M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 13 Actual	FY 14 Working	FY 15 Allowance	FY 14-15 Change	% Change Prior Year
General Fund	$0	$91	$0	-$91	-100.0%
Adjusted General Fund	**$0**	**$91**	**$0**	**-$91**	**-100.0%**
Special Fund	172,646	175,263	198,834	23,571	13.4%
Contingent & Back of Bill Reductions	0	0	-129	-129	
Adjusted Special Fund	**$172,646**	**$175,263**	**$198,705**	**$23,442**	**13.4%**
Federal Fund	2,457	927	0	-927	-100.0%
Adjusted Federal Fund	**$2,457**	**$927**	**$0**	**-$927**	**-100.0%**
Reimbursable Fund	1,426	0	0	0	
Adjusted Reimbursable Fund	**$1,426**	**$0**	**$0**	**$0**	
Adjusted Grand Total	**$176,529**	**$176,281**	**$198,705**	**$22,424**	**12.7%**

- There are two deficiency appropriations for the regulatory commissions totaling $5.75 million. Of this amount, $5.15 million is for the Health Services Cost Review Commission (HSCRC) to cover the cost of increased uncompensated care payments.

- The fiscal 2015 budget for the regulatory commissions increases by $22.4 million, 12.7% over the fiscal 2014 working appropriation. When adjusted for the fiscal 2014 deficiencies, the growth is moderate, $16.7 million (9.2%).

Numbers may not sum to total due to rounding

For further information contact: Simon G. Powell Phone: (410) 946-5530

Personnel Data

	FY 13 Actual	FY 14 Working	FY 15 Allowance	FY 14-15 Change
Regular Positions	98.70	99.70	102.70	3.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**98.70**	**99.70**	**102.70**	**3.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.88	4.89%
Positions and Percentage Vacant as of 12/31/13	6.80	6.82%

- The budget includes 3 new positions, all in HSCRC. These positions are directly or indirectly related to work on the recently agreed upon all-payer model contract between the State and the federal government.

Analysis in Brief

Major Trends

Electronic Data Exchange: Use of the State-designated Health Information Exchange (HIE) is increasing. The HIE is intended to make electronic health records and health information available in a secure environment to providers and patients.

Small Group Market: The percentage of small employers in Maryland offering coverage, which had fallen as a result of the recent recession, appears to have recovered to close to pre-recession levels.

Medicare Waiver: Farewell to the Old Waiver Test: With the transition to a new all-payer model contract, the old way of measuring compliance with the State's Medicare waiver was retired effective January 1, 2014. The most recent data reinforces why a new way to measure what the State is doing with regard to the regulation of hospital spending was required.

Issues

Modernization of Maryland's Medicare All-payer Waiver: A recently signed model all-payer contract between the State and federal government establishes new goals that the State must meet in order to maintain its Medicare all-payer waiver. The State believes that these goals better reflect what the State is trying to do in terms of increasing the quality of care, improving population health, and lowering the growth in the cost of care.

Recommended Actions

1. Add language restricting funds pending the receipt of the criteria to be used in making awards under the proposed new Community Partnership Assistance Program and making the language contingent on legislation enacting such a program.

Updates

Regional Health Delivery and Health Planning in Rural Areas: Joint committee narrative adopted in the 2013 session asked the Maryland Health Care Commission (MHCC) to investigate whether current health planning region designations are appropriate and what the impact has been of recent hospital consolidation on service availability in rural areas. The results of the MHCC study are summarized.

Health Enterprise Zones: Progress Report: Health Enterprise Zones (HEZ), established by Chapter 3 of 2012, have been in operation for one calendar year. An update on HEZ activity is provided.

M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are independent agencies that operate within the Department of Health and Mental Hygiene (DHMH). The agencies variously regulate the health care delivery system, monitor the price and affordability of services offered in the industry, and improve access to care for Marylanders. The three commissions are the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), and the Maryland Community Health Resources Commission (MCHRC).

MHCC, formed by the 1999 merger of the Health Care Access and Cost Commission and the Health Resources Planning Commission, has the purpose of improving access to affordable health care; reporting information relevant to availability, cost, and quality of health care statewide; and developing sets of benefits to be offered as part of the standard benefit plan for the small group market. The commission's goals include:

- improving the quality of care in the health care industry;
- improving access to and affordability of health insurance, especially for small employers;
- reducing the rate of growth in health care spending; and
- providing a framework for guiding the future development of services and facilities regulated under the certificate of need program.

HSCRC was established in 1971 to contain hospital costs, maintain fairness in hospital payment, and provide financial access to hospital care. The commission maintains responsibility for ensuring that the cost of health care is reasonable relative to the cost of service and that rates are set without discrimination. The commission's goals include:

- maintaining affordable hospital care for all Maryland citizens;
- expanding the current system for financing hospital care for those without health insurance; and
- eliminating preferential charging activity through monitoring of hospital pricing and contracting activity.

MCHRC was established in 2005 to strengthen the safety net for uninsured and underinsured Marylanders. The safety net consists of community health resource centers (CHRC), which range from federally qualified health centers to smaller community-based clinics. MCHRC's responsibilities include:

