M00R01
Health Regulatory Commissions
Maryland Department of Health

Operating Budget Data

($ in Thousands)

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change	% Change Prior Year
Special Fund	$160,437	$200,833	$204,928	$4,095	2.0%
Adjustments	0	-124	-2,891	-2,767	
Adjusted Special Fund	**$160,437**	**$200,709**	**$202,037**	**$1,328**	**0.7%**
Federal Fund	803	0	0	0	
Adjusted Federal Fund	**$803**	**$0**	**$0**	**$0**	
Adjusted Grand Total	**$161,240**	**$200,709**	**$202,037**	**$1,328**	**0.7%**

Note: FY 18 Working includes targeted reversions, deficiencies, and across-the-board reductions. FY 19 Allowance includes contingent reductions and cost-of-living adjustments.

- The fiscal 2019 allowance for the Health Regulatory Commissions increases by $1.3 million after contingent and across-the-board actions. The majority of this increase is due to new costs within the Health Services Cost Review Commission (HSCRC) for personnel and contracts related to the proposed new All-payer Model Contract.

- There is one contingent reduction for the Maryland Community Health Resources Commission (MCHRC), which would reduce the appropriation by $3 million in order to utilize those special funds in lieu of general funds for mental health services within the Behavioral Health Administration (BHA). This action is tied to a provision in the Budget Reconciliation and Financing Act of 2018.

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

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Personnel Data

	FY 17 Actual	FY 18 Working	FY 19 Allowance	FY 18-19 Change
Regular Positions	100.90	95.90	103.90	8.00
Contractual FTEs	1.00	1.00	0.00	-1.00
Total Personnel	**101.90**	**96.90**	**103.90**	**7.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	7.16	7.47%
Positions and Percentage Vacant as of 12/31/17	13.00	13.56%

- The fiscal 2019 allowance contains 8 new full-time equivalent (FTE) regular positions for HSCRC. These positions are for new duties and requirements that will have to be met under the new proposed All-payer Model Contract.

- Further, within the fiscal 2018 working appropriation, a total of 5 regular positions were removed from the commissions, including 4 from the Maryland Health Care Commission (MHCC) and 1 from HSCRC, in order to provide positions for the bed expansion within BHA.

- There is also a decrease of 1 contractual FTE for MCHRC that is no longer needed.

- Budgeted turnover is increased in the fiscal 2019 allowance from 5.9% to 7.5%, which requires the commission to maintain 7.1 vacant positions throughout the year. As of December 31, 2017, there were 13 vacant positions, or 13.6%.

Analysis in Brief

Major Trends

New Metrics for the State-designated Health Information Exchange: Beginning this year, MHCC and the Department of Budget and Management (DBM) have adopted new Managing for Results (MFR) metrics for the State-designated Health Information Exchange (HIE). However, there are no objective goals listed for these new measures. **MHCC and DBM should comment on what the objective MFR goals for the HIE are and should be prepared to publish these goals within next year's budget books.**

Maryland All-payer Model Contract Metrics Continue to Show Progress: The 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 2017, the State has surpassed the benchmarks for all of the metrics under the model.

Issues

The All-payer Model Contract: As the All-payer Model Contract enters Year 5, the State is continuing to perform relatively well on the metrics that the State must meet in order to maintain the agreement. Further, two care redesign programs are already underway, and negotiations over the next phase continue between HSCRC, the State, and the federal government. An extension of the current contract has been agreed to but not finalized, and a timeline on the finalization of the next contract is still unclear. **HSCRC should provide an update on when both the extension and new expanded model contract will be signed, and further provide what contingency plans the commission has if the expanded contract is not signed.**

Hospital Profits Continue to Rise: Hospital profits continue to rise under the global budgets and the model contract. Profit margins approaching 6% in fiscal 2018 were reported to the commission in January. **HSCRC should also comment on what plans, if any, it has to address particularly high profit rates at various hospitals.**

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 how they anticipate dealing with the projected fund balance deficit at the end of fiscal 2019. The Department of Legislative Services (DLS) also recommends that the appropriation be reduced to the appropriate level.**

Uncompensated Care Fund: As payments from the Uncompensated Care Fund have been declining in recent years, the Maryland Department of Health has been utilizing the excess special fund appropriation capacity to raise the appropriation of other special funds throughout the department without having to process budget amendments that would be subject to review and comment by the budget committees. **DLS recommends reducing the appropriation for the Uncompensated Care Fund to the appropriate level.**

Operating Budget Recommended Actions

		Funds
1.	Reduce funding for the Integrated Care Networks to the appropriate level.	$ 6,000,000
2.	Reduce Uncompensated Care Fund payments to the appropriate level.	20,000,000
	Total Reductions	**$ 26,000,000**

M00R01
Health Regulatory Commissions
Maryland Department of Health

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are independent agencies that operate within the Maryland Department of Health (MDH). 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. New Metrics for the State-designated Health Information 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 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. Beginning this year, MHCC and the Department of Budget and Management (DBM) have adopted new Managing for Results (MFR) metrics for the HIE, which are presented in **Exhibit 1**, and include the number of provider queries, unique users, Encounter Notification System alerts to physicians, and the number of ambulatory practices connected to the HIE. There are only two years' worth of data, but for all categories, the metrics demonstrate more usage of the system in fiscal 2017.

