M00R01
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change	% Change Prior Year
Special Fund	$164,438	$225,340	$203,882	-$21,458	-9.5%
Adjustments	0	0	-3,799	-3,799	
Adjusted Special Fund	**$164,438**	**$225,340**	**$200,083**	**-$25,257**	**-11.2%**
Federal Fund	1,640	0	0	0	
Adjusted Federal Fund	**$1,640**	**$0**	**$0**	**$0**	
Reimbursable Fund	173	173	0	-173	-100.0%
Adjusted Reimbursable Fund	**$173**	**$173**	**$0**	**-$173**	**-100.0%**
Adjusted Grand Total	**$166,251**	**$225,512**	**$200,083**	**-$25,429**	**-11.3%**

Note: Includes targeted reversions, deficiencies, and contingent reductions.

- The fiscal 2018 allowance for the Health Regulatory Commissions decreases by $25.4 million after contingent and back of the bill reductions. The majority of this decrease is tied to decreased utilization of the Uncompensated Care Fund ($24.9 million).

- There is one contingent reduction for the Maryland Community Health Resources Commission (MCHRC), which would reduce the appropriation by $3.75 million in order to utilize those special funds in lieu of general funds for mental health services within the Behavioral Health Administration. This action is tied to a provision in the Budget Reconciliation and Financing Act of 2017.

Note: Numbers may not sum to total due to rounding.

For further information contact: Jordan D. More Phone: (410) 946-5530

Personnel Data

	FY 16 Actual	FY 17 Working	FY 18 Allowance	FY 17-18 Change
Regular Positions	103.70	98.90	97.90	-1.00
Contractual FTEs	0.00	1.00	1.00	0.00
Total Personnel	**103.70**	**99.90**	**98.90**	**-1.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	5.81	5.93%
Positions and Percentage Vacant as of 12/31/16	13.00	13.14%

- Overall, there is a decrease of 1.0 position for the Health Regulatory Commissions. This position is being transferred from MCHRC to the Prevention and Health Promotion Administration within the Department of Health and Mental Hygiene.

- Turnover expectancy within the allowance is 5.93%, which requires the agency to maintain 5.8 vacant positions throughout the year. As of December 31, 2016, there were 13.0 vacant positions, or 13.14%.

Analysis in Brief

Major Trends

Use of Electronic Data Exchange Continues to Grow: Use of the State-designated Health Information Exchange (HIE) is increasing. However, at this point, it is unclear how many providers in the State have access to the HIE. **The Department of Budget and Management, as well as the Maryland Health Care Commission (MHCC), should consider adding a Managing for Results metric on the percent of providers within the State that have access to the HIE.**

Maryland All-payer Model Contract Metrics Continue to Show Progress: The new Maryland All-payer Model Contract contains numerous tests that the State must meet to maintain its unique all-payer hospital rate-setting system. In calendar 2016, the State appears to once again be on pace to either meet or exceed all of the goals of the contract.

Issues

The All-payer Model Contract: Currently, the State is entering year four of the All-payer Model Contract with the federal government, which allows the Health Services Cost Review Commission (HSCRC) to implement an all-payer hospital rate-setting system. While the State is currently meeting all of the goals and benchmarks of the current contract, a new contract must be negotiated and agreed upon by both the State and the federal government before the expiration of the current contract at the end of calendar 2018. To begin these negotiations, the State has already submitted the Progression Plan, which outlines where the State would like to take the All-payer Model Contract in the future. However, there is some uncertainty at both the State and federal level about how this Progression Plan would be implemented, as well as whether or not changes at the federal level will severely impact the State's ability to maintain this system. **The commissions should comment on what new governance legislation will be presented; provide more detail on how the three entities will share responsibility for the implementation of the Progression Plan; and more concretely identify what resources the State seeks to leverage, outside of the State budget, to make sure that the implementation is successful. HSCRC should also comment on strategies employed to ensure that the State retains its all-payer system in light of the continuing uncertainty at the federal level concerning continuation of prior health care reform efforts.**

Integrated Care Networks: In order to improve care coordination, HSCRC, along with MHCC, have begun to establish Integrated Care Networks. The main vehicle through which the commissions are establishing these networks is through the State-designated HIE, the Chesapeake Regional Information System for our Patients. However, HSCRC is also planning on using some of the designated funding for specific special projects. Further, HSCRC and MHCC were authorized to use specific special fund sources for these projects, including the fund balance from the Maryland Health Insurance Plan, but only through the end of fiscal 2019. **The commissions should comment on the plans for the special projects funding and whether all of the available funds will be expended by the close of fiscal 2019.**

Recommended Actions

		Funds
1.	Reduce indirect costs to the legal allowable level.	$ 1,083,635
	Total Reductions	**$ 1,083,635**

Updates

Special Evaluation of the Three Regulatory Commissions: During the 2016 interim, the Department of Legislative Services (DLS) conducted a special sunset evaluation of all three regulatory commissions to identify areas of overlapping roles and responsibilities. Ultimately, DLS concluded that another evaluation should take place in three years' time once the uncertainty surrounding the renewal of the new All-payer Model Contract is resolved. DLS also reiterated its previous recommendations regarding the assessment caps for both MHCC and HSCRC.