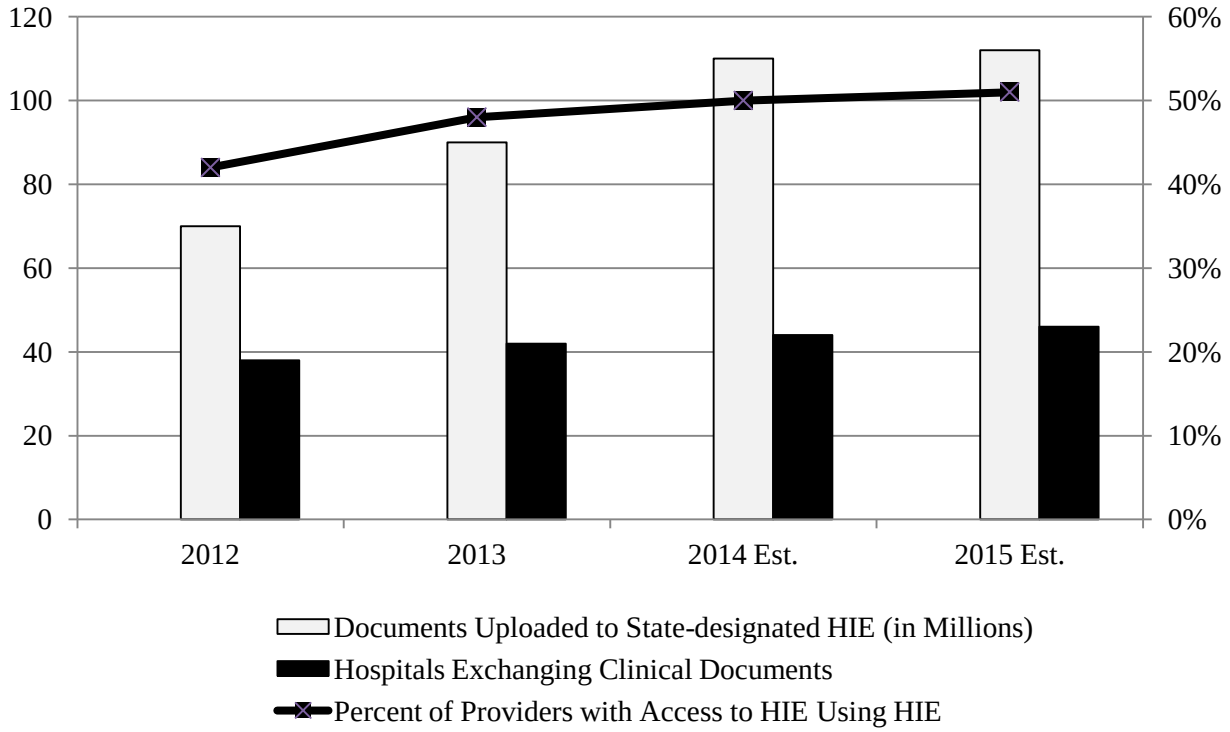
- identifying and seeking federal and State funding for the expansion of CHRCs;
- developing outreach programs to educate and inform individuals of the availability of CHRCs;
- assisting uninsured individuals under 200% of the federal poverty level (FPL) to access health care services through CHRCs; and
- overseeing the implementation of the Health Enterprise Zones (HEZ) established in Chapter 3 of 2012.

Performance Analysis: Managing for Results

1. Electronic Data Exchange

One of the goals of MHCC is to reduce the rate of growth in health care spending in Maryland. One strategy to lower costs is eliminating unnecessary administrative expenses through the adoption of electronic data exchange. A new Managing for Results measure around this strategy was adopted in the fiscal 2014 budget and now has two years of actual data, specifically, the utilization of the State Health Information Exchange (HIE). Maryland's designated HIE is the Chesapeake Regional Information System for our Patients, which is charged with making electronic health records and health information available in a secure environment to providers and patients. **Exhibit 1** shows the number of documents uploaded to the HIE, the number of hospitals exchanging clinical documents, and the percentage of those providers who have access to the HIE who utilize it.

Exhibit 1
Utilization of State-designated HIE
Calendar 2012-2015 Est.



HIE: Health Information Exchange

Source: Department of Health and Mental Hygiene

2. Small Group Market

Exhibit 2 presents data on the small group market. Specifically, the exhibit shows that the percentage of small employers in Maryland offering coverage, which had fallen to 35% in calendar 2011, jumped to 42% in calendar 2012 (the latest period for which data is available). This is an increase from data presented in the fiscal 2014 analysis and represents updated data. This number is almost back to pre-recession levels.

Under current law, the average premium of the Comprehensive Standard Health Benefit Plan must amount to no more than 10% of the Maryland annual average wage – the so-called affordability cap. As shown in Exhibit 2, the average plan costs 101% of the affordability cap in calendar 2012. This jump continues to reflect the additional costs associated with conforming Maryland's insurance products to federal mandates required under the Patient Protection and Affordable Care Act (ACA).

Exhibit 2
Small Group Market – Various Data
Calendar 2008-2012

	2008	2009	2010	2011	2012
Percent of Small Employers Offering Coverage	41%	40%	38%	35%	42%
Average Cost of Plan as Percent of Affordability Cap	93%	85%	88%	95%	101%

Note: Data reported in the Managing for Results measure for the affordability gap in fiscal 2011 was 88%. The data shown here is updated data from the Maryland Health Care Commission.

Source: Department of Health and Mental Hygiene

In the past, if the cap was exceeded, MHCC could raise deductibles or remove a covered health service that is covered to meet affordability requirements (and raising deductibles was the path chosen). Given the fact the Standard Benefit Plan will be replaced by plans offered through the Maryland Health Benefit Exchange (MHBE), MHCC is not taking action at this time.

3. Medicare Waiver: Farewell to the Old Waiver Test

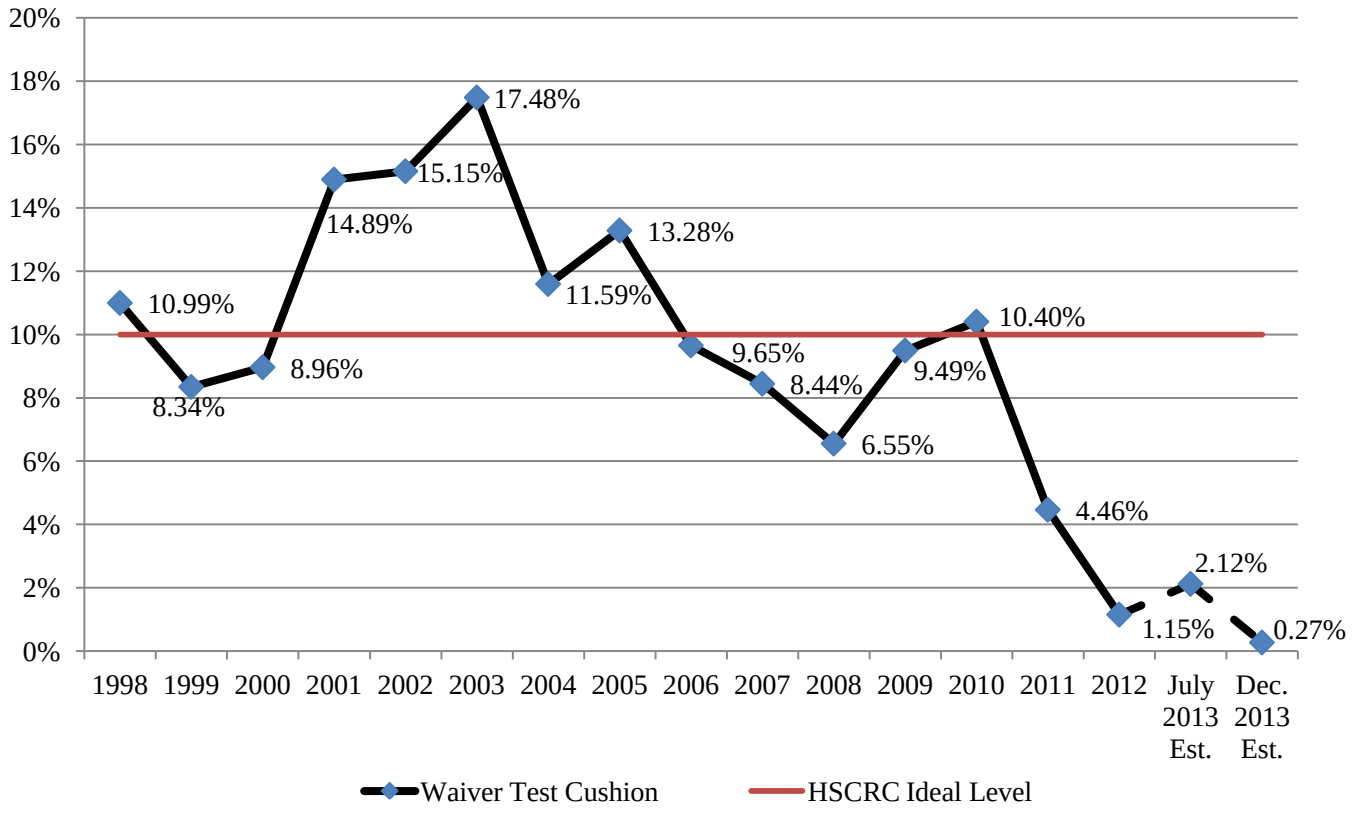
HSCRC sets standard rates that hospitals may charge for the purchase of care. This system encourages access to health care regardless of ability to pay and prevents cost shifting between payers. The commission's ability to standardize rates for all payers, including Medicare and Medicaid, was established in 1980 by federal legislation, with continued regulatory authority contingent on the commission's ability to contain the rate of growth of Medicare hospital admissions costs.

