthorizing health care services.
2013	379	Establishes at least five palliative care pilot programs, administered by MHCC.
2014	316/317	Require MHCC to work with payers and providers to attain benchmarks for overriding a payer's step therapy or fail-first protocol.
	449	Establishes a Community Integrated Medical Home Program to be administered jointly by MHCC and the Department of Health and Mental Hygiene.
	614	Requires MHCC to establish a Health Care Provider-Carrier Workgroup, to provide a mechanism to resolve disputes.

Source: Laws of Maryland

Appendix 2.
Special Fund Revenues and Expenditures for the Maryland Health Care Commission
Fiscal 2011-2016

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Beginning Balance	$2,961,255	$2,784,241	$2,582,541	$1,902,924	$1,955,560	$2,776,661
User Fee Assessments[1]	10,302,708	10,498,730	11,018,016	12,049,694	12,067,442	12,000,000
Other Revenues[2]	200,000	0	0	310,000	880,000	0
Transfers to General Fund	(1,142,890)	(39,000)	0	0	0	0
Total Revenues Available	**$12,321,073**	**$13,243,971**	**$13,870,557**	**$14,262,618**	**$14,903,002**	**$14,776,661**
Direct Costs	$8,793,818	$9,647,536	$11,200,313	$11,451,433	$11,244,322	$11,912,324
Indirect Costs	743,014	743,894	767,320	855,625	882,019	850,000
Total Expenditures	**$9,536,832**	**$10,391,430**	**$11,967,633**	**$12,307,058**	**$12,126,341**	**$12,762,324**[3]
Ending Balance	**$2,784,241**	**$2,852,541**	**$1,902,924**	**$1,955,560**	**$2,776,661**	**$2,014,337**
% of Total Expenditures	29%	27%	16%	16%	23%	16%

[1] User fee assessment revenues may slightly exceed the $12.0 million cap in some years as a result of how fees are collected from health care practitioners that renew on a biennial basis. In years where a higher number of health care practitioners renew licenses, revenues are higher than projected.
[2] Other revenues include administrative expenses for services provided to other State entities, electronic health network renewal fess, and other reimbursement from commission programs.
[3] The commission's fiscal 2016 legislative appropriation is $14,683,912, but actual expenditures are anticipated to be less.

Note: This exhibit includes only revenues and expenditures from the Maryland Health Care Commission's special fund and does not reflect federal revenues and expenditures. Fiscal 2016 revenues and expenditures are estimated.

Source: Maryland Health Care Commission; Department of Legislative Services

Appendix 3.
Distribution and Assessment of User Fees
Fiscal 2015

	Insurance Companies	Hospitals	Nursing Homes	Practitioners	Total
Percentage of Workload	28.0%	33.0%	17.0%	22.0%	100.0%
Industry Assessment	$3,360,000	$3,960,000	$2,040,000	$2,640,000	$12,000,000
Number of Payers[1]	61	54	231	82,500	82,846
Apportionment of Fees	Determined by amount of premiums earned.	Determined by number of admissions and amount of gross operating revenue.	Determined by number of admissions and amount of gross operating revenue.	Each practitioner assessed $27 every two years through licensing board. Assessment exempts low wage earners.	

[1]The number of practitioners listed includes all who are subject to user fees, though only about half pay the fee each year due to typically biennial license renewal schedules.

Source: Laws of Maryland; Maryland Health Care Commission

Appendix 4.
Written Comments of the Maryland Health Care Commission

Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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December 1, 2015

Warren G. Deschenaux
Executive Director
Department of Legislative Services
90 State Circle
Annapolis, MD 21401

Dear Mr. Deschenaux:

Thank you for the opportunity to comment on the preliminary evaluation of the Maryland Health Care Commission (MHCC). Department of Legislative Services staff have done an outstanding job summarizing our responsibilities, new initiatives and financing. The brief version of our response is: **we concur with the report and its recommendation.** Since we are in agreement with the recommendation we will focus our response on our capabilities and key priorities.

MHCC is an independent regulatory agency administratively located in the Department of Health and Mental Hygiene (DHMH). The MHCC is working to achieve a health care system in which informed consumers hold the health care system accountable for making significant improvements in quality and performance. Such a system will create market-based incentives for health care providers to deliver the best quality and most affordable care. The MHCC has four distinct capabilities that can help policy makers and other stakeholders to drive system improvement:

- **Convener and collaborator:** The MHCC is experienced in convening diverse stakeholder groups to encourage collaboration and consensus building, especially on controversial issues. As a trusted partner, MHCC brings stakeholders together to develop innovative solutions to resolve complex problems. Advised by workgroups, the MHCC currently manages initiatives that: plan and implement a statewide Health Information Exchange; implement an ambitious program of ongoing oversight of cardiac services; modernize health planning in an era of global budgets; and improve the collection and dissemination of health data.