Report on the Status of Hospital Partnerships with Community Behavioral Health Providers: The 2016 *Joint Chairmen's Report* required HSCRC to submit a report on the status of hospital partnerships and contracts with nonhospital-owned community behavioral health organizations funded through HSCRC implementation grants and the total amount of implementation grant funding used by hospitals to contract with nonhospital-owned community behavioral health organizations. The report was submitted by HSCRC on December 9, 2016.

M00R01
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 has the charge of improving access to affordable health care, as well as reporting information relevant to availability, cost, and quality of health care statewide. 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 services 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; and
- assisting uninsured individuals under 200% of the federal poverty level to access health care services through CHRCs.

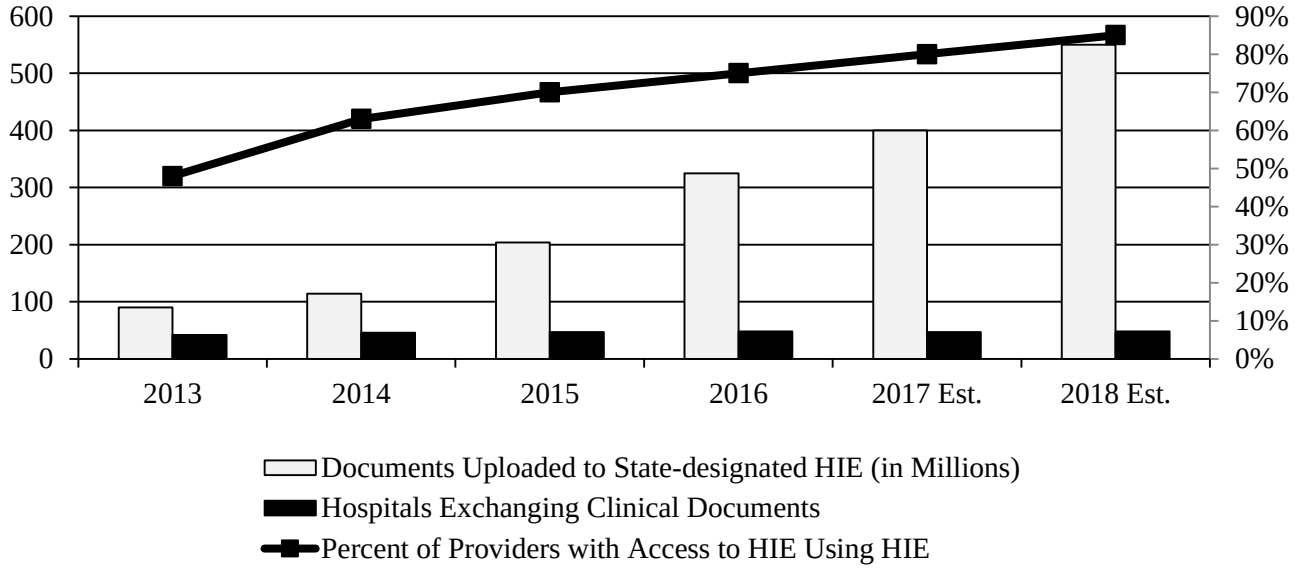
Performance Analysis: Managing for Results

1. Use of Electronic Data Exchange Continues to Grow

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 an electronic data exchange, specifically through the utilization of the State Health Information Exchange (HIE). Maryland's designated HIE is the Chesapeake Regional Information System for our Patients (CRISP), 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 percent of those providers who have access to and utilize the HIE. As displayed in the exhibit, the use of the HIE continues to grow as a higher proportion of providers with access to the HIE use the system. There continues to be pronounced jumps in the number of documents uploaded each fiscal year, with the largest increase to date being from 204 million to 325 million between fiscal 2015 and 2016. This number is expected to increase to 550 million by the end of fiscal 2018.

However, while it is clear that the number of providers who have access are increasing their use, what is unclear is whether access is increasing as a percent of the overall number of providers within the State. **The Department of Budget and Management, as well as MHCC, should consider adding a Managing for Results metric on the percent of providers within the State that have access to the HIE.**

Exhibit 1
Utilization of State-designated HIE
Fiscal 2013-2018 Est.



HIE: Health Information Exchange

Source: Department of Health and Mental Hygiene

2. Maryland All-payer Model Contract Metrics Continue to Show Progress

The All-payer Model Contract requires the State to meet certain metrics throughout the five-year waiver demonstration period in order for the State to maintain the waiver. **Exhibit 2** provides some detail on certain metrics that HSCRC monitors to ensure compliance with the tests that the Center for Medicare and Medicaid Innovation (CMMI) has required of Maryland. So far, the State has been meeting all of the metrics that are tested as part of the model contract. Signs of success include keeping per capita all-payer revenue growth below 3.58% in each calendar year, with 2016 showing the lowest yearly growth-to-date of 0.35%. Further progress has also been exhibited with the Medicare fee-for-service (FFS) savings that Maryland needs to achieve by holding Maryland's per beneficiary growth in hospital expenditures below the national growth rate. In each calendar year, Medicare FFS per beneficiary growth in Maryland has been below the national average growth, resulting in a savings of $429 million to Medicare over the three-year period. The goal for this metric is for the State to save Medicare $330 million over five years, and thus, unless there is a severe increase in the Medicare FFS per beneficiary growth in Maryland compared to the national average over the last two years, Maryland has already exceeded this metric halfway through the demonstration. Maryland is also achieving savings, not only in hospitals, but also in Medicare total cost of care savings throughout the

demonstration, with savings of approximately $319 million to date. Performance on this metric will be extremely important in the future as the next phase of the All-payer Model Contract, as explained more in Issue 1, will emphasize performance on this measure.