Prior to the recent agreement between the State and the federal government on a new all-payer model contract (see Issue 1 below for additional detail), in order to maintain the all-payer system, Maryland had to contain the cost of health care such that the growth of Medicare payments per discharge in the State did not surpass the growth of Medicare payments per discharge nationally. In recent years, while the rate of growth in Maryland remained below the national average, the gap narrowed significantly. This narrowing of the gap between cumulative Maryland and U.S. Medicare per discharge growth rates was reflected in the primary measure used to monitor waiver performance, namely the relative waiver margin calculation, a test performed using an independent economic model that assumed a flat rate of growth in Medicare payments per case. The result of the test was the relative waiver margin, or "waiver cushion," which represents the amount Medicare payments to Maryland could grow, assuming zero growth in Medicare payments nationally, before the State failed to meet its waiver requirements. HSCRC determined that 10.0% was the lowest desirable level for

the waiver margin. The larger the margin, the more flexibility HSCRC had to adjust rates while simultaneously weathering Medicare payment trends.

As shown in **Exhibit 3**, over the past decade, the waiver cushion fluctuated either side of the 10.0% desirable level. However, the cushion shrank from 10.4% at the end of fiscal 2010 to 1.66% for the year ending September 2012 (the most recent actual data available). As also shown in Exhibit 3, HSCRC predicts that by the end of calendar 2013, the waiver cushion would be almost completely eroded. The new model all-payer contract will have different waiver tests.

Exhibit 3
Medicare Waiver Cushion
Fiscal 1998-December 2013 Est.



HSCRC: Health Services Cost Review Commission

Note: Data shown are values/estimates for the end of each fiscal year. July 2013 through December 2013 are estimates.

Source: Department of Health and Mental Hygiene

Fiscal 2014 Actions

Proposed Deficiency

There are two deficiency appropriations for the Health Regulatory Commissions:

- $600,000 for MHCC, of which $100,000 is to cover grants payable from the Maryland Trauma Physician Services Fund. Every other year MHCC gives grants of up to 10% of the value of the fund's surplus. The current surplus in the fund is $4.5 million, but the fiscal 2014 grant amount had been calculated on a lower surplus.

  The other $500,000 is for the Small Employer Health Benefit Premium Subsidy Program. This program was supposed to be phasing out in fiscal 2014 with the creation of the Small Business Health Options Program (SHOP) in MHBE. The SHOP was part of the 2010 federal ACA. However, problems with the roll-out of the MHBE eligibility system (HIX) have meant the development of the SHOP has been delayed. MHBE recently announced a delay in the SHOP until January 1, 2015.

- $5,145,824 for HSCRC to cover increased uncompensated care payments.

Proposed Budget

As detailed in **Exhibit 4**, the proposed fiscal 2015 budget for the health regulatory commissions increases by just over $22.4 million, 12.7%. When adjusted for the fiscal 2014 deficiencies, the growth moderates to $16.7 million, 9.2%.

Exhibit 4
Proposed Budget
DHMH – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Total
2014 Working Appropriation	$91	$175,263	$927	$176,281
2015 Allowance	0	198,705	0	198,705
Amount Change	-$91	$23,442	-$927	$22,424
Percent Change	-100.0%	13.4%	-100.0%	12.7%

Where It Goes:		
Personnel Expenses	**$829**	
New positions (3 regular positions in HSCRC)		$358
Annualization of the fiscal 2014 COLA and increment		352
Regular salaries including fiscal 2015 increments		223
Retirement contributions		64
Turnover adjustments		58
Other fringe benefit adjustments		7
Reclassifications		-40
Employee and retiree health insurance		-193
Maryland Health Care Commission	**-$1,095**	
Medical care database		546
Miscellaneous MHCC contracts		478
DHMH indirect cost allocation		108
Long-term care health IT (federal grant funding expired)		-227
Trauma grants		-300
State HIE cooperative agreement (federal grant funding expired)		-700
Small Employer Health Benefit Premium Subsidy		-1,000

Where It Goes:		
Health Services Cost Review Commission	**$22,802**	
Uncompensated Care Fund		20,000
Outside consulting contracts, primarily related to the new Medicare waiver redesign		2,110
Data processing equipment, including the establishment of a remote recovery site		299
Increased frequency of Maryland hospital inpatient and outpatient data collection from quarterly to monthly. This data is used to perform rate setting activities		192
Various software expenditures		116
DHMH indirect cost allocation		85
Maryland Community Health Resources Commission	**-$54**	
Health Enterprise Zone special projects		-54
Other		-58
Total		**$22,424**

COLA: cost-of-living adjustment
DHMH: Department of Health and Mental Hygiene
HIE: Health Information Exchange
HSCRC: Health Services Cost Review Commission
IT: information technology
MHCC: Maryland Health Care Commission

Note: The fiscal 2014 working appropriation reflects negative deficiencies and contingent reductions. The fiscal 2015 allowance reflects back of the bill and contingent reductions. Numbers may not sum to total due to rounding.

Personnel Expenditures

Personnel expenditures for the regulatory commissions increase by $829,000. Significant increases include:

- $358,000 for 3 new positions in HSCRC. These 3 positions are all directly or indirectly related to the new Medicare all-payer model contract. Specifically:
  - There is a position to manage information technology (IT) infrastructure and data, including new Medicare data sets required under the modernized waiver. The new waiver data set will be larger and monitored more frequently. Specifically, the two provisions that will require additional monitoring are tracking of required Medicare savings and tracking of Medicare total cost of care.