- **Outcomes Measurement and Aggregator:** The MHCC is a major source of information on Maryland's health system performance derived from powerful data sources. The MHCC is

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responsible for the Maryland Health Care Quality Reports, a consumer portal containing quality and outcomes information from hospitals, nursing homes and health plans; the Medical Care Data Base (MCDB) containing claims information from all major payors in the State; and the aggregator of information from cardiac services registries containing comprehensive information on cardiac surgery and interventional cardiology outcomes for Maryland residents. The MHCC draws from this information to publish policy reports, issue papers, and consumer guides, comparing the performance of hospitals, health benefit plans, nursing homes, assisted living facilities, and outpatient surgical facilities. Working with Maryland health occupations boards, MHCC assembles and reports information about Maryland's health care work force for use by other State agencies and non-government and governmental stakeholders.

- **Policy Assessor:** Throughout the past decade, MHCC's work provided the framework to enable compromise among organizations with differing views from health insurance benefits, health information technology (health IT), health quality and safety, and physician payment policy. The MHCC provides objective policy insights upon request of the administration or the General Assembly. State policymakers and health care stakeholders seek MHCC's input on numerous health care issues. Recent examples include assessments of the effectiveness of medical and pharmacy preauthorization, development of patient protections under step-therapy protocols, evaluation on the impact of the Assignment of Benefits law, and the development of broad principles for reforming the Maryland's Patient Referral Law.

- **Health Planner:** The MHCC is responsible for the creation of the State Health Plan for Facilities and Services, a State regulation composed of chapters dealing with specific facilities and services for which the General Assembly requires MHCC regulation. The MHCC implements the State Health Plan through policy direction and through the Certificate of Need, Certificate of Conformance, Certificate of Ongoing Performance, and exemption processes. The MHCC recognizes that health planning is one of many tools in its health policy toolkit. The MHCC uses that flexibility to design new quality and performance-based approaches to address planning for specialized cardiac services. The same approach is being applied to the establishment of home health agency services. These new approaches encourage high performing providers and hold accountable those that deliver inferior care.

Key Priorities of the MHCC

Advancing the use of Health IT to Enhance Care Delivery and Maximize Meaningful Use

The MHCC has led efforts to advance health IT adoption in Maryland for over eight years. The earliest health IT planning and development efforts resulted in the establishing the Chesapeake Regional Information for our Patients (CRISP), the State-designated health information exchange (HIE); harmonizing local HIE efforts; increasing electronic health record

(EHR) adoption and meaningful use by physicians, hospitals, and comprehensive care facilities (nursing homes); and facilitating telehealth use case development.

Connecting all ambulatory practices, local health departments, and nursing homes to CRISP is the biggest challenge in health IT development. Working with providers, sister State agencies, and CRISP, has led to impressive results. In 2010, only 23 percent of ambulatory practices statewide had adopted an EHR; by 2014 the adoption rate had climbed to nearly 64 percent. The MHCC supports acute care hospitals as they seek to expand functionality of their EHRs; all but two hospitals have adopted an EHR. The MHCC provides guidance to nursing homes in implementing EHRs; over the last five years, EHR adoption has increased by almost 19 percent.

The long-term sustainability of CRISP and other HIEs depends on the ability of all participants in the health care system to find value in the exchange of electronic health information. Health care providers benefit from improved access to information at care delivery, payors benefit from reduction in duplicate or unnecessary testing or procedures, and consumers benefit through improved care. As a convener and enabler, MHCC identifies innovative opportunities to expand the value propositions among all public and private initiatives that are underway in Maryland today as follows:

- Convenes planning session with other State agencies to ensure that the use of CRISP services across State agencies is coordinated and scarce technology expertise is utilized most efficiently.
- Works directly with individual agencies, such as the Alcohol & Drug Abuse Administration; Medicaid; the Health Services Cost Review Commission; and the Maryland Health Benefit Exchange to facilitate use of the CRISP infrastructure.
- Provides guidance to health care associations in developing use cases that involve health IT that create value to their members and enhanced patient care.
- Participates on the CRISP Clinical Advisory Board, the Finance & Sustainability Advisory Board, the Privacy and Security Advisory Board, and the Integrated Care Network Infrastructure Steering Committee.