Exhibit 2
Medicare All-payer Waiver Metrics
Calendar 2014-2016

	Goal	Year 1 (2014)	Year 2 (2015)	Year 3 (2016)[1]
Per Capita All-payer Hospital Revenue Growth	**< or = 3.58%**	**1.47%**	**2.31%**	**0.35%**
Maryland Per Beneficiary Medicare FFS Hospital Revenue Growth[2]		-1.12%	1.64%	0.01%
Medicare FFS Hospital Per Beneficiary Growth Comparison[3]				
Maryland		-1.10%	1.80%	-1.70%
National		1.10%	1.90%	1.60%
Cumulative Medicare Savings in Hospital Expenditures Over Five Years	**$330 million**	**$116 million**	**$251 million**	**$429 million**
Cumulative Medicare Total Cost of Care Savings	Lower than the national average growth rate from 2013 base year	$133 million	$213 million	$319 million
Eliminate Gap between Maryland and the National Medicare Hospital Readmission Rate	Maryland rate at or below national rate by end of 2018 (100.00%)	20.00%	57.00%	71.00%
Cumulative Reduction in Hospital Acquired Conditions	**-30.0% over five years**	**-26.00%**	**-35.00%**	**-49.00%**

FFS: fee-for-service

[1] Year-to-date results compare the performance available in calendar 2016 to the same months in the prior year or to the same months in the 2013 base year, unless otherwise noted, as applicable: all-payer revenue through September; hospital acquired conditions though June; and Medicare savings through August.
[2] This data is specific to Maryland and is used for real time monitoring.
[3] This data is based on Center for Medicare and Medicaid Innovation reporting.

Source: Health Services Cost Review Commission

Beyond financial measures, the waiver tests also require hospitals in the State to bring the readmission rate below the national readmission rate, as well as to reduce the number of hospital-acquired conditions by 30% over the five-year demonstration. So far, the State has closed 71% of the gap in the readmission rate for the State compared to the national rate. For hospital-acquired conditions, the State has already exceeded the cumulative goal of 30%, having reduced hospital-acquired conditions by 49% through the end of 2016.

Fiscal 2017 Actions

Section 20 Position Abolitions

The fiscal 2017 budget bill contained a section that directed the Executive Branch to abolish 657 positions and achieve a savings of $25 million, including $20 million in general funds and $5 million in special funds. This agency's share of the reduction is 4.8 positions and $36,182 in special funds.

Proposed Budget

As seen in **Exhibit 3**, the total appropriation for the Health Regulatory Commissions decreases by $25.4 million below the fiscal 2017 working appropriation after contingent reductions. The majority of this decrease is due to expenditures from the Uncompensated Care Fund.

Exhibit 3
Proposed Budget
DHMH – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016 Actual	$164,438	$1,640	$173	$166,251
Fiscal 2017 Working Appropriation	225,340	0	173	225,512
Fiscal 2018 Allowance	200,083	0	0	200,083
Fiscal 2017-2018 Amount Change	-$25,257	$0	-$173	-$25,429
Fiscal 2017-2018 Percent Change	-11.2%		-100.0%	-11.3%

Where It Goes:

Personnel Expenses	
Social Security contributions	-$19
Workers' compensation premium assessment	-27
Employee and retiree health insurance	-102
Retirement contributions	-102
Transferred position (1 regular full-time equivalent from MCHRC)	-119
Turnover adjustments	-142
Salary adjustments	-183
Other Changes	
Integrated Care Networks	2,000
DHMH indirect cost recovery	1,083
Shock Trauma grants	600
Community Health Resources Commission BRFA contingent reduction	-3,750
Uncompensated Care Fund (alignment to actual)	-24,853
Other	184
Total	**-$25,429**

BRFA: Budget Reconciliation and Financing Act
DHMH: Department of Health and Mental Hygiene
MCHRC: Maryland Community Health Resources Commission

Note: Numbers may not sum to total due to rounding.

Across-the-board Reductions

The fiscal 2018 budget bill includes a $54.5 million (all funds) across-the-board contingent reduction for a supplemental pension payment. Annual payments are mandated for fiscal 2017 through 2020 if the Unassigned General Fund balance exceeds a certain amount at the close of the fiscal year. This agency's share of this reduction is $49,159 in special funds. This action is tied to a provision in the Budget Reconciliation and Financing Act (BRFA) of 2017.

Personnel

Personnel spending for all of the regulatory commissions decreases by approximately $694,000 below the fiscal 2017 working appropriation. The largest decreases are for salary adjustments ($183,000) and increased turnover ($142,000), which are mainly within MHCC. There is also 1 position transferred from MCHRC to the Prevention and Health Promotion Administration within DHMH, which decreases the allowance by $119,000.