- One position to assist the deputy director in ongoing daily rate setting responsibilities as the deputy director and other existing staff will be focused on negotiating, monitoring, and revising global budgets.

- A position to deal with additional audit and compliance requirements, including the monthly monitoring of hospital revenue. Under global budgets, rates can increase and decrease with volume changes with the goal of meeting a global budget amount. This level of activity, together with the need to track the impact of the addition or reduction of services at a hospital that would also require the adjustment of the global budget, requires constant monitoring.

- $352,000 for the annualization of the fiscal 2014 cost-of-living adjustment (COLA) (3% effective January 1, 2014) and fiscal 2014 increments (effective April 1, 2014).

- Retirement contributions, which increase by $64,000, even after taking into account contingent savings of $89,732 as a result of reduced retirement reinvestment contributions.

Partially offsetting the increases in personnel costs are:

- A reduction of $40,000 in available funding for reclassifications in fiscal 2015 compared to fiscal 2014. Even with this reduction, the budget includes over $268,000 for reclassifications in MHCC. Of this amount, $61,000 is for ongoing reclassifications supported by the findings of a compensation study completed in fiscal 2012 and 2013. While the commissions have a level of independent salary setting authority in statute, and the reclassifications are supported by an independent review, the issue of parity with general funded agencies is again worth noting. Undertaking compensation studies at the State level are generally resisted simply to avoid the likely outcome of those studies. When they are conducted, they are often not implemented except to the extent that a specific job classification may be occasionally identified for salary increases through the annual salary review (ASR) process. Most of the funding budgeted as reclassifications is actually to support higher fiscal 2015 salaries for positions filled during the first half of fiscal 2014, which were budgeted at lower (base) salaries and do not reflect the salary levels offered to those new employees.

- A reduction of funding for employee and retiree health insurance of $193,000 compared to fiscal 2014. This includes $38,926 in savings as a result of a back of the bill reduction to health insurance spending.

MHCC: Nonpersonnel costs

Nonpersonnel costs at MHCC actually decline by almost $1.1 million. However, it is important to note that the areas of lower spending are in expired federal grants, as well as spending that is supported by special fund sources other than the MHCC fund. Specifically, funding for trauma grants supported by the Maryland Trauma Physician Services Fund (funded through a vehicle registration surcharge) and the small employer premium subsidy program supported by the Averted

Uncompensated Care Fund (funded by an assessment on hospital revenues) both decrease in fiscal 2015.

Other nonpersonnel areas of the MHCC budget that are increasing are funded primarily through the MHCC fund. Increases include funding for:

- An expansion of MHCC's medical care database to include claims from Medicaid, pharmacy benefit managers, dental plans, behavioral health claims from third party administrators, and other non-claim-based payments. The expansion of the database is intended to encompass all paid claims for health services provided in Maryland and represents an increase in contract costs of $546,000 over fiscal 2014.

- A net increase in a variety of MHCC contracts of $478,000. MHCC contracts out for a lot of the work for which it has responsibility. Significant contract changes in fiscal 2015 include increases of $250,000 associated with the Maryland Hospital Performance Evaluation Guide and $200,000 for evaluation of health plan benefits based on certain cultural competency standards. Partially offsetting the increases are lower expenditures on various other contracts including website redesign ($200,000).

- A total of $108,000 for the DHMH indirect cost support.

This discussion about the funding source for those areas of MHCC's budget that are increasing is important because the MHCC fiscal 2015 budget requires support from the MHCC fund of $14.3 million. The MHCC fund is supported through a user assessment on hospitals, nursing homes, payers, and all health care practitioners. Assessments are capped under current law at $12.0 million. MHCC anticipates a fiscal 2014 fund balance of just over $1.5 million, leaving it approximately $800,000 short of the amount of funding it needs to support the proposed fiscal 2015 budget. Unlike HSCRC, for which the Administration has proposed legislation that includes an increase of its fee cap, no similar legislation was introduced for MHCC.

MHCC notes that it will be seeking to manage within available resources by making savings in salaries through keeping vacant positions open, asking DHMH to push a quarterly indirect cost payment into fiscal 2016, potentially seeking reimbursement from other State agencies for data accessed through the medical care database and for other services provided, charging costs where appropriate to federal grants, all in addition to spending down fund balance. MHCC will likely need an increase in its fee cap in the 2015 session.

Finally, the significant drop in funding for the small employer premium subsidy program ($1.0 million from the fiscal 2014 working appropriation and $1.5 million from the working appropriation if the proposed deficiency appropriation is taken into consideration) perhaps portends the need for additional funding in fiscal 2015. The future need for this subsidy is difficult to assess given the uncertainty around when the SHOP part of the MHBE will open. MHBE announced in January 2014 that eligible small businesses would be able to offer small group health plans and

access federal tax credits, effective April 1, 2014. However, the development of the SHOP website appears to be on hold.

HSCRC: Nonpersonnel related costs

There is a significant increase in HSCRC nonpersonnel-related costs in fiscal 2015 compared to fiscal 2014, $22.8 million. The two largest areas of increase are:

- A total of $20.0 million in projected expenditures from the Uncompensated Care Fund. The Uncompensated Care Fund is used to more fully share the costs of uncompensated care between hospitals. Hospitals that have lower than average uncompensated care pay into the fund to reduce uncompensated care for those hospitals with higher than average uncompensated care. In fiscal 2013, 21 hospitals paid into the fund, while 27 hospitals received disbursements from the fund.

  Given the expansion of access to health care effective January 1, 2014, especially with the expansion of the Medicaid program with almost 130,000 new Medicaid enrollees having access to full Medicaid benefits in January 2014, it might be asked how the Uncompensated Care program run by HSCRC will change moving forward.

  HSCRC notes that under its current methodology, any impact of expanded coverage through Medicaid expansion and qualified health plans (QHP) would not normally be reflected in uncompensated care rates until fiscal 2016. However, the commission will be expediting changes in its methodology to apply the impact to fiscal 2015, at least to the extent that it can calculate the amount of uncompensated care consumed by former recipients of the Primary Adult Care (PAC) program (the program for childless adults up to 116% FPL with limited Medicaid benefits and excluding inpatient and other outpatient services). QHP enrollees will not be part of the calculation (the commission does not know the extent to which these individuals had prior coverage, the extent to which uncompensated care for these enrollees might increase depending on QHP deductibles and co-pays versus prior coverage, and in any event, enrollment has been relatively modest). Based on this review of the former PAC enrollees, the commission may well be making downward revisions in its estimate of funding through the Uncompensated Care program.

  Additionally, the commission will be revisiting the basic uncompensated care program methodology and looking at refinements generally.