MHCC has unique role in the adoption of health IT in Maryland. Trust in the new technologies is a precondition to widespread adoption. In our role as designator of the State-designated HIE, we oversee financial and technical audits of CRISP and ensure compliance with auditor recommendations. Similarly, increased privacy and security is crucial to safeguarding electronic health information and building consumer trust in the technology. The MHCC collaborates with a broad array of stakeholders in order to assure comprehensive input in MHCC's development of privacy and security regulations that balance the need for increased protections with rapidly evolving technical capabilities of health IT.

The MHCC is advancing telehealth adoption and meaningful use as an emerging area of health IT. Over the last 18 months, MHCC has used its authority to launch telehealth initiatives in rural areas and other underserved areas of the State. In spite of tight budgets, the MHCC has sparked telehealth innovation by awarding grants for nine incubator projects that coordinate care

delivery between a nursing home and an acute care hospital using video consultations[1]; demonstrate the impact of remote patient monitoring on hospital readmissions; and test telehealth effectiveness on various chronic conditions, providers, and settings. Learning lessons from these incubator projects will inform industry implementation efforts. Recently, CareFirst BlueCross BlueShield announced that it will issue various telehealth grants, consistent with the recommendations in the MHCC's *2014 Telemedicine Task Force Report*, which contains recommendations evaluated by approximately 60 organization Task Force members.[2]

Expand Reporting of Health System Performance to Drive Transparency

The MHCC is committed to sending a clear message to Maryland providers, employers, and consumers that their participation and preferences on performance reporting matter. As directed under Health-General §19-134, MHCC reports on the comparative quality of health plans, nursing homes, hospitals, and ambulatory surgery centers. The MHCC launched the Health Benefit Plan Quality and Performance Report in 1996. The Consumer Guide to Long Term Care and the Hospital Performance Evaluation Guide were added in 2002. The MHCC quality guides include clinical, consumer satisfaction, and cost information. Additionally, Maryland is one of a few states that collects and publicly reports on racial and ethnic health care disparities for health plans.

The MHCC has embarked on an ambitious effort to expand and refine information that is needed to drive transparency. In October 2014, MHCC took an important first step by creating a single website for its hospital, long-term care, and health plan reporting efforts. The new Maryland Health Care Quality Reports[3] website brings all of MHCC's quality reporting initiatives together to create a comprehensive website and resource tool for consumers. Maryland is the first state to integrate the open-source MONAHRQ Version 6.0 developed by the federal Agency for Health Care Research and Quality into its state quality reporting application. Use of open source MONAHRQ reduces the cost of maintaining the reporting system. In 2015, more detailed information on hospital charges was added and plans are underway to include physician prices to provide estimates of the total costs of care for certain elective procedures.

A major strength of the quality reporting strategy in Maryland is that a trusted source assembles the information, all providers are subject to reporting, and the information is carefully reviewed and, in most instances, audited by an independent entity. The MHCC conducts independent quality audits of information reported by health plans and providers. Consumers and purchasers have indicated in focus groups and surveys that they have more confidence in the quality information provided by government agencies such as MHCC. The MHCC includes consumers, providers and employers in the workgroups that plan improvements to the guides and reports and, to the extent permitted by its budget, conducts focus groups that evaluate the reports and suggest areas of improvement. Before releasing new information, MHCC previews the data with each involved health plan, hospital, and long-term care organization. Giving early access

[1] http://mhcc.maryland.gov/mhcc/Pages/hit/hit_telemedicine/hit_telemedicine.aspx
[2] http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/tlmd/tlmd_ttf_rpt_102014.pdf
[3] http://mhcc.maryland.gov/mhcc/consumer.aspx

and opportunities to review their own results, builds trust and fosters a climate of continued improvement among organizations that are subject to quality reporting.

The MHCC collaborates with other State agencies, health plans, providers, purchasers, and consumer representatives in developing the reports. The MHCC seeks input from health plans, hospitals, and nursing home representatives to determine the quality measures, audit procedures, time lines, and reporting formats. Information MHCC develops is shared with HSCRC, Maryland Medicaid, the Department of Aging, and the Maryland Health Benefit Exchange (MHBE), enabling those agencies to avoid duplicative reporting efforts.