Other Changes

There are two large increases in the budgets for the commissions. The first is $2 million to continue the Integrated Care Networks (ICN) project. More on this is presented later in the analysis. There is also a $1 million increase in indirect cost recovery funds from MHCC and HSCRC to the DHMH – Administration budget. However, this increase from an 18.0% rate to a 30.5% rate is contradictory to the statutes for both commissions, which limit the rate to 18.0%. **Thus, the Department of Legislative Services (DLS) is recommending that the funds be reduced to the legal allowable level.**

There are also some large decreases in the budgets for the commissions. The largest decrease is $24.9 million in the Uncompensated Care Fund. This fund is mainly a revolving fund where hospitals with a disproportionately lower share of uncompensated care pay into the fund, which then pays out to those hospitals with a disproportionately higher share. The reduction simply aligns spending from that account closer to the most recent actual. The allowance amount of $120.0 million is still above the most recent actual spending in fiscal 2016 of $110.3 million.

There is a deficiency appropriation in the Medicaid budget, which uses $10 million from the fund balance of Uncompensated Care Fund to support Medicaid expenditures. DLS has reservations about diverting revenues from a pass-through account and the legality due to the lack of express authority to use the fund for this purpose. More information about this can be found in the Medicaid analysis.

There is also one contingent reduction, $3.75 million to MCHRC that is tied to a provision in the BRFA of 2017 to reduce the mandated appropriation for MCHRC from $8.0 million to $4.0 million in fiscal 2018 and each fiscal year thereafter (although the fiscal 2018 allowance for MCHRC prior to the contingent reduction is, in fact, only $7.9 million). This $3.75 million would then be transferred to the Behavioral Health Administration budget to supplant general funds used for mental health services.

While there are no major changes in the budgets for MHCC or HSCRC that rely on their respective user fee assessments, recent sunset evaluations conducted by DLS have made an issue about the abilities of each commission to continue to fulfill their duties under their current user fee assessment caps. In the fiscal 2018 allowance, the appropriation for MHCC is $15.1 million, on a cap of only $12.0 million, while the appropriation for HSCRC is $14.1 million on a cap of also $12.0 million. If MHCC and HSCRC were to spend all of each commission's current working appropriation as well as allowance, with the increased cost recovery backed out, MHCC would end fiscal 2018 with a negative fund balance of $1.5 million and HSCRC would end with a balance of only $452,000. **The**

commissions should comment on how the current user fee assessment caps are affecting their ability to fulfill their current duties and responsibilities.

Issues

1. The All-payer Model Contract

Effective January 1, 2014, Maryland entered into a contract with the federal government to replace the State's 36-year-old Medicare waiver with the new Maryland All-payer Model Contract. Whereas under the old waiver test, Maryland's success was based solely on the cumulative rate of growth in Medicare inpatient per admission costs, the new model contract contains completely different benchmarks and components that the State must meet throughout the 5-year demonstration model to continue to have a waiver and be able to set Medicare hospital rates.

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 5-year demonstration model, which began on 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 3 years of the demonstration). After year 3, the State could have adjusted the overall cap based on updated data. However, the State is not going to adjust this goal.

- ***Medicare Hospital Savings:*** Maryland has agreed to produce $330 million in cumulative Medicare hospital savings over 5 years by holding the growth in Maryland Medicare FFS hospital spending below the national Medicare growth rate.

- ***Population-based Revenue:*** Initially, HSCRC had agreed under the contract to have 80.0% of all hospital-based revenue into population-based models by year 5 of the contract, *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. However, all hospitals agreed to global budgets, which began on July 1, 2014, and these global budgets already include approximately 95.0% of all hospital revenue.

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

- ***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 5 years.

- ***Medical Education Innovation:*** Maryland must develop a 5-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 model contract, a so-called triggering event could lead CMMI to send the State a warning notice and potentially require a corrective action plan. However, as noted in the performance analysis earlier in this document, HSCRC is currently meeting or exceeding all of the model contract goals.

Next Steps for the Model Contract – Care Redesign Amendment

In early recognition of the fact that payment and performance measures were not efficiently aligned across hospitals as well as physicians and other health care providers, the State applied for, and was granted, a Care Redesign Amendment for the current contract in September 2016. The amendment aims to modify the model by implementing effective care management and chronic care management; incentivizing efforts to provide high-quality, efficient, and well-coordinated episodes of care; and supporting hospitals' ability, in collaboration with their nonhospital care partners, to monitor and control Medicare beneficiaries' total cost of care growth.

Under the amendment, hospitals can choose to participate in one or both of the first two Care Redesign Programs: the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). The HCIP will be implemented by hospitals and physicians with privileges to practice at hospitals and will seek to improve the efficiency and quality of care by encouraging effective care transitions, encouraging effective management of inpatient resources, and promoting decreases in potentially avoidable utilization. The CCIP will be implemented by hospitals in collaboration with community physicians and practitioners and will strive to link hospitals' resources for managing the care of individuals with severe and chronic health issues with primary care providers' efforts to care for the same populations as well as patients with rising needs. The primary driving factor behind both programs is that hospitals will be able to share resources and provide incentives to physicians and other practitioners in ways that will better align everyone's goals with the All-payer Model Contract, and in doing so, improve health outcomes while lowering the total cost of care. Physicians and other providers will be incentivized to participate due to changes in the Medicare Access and the Children's Health Insurance Program Reauthorization Act and other new federal regulations and initiatives. Further, the amendment gives Maryland the flexibility to expand and refine Care Redesign Programs based on learned experience, as well as the changing levels of sophistication of Maryland's health care system players and consumers.