- A $2.1 million increase in outside consulting contracts, almost all of this increase driven by contracts associated with the new Medicare all-payer mode contract. HSCRC anticipates contractual assistance in these areas, such as the development of a methodology to look at total cost of care; purchasing data from Medicare to monitor growth in Maryland compared to the nation; an automated data collection process; analysis of market share; risk issues; and hospital revenue predictive modeling.

As noted above, unlike MHCC, legislation was proposed by the Administration to support, among other things, an increase in the fee cap for HSCRC (HB 298/SB 335). The HSCRC fund is supported through an assessment of hospitals and related institutions whose rates are approved by the commission. The current cap is $7 million. The legislation proposes to increase that cap to $12 million.

Finally, it should be noted that the Budget Reconciliation and Financing Act (BRFA) of 2014 contains a provision related to HSCRC. Specifically, the BRFA establishes a Community Partnership Assistance Program. A community partnership is broadly defined as a partnership between a hospital and a corporate, business, provider, or citizen organization intended to improve community health and well-being. Proposed community partnerships must meet guidelines that are to be established by DHMH and HSCRC. DHMH and HSCRC will review proposed partnership plans, with DHMH approving the plans. Plans will be funded through the rates of hospitals participating in a community partnership plan. Funding is set at $30 million in fiscal 2015 and $40 million in fiscal 2016 and beyond. Like a number of other programs currently funded through hospital rates (Nurse Support Program I, the Maryland Patient Safety Center, and the HIE), the Community Partnership Program will be a nonbudgeted program.

At this point, there are no specifics as to project criteria and whether projects can be multi-year applications, but the commission recognizes the need to require reporting on any funded project to ensure savings to the hospital system, as well as appropriate performance quality.

The Department of Legislative Services (DLS) recommends that budget bill language be added requiring HSCRC and DHMH to submit the guidelines for project applications for review and comment prior to program implementation.

Issues

1. Modernization of Maryland's Medicare All-payer Waiver

Maryland is the only state with an all-payer, rate-regulated hospital financing system. The authority of HSCRC to standardize rates for all payers, including Medicare and Medicaid, was established in 1980 by federal legislation. Prior to January 1, 2014, as noted above, to maintain the waiver, the cumulative rate of growth in Medicare inpatient per admission costs at Maryland hospitals from 1981 to the present had to remain no greater than the cumulative rate of growth in Medicare inpatient per admission costs at hospitals nationally over the same time period.

As has been discussed in prior budget analyses, according to HSCRC, the drive for efficiency in health care has shifted from seeking to reduce resource use within an individual hospital stay to managing episodes of care across multiple settings and placing additional focus on prevention and population health. HSCRC has adopted rate-setting methodologies to encourage improved provision of services across settings by reducing preventable readmissions and providing capped revenue for hospital services to encourage provision of care at lower levels of acuity. Unfortunately, these methodologies, while promoting best practices, worked at cross-purposes in terms of the waiver test and its focus on Medicare per admission costs.

Thus, since 2012, HSCRC has worked with payers, DHMH, and hospitals to modernize the waiver to align the incentives in the State's hospital financing system with improved quality, improved population health, and lower growth in the cost of care. Based on these discussions, HSCRC prepared a model design proposal for the federal Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation.

The Maryland All-payer Model Contract

After a process that included a draft proposal, stakeholder input, and changes to the original draft proposal, Maryland and the federal government agreed to a new five-year demonstration model beginning January 1, 2014. The model includes the following major components:

- **All-payer Total Hospital Cost Growth Ceiling:** Maryland will limit inpatient and outpatient hospital cost growth for all payers to a trend based on the State's average 10-year compound annual gross state product per capita between 2003 and 2012 (3.58% for the first three years of the demonstration). After year 3, the State may adjust the overall cap based on updated data. The model agreement also allows the State to seek adjustments to the target based on per capita increases considered unrelated to the model, for example, a disease outbreak or the construction of a new hospital facility in Prince George's County. Adjustment is at the sole discretion of CMS.

- **Medicare Total Hospital Cost Growth Ceiling:** Maryland will limit Medicare per beneficiary total hospital cost growth (inpatient and outpatient), setting a per beneficiary spending target sufficient to produce $330.0 million in cumulative Medicare savings over five years, beginning with an estimated $49.5 million in savings in 2015. Savings will be calculated by establishing a baseline of the actual Medicare per beneficiary total hospital expenditures for Maryland Medicare fee-for-service (FFS) beneficiaries in 2013, trending forward by the national average growth rate in Medicare per beneficiary expenditures in each year of the model, and comparing Maryland's annual Medicare per beneficiary total hospital expenditures to that baseline.

  The $330.0 million in cumulative savings represents a spending rate that is at the national trend in year one and approximately 0.5% below the national trend in years 2 through 5. Proposed savings are as detailed in **Exhibit 5**.

Exhibit 5
Medicare Annual and Cumulative Savings
Under Maryland All-payer Model Contract
Calendar 2014-2018
($ millions)

	2014	2015	2016	2017	2018
Medicare annual savings	$0.0	$49.5	$82.5	$115.5	$82.5
Medicare cumulative savings	$0.0	$49.5	$132.0	$247.5	$330.0

Source: Maryland All-payer Model Agreement, February 2014

Again, adjustments to the Medicare savings calculation are permitted to be made under various circumstances, at the discretion of CMS.

- **Population-based Revenue:** Hospital reimbursement will shift from a per-case system to a population-based system: defined as directly population-based, *i.e.*, hospital reimbursement tied to the projected services of a specified population of residents; or a fixed global budget for hospitals for services unconnected to the assignment of a specific population. There are various payment models currently used by HSCRC that meet this definition, and others could be developed and utilized. Examples of current payment models which meet this description include Total Patient Revenue payments, which began in 10 predominantly rural hospitals in fiscal 2011 and which guarantee fixed inpatient and outpatient revenue levels regardless of volume.

While Maryland hopes to have virtually 100% of all hospital-based revenue into population-based models by the end of the contract period, the agreement's targets are slightly more modest: by year 2, at least 50% of hospital revenues shifted to population-based budgets; year 3, 60.0%; year 4, 70.0%; and year 5, 80.0%.

- **Reduction of Hospital Readmissions:** Maryland must reduce its Medicare readmission rate over five years. Specifically, the aggregate Medicare 30-day readmission rate by year 5 is equal to or less than the national readmission rate for Medicare FFS beneficiaries.

- **Reduction of Hospital Acquired Conditions:** Maryland will achieve an annual aggregate reduction of 6.89% across all potentially preventable conditions measures that comprise Maryland's Hospital Acquired Condition program. This represents a cumulative reduction of 30.0% over five years.

- **Medical Education Innovation:** Maryland must develop a five-year plan for medical and health professional schools to serve as a nationwide model for transformation initiatives.