In collaboration with HSCRC, MHCC expanded hospital inpatient reporting requirements in 2014 to align with CMS' requirements. The MHCC's expanded data collection requirements support Maryland's new all-payor hospital model negotiated with CMS.

- The MHCC shares information on the Nursing Home Family Satisfaction Survey, a key element of the Long-term Care Guide, with Medicaid for use in Medicaid's Nursing Home Pay for Performance program.
- The MHCC collaborates with the federal Centers for Disease Control in accessing the information from the National Healthcare Safety Network infection surveillance system and shares that information with HSCRC and DHMH in addition to publishing in MHCC's hospital quality report.
- The Department of Aging uses the MHCC's Guide to Long-term Care in its outreach efforts with seniors.
- The MHBE collaborates with MHCC in the development of health plan reports. MHBE posts MHCC's health plan results on its enrollment site to enable consumers to compare health plan performance information.

These collaborations widen the benefit of quality reporting, reduce redundancy in quality reporting, and allow the State to acquire the technical expertise at the lowest cost.

Modernize Health Planning to Address Changing Capacity Needs of a High-Performing, Integrated System

The current health planning process serves as the foundation for the establishment of new, updated, or expanded health care facilities and services, which include hospitals, nursing homes, home health agencies, hospices, and ambulatory surgical facilities. The changes sweeping the Maryland health care system, including national health care reform and the launch of the new all-payor hospital model, require short-term modernization of health planning to align with hospital payment reform and a longer term and broader reinvention to address the systemic changes expected across a range of facilities and services provided to patients following hospitalization.

Global budgets that constrain hospital revenue growth are becoming the dominant financial lever in the new all-payor hospital model. These spending limits, used in conjunction with the quality and performance incentives and penalties under the new model are intended to incentivize providers to produce higher value care and will spur innovation in more efficient care delivery. It will encourage hospital providers to look beyond hospital walls and to partner with colleagues in the community in order to reduce admissions, readmissions, and days of

hospitalization. Providers may seek to develop projects that do not fall neatly in traditional facility and service categories historically found in state health planning and licensure definitions. Hospital and health care systems are likely to create new types of organizations for delivering a continuum of care, combining the efforts of several providers who have historically acted in isolation and, in some cases, sharing the revenue bundled for specific episodes of care among physicians and multiple institutional providers. The current planning process that is focused on reacting to individual organizations' project requests needs to evolve.

In the short-term, this modernization effort will involve new approaches to decision-making for hospital projects already in the planning pipeline or soon to be submitted. These projects include requests for replacement hospitals, applications for new specialized services, and added surgical capacity. Closer collaboration with HSCRC in project review is already occurring and work is underway to establish an approach that will allow capital projects to be considered in a timely manner within the framework of a global budget.

A longer-term reinvention process will align MHCC planning for health care facilities with initiatives and policies of other DHMH agencies, local health care coalitions, and private sector entities focused on improving health status, meeting community-identified needs, and managing population health. The objectives of this longer-term modernization will be to create a health planning and regulatory process that:

- Plans for improvement of the health status of Maryland's population rather than planning for health care facility service capacity;
- Rewards improvements in health systems performance and denies development opportunities for poor or mediocre performers rather than perpetuating the same institutional patterns of care; and
- Holds expansion of the health care resource base to a sustainable growth rate, in order to improve the affordability of care, rather than planning and regulating without limits to spending.

Work on these short and long-term efforts is underway in parallel with existing review activities.

Expanding the All Payor Claims Database[4] to Support Health Care Reform and Further Price Transparency

The MHCC is currently undertaking a major expansion and enhancement of Maryland's All Payor Claims Database (APCD) to support important initiatives outlined below. The list of payors required to submit information to the APCD has been expanded to include third-party administrators and pharmacy benefit managers so that health care utilization and spending in the self-insured market will be available in the database. To make the APCD as current as possible, data is now collected quarterly through an automated process, and then transferred to data warehouse designed to facilitate complex analyses. Other enhancement activities include regular data reconciliation meetings with carriers to insure confidence in the data, the addition of a Master Patient Identifier (from CRISP) to identify the same person across insurance products,

[4] Maryland's All Payor Claims Database (APCD) is referenced as the Medical Care Data Base in Maryland law. Maryland and seventeen other states have or are developing APCDs.

and the addition of episode of care definitions. These expansion and enhancement efforts are currently funded by federal grants (see Budgetary Outlook).