Moving on to Phase II – the Progression Plan

Building on the success of the first phase of the model contract, HSCRC is developing and implementing changes that will shift the focus from the cost of hospital care to the total cost of care in the State. A plan for Phase II of the contract, known as the Progression Plan, was submitted to the federal Centers for Medicare and Medicaid Services (CMS) in December 2016. The key themes of the plan are to (1) foster accountability by organizing hospitals, physicians, and other providers to take accountability for groups of patients or populations within a geographic area; (2) align measures and incentives for all providers with the goals of the model; (3) encourage and develop payment and delivery system transformation to drive coordinated efforts and systemwide goals; (4) ensure availability of tools to support providers in achieving transformation goals; and (5) devote resources to increasing consumer engagement.

Revisions to the model, in addition to those changes already authorized under the Care Redesign Amendment, will include integrated care incentives, such as integrated care networks, pay-for-performance programs, and gain-sharing programs to achieve the goals of care coordination and provider alignment. As part of the care redesign strategies both under the amendment and the Progression Plan, two of the larger initiatives that the State is developing are for an Accountable Care Organization serving individuals eligible for both Medicare and Medicaid, and the Maryland Comprehensive Primary Care Model. (See separate issue write-ups on the Accountable Care Organization and Maryland Comprehensive Primary Care Model in the Medical Care Programs Administration and Public Health Administration analyses, respectively.) **Exhibit 4** below provides an overview of the goals and key elements of the new Progression Plan.

The main theme of the Progression Plan is for the State to begin to control the growth of total Medicare spending within the State by focusing on population health initiatives as well as on the Medicare-Medicaid dual-eligible population, which not only tends to be a high utilizer of health services but is also projected to grow in the coming years. However, with this focus, total cost of care metrics will still remain solely focused on Medicare spending and not necessarily on Medicaid spending if the Progression Plan as introduced is approved.

Exhibit 4
Maryland's All-payer Model Contract Progression Plan: Strategies and Key Elements

Strategy One: Foster Accountability

Key Element 1a: Leverage Existing Provider and Payer Accountability Structures
Key Element 1b: Implement Local Accountability for Population Health and Medicare Total Cost of Care through the Geographic Value-based Incentive
Key Element 1c: Establish a Dual Eligible Accountable Care Organization

Strategy Two: Align Measures and Incentives

Key Element 2a: Reorient Hospital Measures to Align with New Model Goals
Key Element 2b: Align Measures across Providers and Programs
Key Element 2c: Engage Physicians and Other Professionals by Leveraging Medicare Access and CHIP Reauthorization Act

Strategy Three: Encourage and Develop Payment and Delivery System Transformation

Key Element 3a: Develop a Maryland Comprehensive Primary Care Model
Key Element 3b: Develop Initiatives Focused on Post-acute and Long-term Care
Key Element 3c: Explore Initiatives to Include Additional Physicians and Providers and Services in Care Transformation
Key Element 3d: Improve the Financing and Organization of the Behavioral Health Delivery System
Key Element 3e: Promote Investments in Innovation, Technology, and Education

Strategy Four: Ensure Availability of Tools to Support All Types of Providers in Achieving Transformation Goals

Key Element 4a: Enable and Support the Health Care Community to Appropriately Share Data to Improve Care

Strategy Five: Devote Resources to Increasing Consumer Engagement

Key Element 5a: Transform the Health Care Delivery System with Consumer-driven and Person-centered Approaches
Key Element 5b: Engage, Educate, and Activate Patients, Providers, and All Stakeholders

CHIP: Children's Health Insurance Program

Source: Health Resources Cost Review Commission

One of the largest issues surrounding the Progression Plan is whether or not it will actually be approved by CMS in the next year. Negotiations are already underway. However, as described in

greater detail below, after the November 2016 national elections, there is more uncertainty surrounding the negotiations due to potential federal changes to the Affordable Care Act (ACA). Beyond this uncertainty, however, there are two other concerns with the Progression Plan as is. The first is a resource issue. All of these strategies will require new resources for either HSCRC, MHCC, or DHMH as they move forward with enhanced monitoring, value based payment, and infrastructure transformation. While the Progression Plan states that the State plans to rely on the private resources of health systems, payers, and others, as well as public-private partnerships to provide the infrastructure and transformation resources that will be needed, it is unclear at this time where those resources will be coming from. Further, the current fee assessment caps on both MHCC and HSCRC appear inadequate to allow either commission to increase their respective budgets to cover the cost of any enhanced monitoring that may be needed for this proposal.