- **Regulated Revenue at Risk:** Maryland must ensure that the aggregate percentage of regulated revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include readmissions, hospital acquired conditions, and value-based purchasing programs.

During the course of the waiver, a so-called triggering event could lead CMS to send the State a warning notice and potentially require a corrective action plan (see **Exhibit 6**). Unsurprisingly, as noted in the exhibit, while the new all-payer model seeks to generate savings for all payers, the focus of CMS's concerns is very much on trends related to Medicare.

Exhibit 6
Maryland All-payer Model Contract: Triggering Events

Triggering Event
The State has not produced aggregate savings in Medicare per beneficiary hospital expenditures for Maryland resident fee-for-service beneficiaries for two consecutive years.
The State has failed to meet the cumulative Medicare savings targets by more than $100 million.
The annual growth rate in Medicare per beneficiary total cost of care for Maryland residents is greater than 1.0 percentage point above the annual national Medicare per beneficiary total cost of care during a single year.
Beginning in year 2 of the model, the annual growth rate in Medicare per beneficiary total cost of care for Maryland residents (regardless of state of service) is greater than the annual national Medicare per beneficiary total cost of care growth rate for two consecutive years.
The percentage of hospital revenue attributable to nonresident Medicare beneficiaries is 1.5 percentage points above the percentage level of calendar 2013.
A determination by CMS that the quality of care to Medicare, Medicaid, and MCHP recipients has deteriorated.

CMS: Centers for Medicare and Medicaid Services
MCHP: Maryland Children's Health Program

Source: Maryland All-payer Model Agreement, February 2014

Implementation activities for the new contract began in late 2013, including the convening of an advisory council to provide broad input on guiding principles to consider in implementing new payment systems. Workgroups will be convened on specific methodological issues and policy questions to provide advice on long-term policy changes. As the State transitions to the new model, a bridge process (managed by HSCRC) will be used to implement short-term changes and interim solutions.

As noted above, legislation is currently pending before the General Assembly, HB 298/SB 335 with regard to the financing and authority of HSCRC. In addition to allowing HSCRC to raise its fee cap to support all of the commission's activities, as well as the contract needs required to implement the new all-payer model, the proposed legislation also clarifies the authority of HSCRC with regard to supporting the implementation of the new all-payer model contract.

Recommended Actions

1. Add the following language to the special fund appropriation:

, provided that, contingent upon enactment of legislation creating a Community Partnership Assistance Program, $100,000 of this appropriation made for the purpose of administration may not be expended until the Health Services Cost Review Commission (HSCRC) and the Department of Health and Mental Hygiene (DHMH) submit to the budget committees:

(1) the guidelines by which plans under the proposed Community Partnership Assistance Program shall be developed; and

(2) the criteria to be used in reviewing those plans.

The budget committees shall have 30 days to review and comment on the guidelines and criteria developed by HSCRC and DHMH. Funds restricted pending the receipt of the guidelines and criteria may not be transferred by budget amendment or otherwise to any other purpose and shall be canceled if the guidelines and criteria are not submitted to the budget committees.

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2014 includes a section establishing a new Community Partnership Assistance Program. The program encourages community consortia spearheaded by hospitals to submit proposals to improve community health and well-being to HSCRC and DHMH for funding consideration. If approved, funding will be provided through the rates of the submitting hospital/hospitals. The BRFA establishes funding limits on the program of $30 million in fiscal 2015 and $40 million in fiscal 2016 and beyond. The language provides that if such a program is created, the guidelines and criteria used to review proposals be submitted to the budget committees for review and comment.

Information Request	**Authors**	**Due Date**
Community Partnership Assistance Programs	HSCRC DHMH	30 days prior to the expenditure of funds

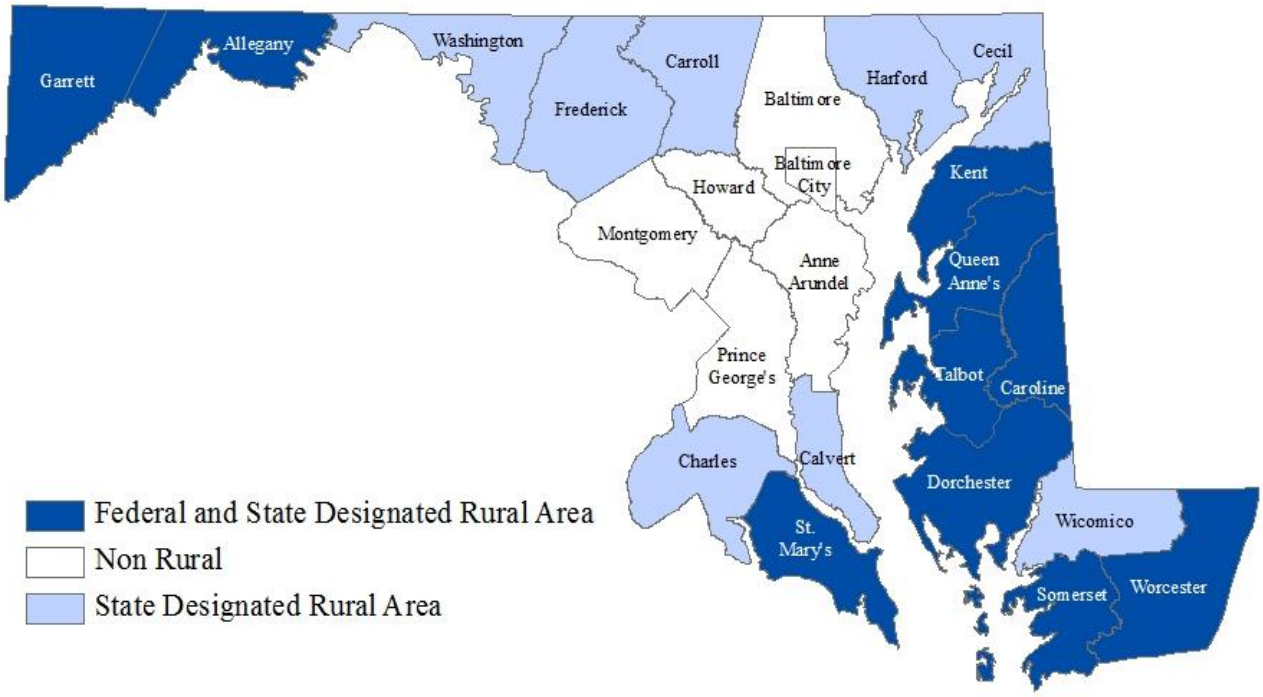
Updates

1. Regional Health Delivery and Health Planning in Rural Areas

2013 *Joint Chairmen's Report* committee narrative requested that MHCC report back on two issues: are the health planning region designations currently used in Maryland appropriate; and what has been the impact of recent hospital consolidation on the availability of services in rural areas. MHCC convened a stakeholder group during the 2013 interim to discuss these issues, as well as several others, including the adequacy of the health workforce in rural areas, barriers to accessing health services caused by distance, and the adequacy of transportation to health care services.