The expanded and enhanced APCD will support Maryland's new all-payor hospital model, which places almost all hospital spending under a global budget. Monitoring total cost of care is one of the requirements under this model, and Maryland has developed its own total cost of care monitoring tool with the APCD as the source data for the commercial patient cost metrics. The MHCC, as an active participant in examining alternative approaches to measuring the total cost of care, recognizes that understanding total cost of care and identification of low value services by clinicians, hospitals, payors, and consumers are essential if the new model is to succeed in Maryland.

The enhanced APCD also allows the Commission to report on more price transparency metrics to State partners and the public. The MHCC recently developed a data dashboard for use by the Maryland Insurance Administration in rate review analysis. The MHCC is also developing public-facing webpages to display utilization and cost/price transparency information for industry stakeholders and a specialized portal targeting consumers. The enhanced APCD gives MHCC the ability to define and analyze episodes of care, including the total resources and expenditures associated with the service bundle and how episode resource use varies across providers, which will significantly add to the valuable information the MHCC generates from its APCD. Information on episodes of care costs will be included on the consumer portal.

Finally, MHCC was recently selected by the Network for Regional Healthcare Improvement to participate in its Total Cost of Care expansion project. The project provides MHCC with a cost of care tool designed to generate information for primary care practices. When applied to the APCD, this tool will give practices information on the total utilization/cost of care for their patients. The MHCC will recruit a set of primary care practices familiar with total cost of care concepts to assess the utility of the information in managing their patients' health care utilization.

MHCC's Budgetary Outlook

The MHCC's requested appropriation for FY 2017 is $14.6 million. The MHCC's budget is 100% special funds through a user fee assessment on hospitals, nursing homes, payors, and through the licensing process of the Health Occupation Boards. Currently, the Commission assesses: 1) payors for an amount not to exceed 28 percent of the total budget; 2) hospitals for an amount not to exceed 33 percent of the total budget; 3) the Health Occupation Boards for an amount not to exceed 22% of the total budget; and 4) nursing homes for an amount not to exceed 17% of the total budget. As DLS has recommended, MHCC is already examining more equitable methods of assessments that would combine the current method of retrospective workload analysis with a prospective workload analysis.

The MHCC has pursued a three-pronged financial strategy to align responsibilities with funding sources because its assessment cap is set at $12 million.

- First, MHCC has aggressively pursued grant opportunities. Since FY 2014, MHCC has been awarded approximately $4.0 million in federal grants from the Centers for Medicare and Medicaid Services. (CMS). These funds have been used to develop the APCD infrastructure,

create a rate review process using the APCD, and develop a price transparency initiative. Almost $200,000 from the Network of Regional Health Initiatives (NRHI) with almost an equivalent amount of in-kind support from NRHI technical staff has supported the MHCC's strategic priority to expand applications for the APCD. MHCC obtained grants from Robert Wood Johnson Foundation's (RWJ) State Health and Value Strategies, Technical Assistance Program (SHVS TA) in 2014 and 2015. MHCC projects more limited federal grant opportunities in 2017 and beyond. Grant opportunities from foundations such as RWJ are uncertain.

- Second, MHCC has requested reimbursement from agencies that receive services from MHCC. The MHBE and HSCRC are key collaborators and will provide funds for MHCC's development of the Qualified Health Plan Quality Report and MCDB development respectively.

- Third, MHCC has tightly managed the operating budget, deferring hiring when necessary, achieving operational efficiencies where possible, and narrowing the scope of existing contracts when feasible. This strategy has enabled MHCC to build a projected reserve sufficient to fund the projected FY 2017 appropriation of $14.6 million. Meeting mandated responsibilities by squeezing operational savings from elsewhere in the organization is a short term solution, but reduces MHCC's ability to complete its work.

MHCC cannot sustain the current level of effort without additional sources of revenue in FY 2018. The existing assessment cap of $12 million was established in 2008. The MHCC's mandated duties have expanded in the past nine years, and include oversight of health IT, expanded quality reporting for hospitals and nursing home, significant role in assessing health disparities, and expansion of the APCD to enable more comprehensive and timely data capture. Aside from terminating Comprehensive Standard Health Benefit Plan, no other mandated responsibility has been eliminated.

The Commission looks forward to continuing to work with the General Assembly and assisting in the future review of the missions and responsibilities of the three health regulatory commissions.

Sincerely,

Ben Steffen
Executive Director