The second issue revolves around governance. While the Progression Plan notes that all three of HSCRC, MHCC, and DHMH will be involved in implementing the new plan, it also notes that DHMH will be taking the lead on efforts to establish the appropriate governance and infrastructure approach. While this may be beneficial as the new plan will require more than just hospital buy-in to succeed, and thus may need more governance from a wider range of entities than just HSCRC, it is unclear how DHMH will be leading in implementing these changes. Further, as pointed out in the recent special sunset evaluation of all three commissions, this broadening scope is already leading to overlapping responsibilities and issues between MHCC and HSCRC. **The commissions should comment on what new governance legislation will be presented, provide more detail on how the three entities will share responsibility for the implementation of the Progression Plan, and more concretely identify what resources the State seeks to leverage, outside of the State budget, to make sure that the implementation is successful.**

Implications of the ACA Repeal and Other Federal Changes

Even with Maryland's performance on all of the measures so far, the future of the All-payer Model Contract is still fraught. To begin with, the State's contract with CMS is authorized in federal statute under provisions that were in the ACA under the creation of CMMI. If these provisions are repealed and not subsequently replaced, the State would have to find other statutory language that would allow the State to seek this specific waiver.

Further, even if the language that allows CMMI to exist and approve such waivers is renewed, there is still uncertainty surrounding the new federal administration. The current round of negotiations may be with members of the new federal administration who are under no obligation to approve a new model contract on any timeline, or for that matter approve a new contract at all. All of this will also be taking place in the context of what could be significant changes in federal health care policy, which will most likely require the lion's share of the attention of the new administration to implement.

Finally, the coverages provided by the ACA have had a profound impact upon hospital revenues. As previously mentioned, the cost of uncompensated care at hospitals within the State has been declining in recent years. Similarly, the State has removed the assessment on hospitals that funded the Maryland Health Insurance Plan (MHIP), the State's high-risk pool, as well as reducing the Medicaid deficit assessment on hospitals. This has allowed hospitals to maintain greater profits without

having to significantly increase the global budget revenues that they receive, which helps with the main contract test. To the extent that coverage levels are rolled back due to federal health care reform, this could mean a return of greater levels of uncompensated care, and thus place greater stress on the global budgets of hospitals at the same time that they are becoming accustomed to the next All-payer Model Contract. **HSCRC should also comment on what strategies it will employ to ensure that the State retains its all-payer system in light of the continuing uncertainty at the federal level concerning continuation of prior health care reform efforts.**

2. Integrated Care Networks

Starting in fiscal 2016, both MHCC and HSCRC engaged CRISP to initiate and complete the buildout of the software and other information technology infrastructure for an ICN. The purpose of an ICN is to create a system where multiple providers can coordinate care and integrate their efforts in order to better meet the needs of patients, as well as the goals and purposes of the All-payer Model Contract.

This year, work on the ICN has focused on the four main venues where information is shared: (1) the point of care; (2) care managers and coordinators; (3) the population health team, or PaTH; and (4) patients. While all four of these venues have seen dramatic improvement over the past year, there are still some challenges facing the project, including that approaches to care coordination interventions among stakeholders are not consistent, making shared infrastructures more difficult to deploy; ambulatory providers, acute providers, post-acute providers, and managed care organizations have not been fully aligned in their approaches to meet new waiver goals or their vision as to the end state; difficulties in obtaining Medicare data to produce reports; the overall pace of the project was somewhat slow compared to the plan and spending was below budget; and operationally, the project team feels the need to simplify the message to participants and focus on a smaller set of goals.

Funding Sources

Funding for this project is derived from two main sources. The first is through hospital rates as authorized by the BRFA of 2014. The Act authorized HSCRC to include within hospital rates up to $15 million for care coordination activities, the majority of which was diverted to the ICN project. Second, the BRFA of 2015 authorized HSCRC in fiscal 2016 through 2019 to utilize a portion of the remaining fund balance of MHIP to support ICNs designed to reduce health care expenditures and improve outcomes for specified Medicare and dual-eligible patients, consistent with the goals of the All-payer Model Contract. **Exhibit 5** provides more detail on the funding sources for this project, including what other projects have been funded, what other projects are slated to be funded, and the fund balances.

Exhibit 5
Integrated Care Networks Expenditures
Fiscal 2016-2018

	BRFA of 2014 Set Aside			MHIP Fund Balance		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**
Total Revenues and Expenditures						
Starting Balance	$0	$1,674,782	$1,024,782	$0	$52,978,322	$30,600,329
Revenues	11,500,884	0	0	52,978,322	0	0
Expenditures	9,826,102	650,000	650,000	0	22,377,993	25,377,993
Ending Balance	**$1,674,782**	**$1,024,782**	**$374,782**	**$52,978,322**	**$30,600,329**	**$5,222,336**
Spending by Project						
HSCRC – ICN Special Projects	$0	$0	$0	$0	$3,000,000	$6,000,000
CRISP – ICN	9,779,252	0	0	0	19,377,993	19,377,993
IAPD	46,850	650,000	650,000	0	0	0
Totals	**$9,826,102**	**$650,000**	**$650,000**	**$0**	**$22,377,993**	**$25,377,993**

BRFA: Budget Reconciliation and Financing Act
CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Resources Cost Review Commission
IAPD: Implementation Advanced Planning Document
ICN: Integrated Care Networks
MHIP: Maryland Health Insurance Plan

Source: Health Resources Cost Review Commission; Maryland Health Care Commission

While MHIP funding is projected to have a low balance at the end of fiscal 2018, the authorization for the expenditure of these funds expires at the end of fiscal 2019. Further, to date, funding for the ICN at CRISP, as well as funding on the special projects within HSCRC, have slowed significantly with only approximately $500,000 having been spent on the special projects and only $5.3 million for the CRISP ICN project through December 2016. If expenditures do not match the projections for fiscal 2017 or 2018, it is unclear what the commissions will do with the remaining balances. **HSCRC should comment on the plans for the special projects funding, and whether all of the available funds will be expended by the close of fiscal 2019.**