The Maryland definition of "rural" currently includes 18 Maryland jurisdictions (all but Anne Arundel, Baltimore, Howard, Montgomery, and Prince George's counties and Baltimore City). As shown in **Exhibit 7**, this definition is significantly broader than the federal designation of rural areas in Maryland.

Exhibit 7
State and Federal Rural Designation in Maryland



Source: Maryland Health Care Commission

Generally speaking, outside of Baltimore City, Maryland's rural health communities have fewer health care providers, higher rates of chronic disease and mortality, more difficult socioeconomic characteristics, and lower levels of health literacy.

Health Planning Region Designations

Three different regional designations were identified as being used by State health agencies:

- MHCC designates regions for each of its regulated health services;
- the Maryland Institute for Emergency Medical Services Systems designates regions based on the objective of optimizing travel time to critical patient services; and
- MHBE, through its Connector Program, designates regions in order to allocate resources facilitating the implementation of the ACA.

The report concluded that the different regions used by these agencies in their planning and regulatory activities were appropriate. Further, the regions were not static and were subject to periodic adjustment. Thus, the use of these regions did not adversely impact the development of health facilities or services in rural areas.

Adequacy of Health Care Workforce

The report noted that recruitment and retention of health care workers in rural areas represents a bigger challenge than in urban/suburban regions and medical facility hubs. Among the recommendations of the report are making improvements to existing health care reimbursement policies; improving training to focus on rural issues; supporting programs that encourage recruitment and retention in rural areas, including expanding loan reimbursement programs; and improving measurement and evaluation of the health care workforce generally.

Barriers to Accessing Health Care Services Caused by Distance

The report noted a variety of innovative service delivery models to overcome barriers to health care services caused by distance, including HEZs: telemedicine services; community-based health care delivery; visiting practitioner models; community paramedicine; and other nontraditional models that aim to get practitioners and services to patients. However, it should be noted that the report could also find no data to support the conclusion that rural Marylanders face any particular barrier to accessing general acute care hospital services. It may be that these individuals have fewer provider choices, but use of these services by rural patients was no different than by nonrural patients.

Adequacy of Transportation to Health Care Services

The report notes ways to improve access through improved transportation; the most obvious solution is increasing funding for transportation services. The report notes that funding is often inconsistent and, if done through grants, tied to the granting agencies' priorities, which may not result in the most efficient use of funding. Other suggestions include modifying reimbursement guidelines to improve efficiency; improving coordination between different transportation providers; and improving public awareness of transportation services.

Impact of Hospital Consolidation on the Availability of Health Care Services in Rural Areas

Rural hospitals have been consolidating into larger centralized systems since 2006. Currently, of the State's 17 rural hospitals, 7 are affiliated with a larger system (accounting for 32% of the licensed acute care bed inventory in independent hospitals). The 10 remaining independent hospitals located in rural areas represent the vast majority (10 of 12) of the hospitals not part of a larger system based inside or outside of Maryland. However, at the time of the writing of this report, 3 of those hospitals in Western Maryland are considering the possibility of some form of strategic alliance. The report notes that integration of hospital services can drive prices down (although given Maryland's unique all-payer system, the relationship between market concentration and price is likely different than in other states), consolidate management, produce economies of scale, streamline patient care management, and improve staff recruitment and retention. Often, however, such consolidation can have both benefits and costs.

Generally, the report notes that recent consolidation has not had any negative impact on the availability of health care services. However, it recommends that for any future consolidation, attention should be paid to the impact on local employment; existing community-based health resources; and the need to track and report community health measures. However, the report does not recommend that there is a need for increased regulatory oversight of hospital systems formation or the need for new health care planning initiatives.

2. Health Enterprise Zones: Progress Report

The creation of HEZs was among the recommendations of the Health Disparities Workgroup under the Maryland Health Quality and Cost Council. Specifically, that workgroup recommended the creation of HEZs modeled after the Harlem Children's Zone and Promise Neighborhood programs to reduce health and health care disparities, improve outcomes, and stem the rise in health care costs. In HEZs, community-based organizations apply for funds specifically to improve health in a zone. A zone can be designated using various criteria, including high rates of chronic disease, health disparities, and a lack of access to primary care.

As established in Chapter 3 of 2012, additional parts of the HEZ model include access to the Loan Assistance Repayment Program to support existing and new primary care clinicians in a HEZ; income, property, and/or hiring tax credits; assistance for health IT; priority to enter the State's patient centered medical home program; other grant funding from MCHRC; facility and capital equipment grants; and other medical practice expenses. Ultimately, the goal of a HEZ is to work with existing providers, insurers, the public health system, nonmedical community agencies, and other stakeholders to create an integrated health care system with improved health care access.

Five HEZs were ultimately selected in Dorchester/Caroline counties; Lexington Park in St. Mary's County; Capitol Heights in Prince George's County; West Baltimore; and Annapolis in Anne Arundel County. Annual funding from MCHRC was established at $4 million beginning in fiscal 2013, an amount which is maintained in the fiscal 2015 budget. Funding for the HEZs is on a calendar year basis.

The first annual report since the HEZs were established was recently released and highlighted initial successes as well as challenges:

- Initial successes included expanding service delivery capacity, the addition of 43 new practitioners (physicians, nurse practitioners, and registered nurses), and the creation of a total of 87 new jobs (practitioners and other jobs). Across the HEZs, 4 (excluding Anne Arundel County) requested tax credits totaling $264,145.

- Early challenges include difficulty in certain HEZs (primarily rural-based HEZs) in recruiting practitioners, although 4 out of 5 of them met recruiting goals. For example, accessing loan repayment assistance was not always possible because of program restrictions. HEZs also reported difficulty in collecting patient outcome data across multiple provider sites.

MCHRC is working with the HEZs to collect and report patient clinical outcomes, including the development of baseline data.