Recommended Actions

		Amount Reduction	
1.	Reduce funding for indirect costs to the legal allowable level of 18%.	$ 1,083,635	SF
	Total Special Fund Reductions	**$ 1,083,635**	

Updates

1. Special Evaluation of the Three Regulatory Commissions

In December 2015, DLS completed preliminary sunset evaluations of HSCRC and MHCC. These evaluations concluded that both commissions function well to fulfill their expanding statutory requirements, meet their respective performance metrics, and provide important policy guidance to the State. Both evaluations noted concerns about MHCC and HSCRC regarding resource constraints due to expansion of the commissions' responsibilities. The evaluations also noted that the landscape of health policy in Maryland has changed significantly. In particular, under the Maryland All-payer Model Contract, the State is moving to a population-based approach that now impacts both hospitals and community providers. DLS noted that the three health care commissions, MHCC, HSCRC, and MCHRC may have developed overlapping responsibilities. Based on these findings, DLS recommended that the Legislative Policy Committee waive HSCRC and MHCC from full evaluation and require DLS to conduct a review of the missions and responsibilities of all three health care commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned.

Observations and Recommendations

Overall, DLS noted that the duties and responsibilities of HSCRC and MHCC increasingly overlap in four main areas: (1) oversight of the Certificate of Need (CON) process; (2) oversight of the statewide HIE; (3) creation of the ICN project; and (4) use and management of the Medical Care Data Base (MCDB). Further, the roles of MCHRC and HSCRC overlap in large part due to the All-payer Model Contract as each commission increasingly focuses on encouraging partnerships between community providers and hospitals in order to fulfill the goals of the current phase as well as the next phase of the contract. However, DLS noted that there is significant reason to be cautious at this time with any effort to realign or condense commission functions. This caution is mostly based on the fact that implementation of the Progression Plan will likely require additional changes to the CON process; the duties, funding, and oversight of CRISP; the duties of HSCRC and MHCC; and how HSCRC utilizes the MCDB to evaluate waiver performance. As a result, any attempts to modify the CON, CRISP, or the MCDB may interfere with the complex negotiations that HSCRC is currently engaged in with CMS.

As a result of this caution, DLS recommended that the evaluation dates of both HSCRC and MHCC be extended by three years to July 1, 2020, and that another special evaluation be required of all three health care commissions in the 2019 interim. This evaluation should focus on areas of overlap identified in this most recent review, as well as any new structures that have been developed, or are developing, due to the implementation of the Progression Plan or whatever new phase of the All-payer Model Contract is approved by CMS. Further, DLS made clear that while MCHRC is not subject to sunset review, MCHRC should remain a part of any further evaluation. DLS also reiterated its previous recommendations that the user-fee assessment caps of both MHCC and HSCRC be reviewed to ensure that both commissions have sufficient resources to carry out their current missions and responsibilities.

2. Report on the Status of Hospital Partnerships with Community Behavioral Health Providers

The 2016 *Joint Chairmen's Report* required HSCRC to submit a report on the status of hospital partnerships and contracts with nonhospital-owned community behavioral health organizations funded through HSCRC implementation grants and the total amount of implementation grant funding used by hospitals to contract with nonhospital-owned community behavioral health organizations. The report was submitted by HSCRC on December 9, 2016.

In the report, HSCRC provided details on projects known as Transformation Implementation Grants, which were approved by the commission in June 2015. At that time, the commission authorized up to 0.25% of total hospital rates to be distributed to grant applicants under a competitive process for "shovel-ready" care transformation improvements that will generate more efficient care delivery in collaboration with community providers and achieve immediate results. In June 2016, HSCRC approved nine proposals for a total of approximately $30.57 million. Of these awards, eight have behavioral health components, with preliminary reporting in October 2016 suggesting that $5.04 million of these transformation dollars will be spent toward behavioral health initiatives. Of those dollars, approximately $2.9 million are dollars that are spent toward providers that are independent of hospitals.

Further, HSCRC provided additional detail on the importance of behavioral health issues to hospitals in the State as well as to the goals of the All-payer Model Contract. They reviewed how the Maryland Hospital Association has recently conducted an environmental scan of behavioral health services, as well as the work of HSCRC, in fulfillment of a requirement of the fiscal 2017 Update Factor, to convene a subgroup of the Performance Measurement Workgroup called the Behavioral Health Performance Measurement Subgroup.

Appendix 1
Current and Prior Year Budgets
DHMH – Health Regulatory Commissions
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2016					
Legislative Appropriation	$0	$198,360	$228	$173	$198,760
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	0	28,035	2,264	0	30,299
Reversions and Cancellations	0	-61,956	-852	0	-62,808
Actual Expenditures	**$0**	**$164,438**	**$1,640**	**$173**	**$166,251**
Fiscal 2017					
Legislative Appropriation	$0	$230,259	$0	$173	$230,431
Cost Containment	0	0	0	0	0
Budget Amendments	0	-4,919	0	0	-4,919
Working Appropriation	**$0**	**$225,340**	**$0**	**$173**	**$225,512**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions. Numbers may not sum to total due to rounding.

Fiscal 2016

Actual expenditures for the Health Regulatory Commissions were $32,509,548 below the legislative appropriation. Budget amendments added $30,298,942, including $28,035,108 in special funds and $2,263,834 in federal funds. Special fund increases included:

- $18,472,102 to the Health Services Cost Review Commission (HSCRC) to begin the Integrated Care Networks project;
- $14,750,000 for the Chesapeake Regional Information System for our Patients to be paid out of hospital rates per the Budget Reconciliation and Financing Act of 2014;
- $1,718,206 for HSCRC to cover deficits in salaries and contractual services;
- $214,169 to restore a 2% salary reduction;
- $200,000 to increase the allotment for the University of Maryland Medical System Shock Trauma Center grant; and
- $100,000 for a grant from the Network for Regional Health Care Improvements.

There were also decreases in special funds through budget amendments totaling $7,419,369 due to lower than projected activity in the Uncompensated Care Fund. The federal fund amount is entirely due to a grant to the Maryland Health Care Commission to conduct Cycle IV of the Health Insurance Premium Rate Review under the federal Affordable Care Act.

Cancellations totaled $62,808,490, including $61,956,479 in special funds and $852,011 in federal funds. The majority of the special fund cancellations were related to higher than expected turnover and further underutilization of the Uncompensated Care Fund, while the federal fund cancellations are due to the project being completed under budget.

Fiscal 2017

To date, the working appropriation for the commissions has decreased by $4,919,042, all in special funds. The majority of this decrease is $5,147,003 in the appropriation for the Uncompensated Care Fund due to a lower than projected need for fiscal 2017. This decrease was partially offset by $214,355 in special funds for the transfer of funds for increments in fiscal 2017, as well as $13,606 to realign special funds for the implementation of Section 20 of the budget bill.

Appendix 2
Object/Fund Difference Report
DHMH – Health Regulatory Commissions

Object/Fund	FY 16 Actual	FY 17 Working Appropriation	FY 18 Allowance	FY 17 - FY 18 Amount Change	Percent Change
Positions					
01 Regular	103.70	98.90	97.90	-1.00	-1.0%
02 Contractual	0.00	1.00	1.00	0.00	0%
Total Positions	**103.70**	**99.90**	**98.90**	**-1.00**	**-1.0%**
Objects					
01 Salaries and Wages	$ 12,346,430	$ 13,408,659	$ 12,764,216	-$ 644,443	-4.8%
02 Technical and Spec. Fees	22,781	37,633	109,278	71,645	190.4%
03 Communication	95,744	75,762	82,200	6,438	8.5%
04 Travel	120,949	237,177	236,100	-1,077	-0.5%
08 Contractual Services	141,858,009	200,416,598	178,895,774	-21,520,824	-10.7%
09 Supplies and Materials	64,672	79,670	60,359	-19,311	-24.2%
10 Equipment – Replacement	40,257	21,300	22,500	1,200	5.6%
11 Equipment – Additional	83,049	168,800	200,000	31,200	18.5%
12 Grants, Subsidies, and Contributions	11,191,611	10,560,345	10,973,468	413,123	3.9%
13 Fixed Charges	427,315	506,431	538,472	32,041	6.3%
Total Objects	**$ 166,250,817**	**$ 225,512,375**	**$ 203,882,367**	**-$ 21,630,008**	**-9.6%**
Funds					
03 Special Fund	$ 164,438,376	$ 225,339,875	$ 203,882,367	-$ 21,457,508	-9.5%
05 Federal Fund	1,639,941	0	0	0	0.0%
09 Reimbursable Fund	172,500	172,500	0	-172,500	-100.0%
Total Funds	**$ 166,250,817**	**$ 225,512,375**	**$ 203,882,367**	**-$ 21,630,008**	**-9.6%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.

Appendix 3
Fiscal Summary
DHMH – Health Regulatory Commissions

Program/Unit	FY 16 Actual	FY 17 Wrk Approp	FY 18 Allowance	Change	FY 17 - FY 18 % Change
01 Maryland Health Care Commission	$ 38,303,603	$ 34,399,121	$ 55,919,104	$ 21,519,983	62.6%
02 Health Services Cost Review Commission	119,646,007	183,025,620	140,080,920	-42,944,700	-23.5%
03 Maryland Community Health Resources Commission	8,301,207	8,087,634	7,882,343	-205,291	-2.5%
Total Expenditures	**$ 166,250,817**	**$ 225,512,375**	**$ 203,882,367**	**-$ 21,630,008**	**-9.6%**
Special Fund	$ 164,438,376	$ 225,339,875	$ 203,882,367	-$ 21,457,508	-9.5%
Federal Fund	1,639,941	0	0	0	0.0%
Total Appropriations	**$ 166,078,317**	**$ 225,339,875**	**$ 203,882,367**	**-$ 21,457,508**	**-9.5%**
Reimbursable Fund	$ 172,500	$ 172,500	$ 0	-$ 172,500	-100.0%
Total Funds	**$ 166,250,817**	**$ 225,512,375**	**$ 203,882,367**	**-$ 21,630,008**	**-9.6%**

DHMH: Department of Health and Mental Hygiene

Note: Does not include targeted reversions, deficiencies, and contingent reductions.