DLS noted last year that because the HEZ pilot will now be financed for calendar 2013 through 2016, the implementing statute needed to be amended to clarify that the HEZ pilot would run for four calendar years rather than the four fiscal years specified in Chapter 3, and also that tax benefits will be available for the full four-year period, through tax year 2016 as opposed to through tax year 2015, as currently stated. HB 668 has been introduced in the 2014 session to make these and other changes concerning the ability of HEZs to access income tax credits.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
Health Regulatory Commissions
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2013					
Legislative Appropriation	$0	$162,052	$2,800	$100	$164,952
Deficiency Appropriation	0	12,087	0	0	12,087
Budget Amendments	0	473	175	1,427	2,074
Reversions and Cancellations	0	-1,967	-518	-100	-2,584
Actual Expenditures	**$0**	**$172,646**	**$2,457**	**$1,426**	**$176,529**
Fiscal 2014					
Legislative Appropriation	$0	$174,946	$927	$0	$175,873
Budget Amendments	91	317	0	0	408
Working Appropriation	**$91**	**$175,263**	**$927**	**$0**	**$176,281**

Note: The fiscal 2014 working appropriation does not include deficiencies or contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2013

The fiscal 2013 legislative appropriation for the Health Regulatory Commissions was increased by $11.6 million. This increase was derived as follows:

- Deficiency appropriations added $12.1 million, all special funds. Of this amount:
  - Almost $1.1 million was for MHCC, including $423,000 to cover costs associated with the Small Employer Health Benefit Premium Subsidy Program, and $640,000 for increased costs of the patient centered medical home program.
  - Just over $11.0 million was for HSCRC, of which $10.9 million recognizes increased funding available for uncompensated care payments with the remainder for HSCRC administrative costs.
- Budget amendments added a further $2.1 million to the legislative appropriation. Specifically:
  - Special funds were increased by $473,000. Of this amount, $88,000 supported the fiscal 2013 COLA. A further $385,000, available from prior year Community Health Resources Commission Fund encumbrance cancellations, was used to fund substance abuse and mental health services to court-involved individuals in Baltimore City ($250,000), behavioral health services to low-income and uninsured individuals in Montgomery County ($85,000), and dental services to low-income and uninsured individuals in Carroll County ($50,000).
  - Federal funds increased by $175,000 related to a State Innovation Model Design and Model Testing Assistance grant awarded by the U.S. Department of Health and Human Services. These grant funds will be used to develop a model of care that will integrate patient-centered medical care with community-based resources while enhancing the capacity of local health entities to monitor and improve the health of individuals and their communities as a whole. The funds were provided to MHCC for project design and testing activities.
  - Similarly, the appropriation was increased through reimbursable fund budget amendments totaling just over $1.4 million. In fiscal 2012, over $6.0 million of reimbursable funding was received from the Developmental Disabilities Administration (DDA) for the award of one-time grants to be made by the MCHRC. At the time of the transfer, these funds were believed to be surplus to funding requirements for DDA's ongoing community services programs, although DDA ultimately ended fiscal 2012 with a significant deficit. MCHRC committed the funding in fiscal 2012 but did not expend all of the appropriation, necessitating the re-appropriation of this $1.4 million. Again, the funding was for one-time grants and also supported a part-time auditor to monitor the grants.

- Cancellations partially offset the increase in the legislation appropriation derived from deficiency appropriations and budget amendments, reducing the appropriation by almost $2.6 million. Of this, just under $2.0 million was in special funds, $518,000 in federal funds, and $100,000 in reimbursable funds.

Fiscal 2014

To date, the fiscal 2013 legislative appropriation for the Health Regulatory Commissions has been increased by $408,000. Specifically:

- General funds have been increased by $91,000, representing funding originally budgeted in the Office of the Secretary to develop an Advance Directive Registry.

- Special funds have been increased by $317,000, including $183,000 to support the fiscal 2014 COLA and increments approved in the 2013 session but not included in the original allowance, $9,000 related to the realignment of the Department of Information Technology and the State Retirement Agency administrative fees, and $125,000 for various HEZ and safety net grant activities.

Object/Fund Difference Report
DHMH – Health Regulatory Commissions

Object/Fund	FY 13 Actual	FY 14 Working Appropriation	FY 15 Allowance	FY 14 - FY 15 Amount Change	Percent Change
Positions					
01 Regular	98.70	99.70	102.70	3.00	3.0%
Total Positions	**98.70**	**99.70**	**102.70**	**3.00**	**3.0%**
Objects					
01 Salaries and Wages	$ 10,161,806	$ 11,338,153	$ 12,296,100	$ 957,947	8.4%
02 Technical and Spec. Fees	26,572	37,541	34,233	-3,308	-8.8%
03 Communication	72,742	86,879	87,090	211	0.2%
04 Travel	95,866	132,934	158,570	25,636	19.3%
08 Contractual Services	154,981,417	153,809,994	174,930,763	21,120,769	13.7%
09 Supplies and Materials	77,849	79,424	79,553	129	0.2%
10 Equipment – Replacement	41,000	40,800	21,600	-19,200	-47.1%
11 Equipment – Additional	14,182	56,200	354,800	298,600	531.3%
12 Grants, Subsidies, and Contributions	10,671,563	10,251,559	10,394,643	143,084	1.4%
13 Fixed Charges	386,206	447,647	476,632	28,985	6.5%
Total Objects	**$ 176,529,203**	**$ 176,281,131**	**$ 198,833,984**	**$ 22,552,853**	**12.8%**
Funds					
01 General Fund	$ 0	$ 91,000	$ 0	-$ 91,000	-100.0%
03 Special Fund	172,645,629	175,263,371	198,833,984	23,570,613	13.4%
05 Federal Fund	2,457,151	926,760	0	-926,760	-100.0%
09 Reimbursable Fund	1,426,423	0	0	0	0.0%
Total Funds	**$ 176,529,203**	**$ 176,281,131**	**$ 198,833,984**	**$ 22,552,853**	**12.8%**

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

Program/Unit	FY 13 Actual	FY 14 Wrk Approp	FY 15 Allowance	Change	FY 14 - FY 15 % Change
01 Maryland Health Care Commission	$ 31,613,094	$ 31,528,898	$ 30,937,753	-$ 591,145	-1.9%
02 Health Services Cost Review Commission	136,178,258	136,616,411	159,857,986	23,241,575	17.0%
03 Maryland Community Health Resources Commission	8,737,851	8,135,822	8,038,245	-97,577	-1.2%
Total Expenditures	**$ 176,529,203**	**$ 176,281,131**	**$ 198,833,984**	**$ 22,552,853**	**12.8%**
General Fund	$ 0	$ 91,000	$ 0	-$ 91,000	-100.0%
Special Fund	172,645,629	175,263,371	198,833,984	23,570,613	13.4%
Federal Fund	2,457,151	926,760	0	-926,760	-100.0%
Total Appropriations	**$ 175,102,780**	**$ 176,281,131**	**$ 198,833,984**	**$ 22,552,853**	**12.8%**
Reimbursable Fund	$ 1,426,423	$ 0	$ 0	$ 0	0.0%
Total Funds	**$ 176,529,203**	**$ 176,281,131**	**$ 198,833,984**	**$ 22,552,853**	**12.8%**

Note: The fiscal 2014 appropriation does not include deficiencies. The fiscal 2015 allowance does not include contingent reductions.