Exhibit 1
Utilization of the State-designated Health Information Exchange
Fiscal 2016-2017

	2016	2017
Provider Queries	1,257,956	1,346,684
Unique Users	25,862	53,189
Encounter Notification System Alerts to Physicians	18,019,775	18,488,775
Ambulatory Practices Connected to HIE	1,349	1,463

HIE: Health Information Exchange

Source: Budget Books

What is unclear is what these metrics are meant to tell us. There are no objective goals listed for these new measures, such as how many unique users the HIE desires to have or even any comment on the goal or metric suggested last year in the analysis about what proportion of all eligible users are currently utilizing the HIE. Without clear, objective benchmarks, there is no way of knowing how the HIE is performing based on this data. **MHCC and DBM should comment on what the objective MFR goals for the HIE are, and they should be prepared to publish these goals within next year's budget books.**

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 contract. **Exhibit 2** provides some detail on certain metrics that HSCRC monitors to ensure compliance with the tests that the Centers 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. As shown in Exhibit 2, for Year 4, the State is at a 3.05% per capita growth rate for hospital revenues, which is below the 3.58% annualized average goal contained in the contract.

More progress has 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 $856 million to Medicare over the four-year period. The goal for this metric is for the State to save Medicare $330 million over five years, which means that Maryland has already more than exceeded this metric for the demonstration. Maryland is also achieving savings, not only in hospitals, but also in Medicare total cost of care (TCOC) throughout the demonstration, with savings of approximately $579 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.

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. By Year 4, the State has closed the gap in the readmission rate for the State compared to the national rate, with the reduction totaling 114% of the previous gap (meaning the State is outperforming the nation). For hospital-acquired conditions, the State has already exceeded the cumulative goal of 30%, having reduced hospital-acquired conditions by 50% through the end of September 2017.

Exhibit 2
Maryland All-payer Waiver Metrics
Calendar 2014-2017
($ in Millions)

	Goal	Year 1 (2014)	Year 2 (2015)	Year 3 (2016)[1]	Year 4 (2017)[1]
Per Capita All-payer Hospital Revenue Growth	**< or = 3.58%**	**1.47%**	**2.31%**	**0.80%**	**3.05%**
Maryland Per Beneficiary Medicare FFS Hospital Revenue Growth [2]		-1.06%	1.15%	-0.95%	1.64%
Medicare FFS Hospital Per Beneficiary Growth Comparison [3]					
Maryland		-1.0%	1.6%	-0.8%	2.9%
National		1.2%	2.0%	2.0%	3.0%
Cumulative Medicare Savings in Hospital Expenditures Over 5 Years	**$330**	**$120**	**$275**	**$586**	**$856**
Medicare Total Cost of Care Savings	Lower than the national average growth rate from 2013 base year	$142	$263	$461	$579
Reduction in Hospital Medicare Readmission Rate	**Reduction to at or below national rate by end of calendar 2018**	**20%**	**57%**	**80%**	**114%**
Cumulative Reduction in Hospital Acquired Conditions	**-30.0% over five years**	**-26%**	**-35%**	**-43%**	**-50%**

FFS: fee-for-service

[1] Year-to-date results compare the performance available in calendar 2017 to the same months in prior year or to the same months in the 2013 base year, unless otherwise noted, as applicable: all-payer revenue through December; hospital acquired conditions through June; and Medicare savings through October.
[2] This data is specific to Maryland and is used for real time monitoring.
[3] This data is based on the Center for Medicare and Medicaid Innovation reporting.

Source: Health Services Cost Review Commission

Fiscal 2018 Actions

Across-the-board Employee and Retiree Health Insurance Reduction

The budget bill includes an across-the-board reduction for employee and retiree health insurance in fiscal 2018 to reflect a surplus balance in the fund. This agency's share of this reduction is $124,265 in special funds.

Proposed Budget

As seen in **Exhibit 3**, the fiscal 2019 allowance for the Health Regulatory Commissions increases by $1.3 million above the fiscal 2018 working appropriation net of the contingent as well as across-the-board actions.

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

How Much It Grows:	Special Fund	Federal Fund	Total
Fiscal 2017 Actual	$160,437	$803	$161,240
Fiscal 2018 Working Appropriation	200,709	0	200,709
Fiscal 2019 Allowance	202,037	0	202,037
Fiscal 2018-2019 Amount Change	$1,328	$0	$1,328
Fiscal 2018-2019 Percent Change	0.7%		0.7%

Where It Goes:	
Personnel Expenses	
New positions (8 positions)	$771
General salary increase	109
Employee and retiree health insurance	6
Other fringe benefit adjustments	-32
Turnover adjustments	-157
Salaries and other compensation	-251
Maryland Health Care Commission	
Special projects	175
Shock Trauma operating grant	100
Contractual expenses	-79

Where It Goes:	
Data processing	-123
Trauma services equipment grants	-600
Health Services Cost Review Commission	
All-payer Model Contract expenses	1,155
Equipment	67
Maryland Community Health Resources Commission	
Grants	139
Contractual services	40
Contractual employee	-71
Other Changes	
Administrative allocation	61
Other	18
Total	**$1,328**

MDH: Maryland Department of Health

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

Personnel

The largest change in personnel expenditures is approximately $771,000 for 8 new positions within HSCRC. These positions are to support the commission's efforts under the new proposed All-payer Model Contract, which will require even more extensive monitoring and metric compliance than the current contract.

Other major personnel changes include a decrease of $142,000 in salaries and other compensation. This change is a result of $251,000 worth of negative salary adjustments due to positions being removed during fiscal 2018, offset by a $109,000 increase for the 2% general salary increase for all State employees effective January 1, 2019. Also, expected agency turnover is being increased from 5.9% to 7.5%, resulting in a decrease of $157,000.

Other Changes

The largest nonpersonnel change for the commissions is an increase of $1.1 million in additional contractual expenses tied to the new performance metrics and conditions of the new All-payer Model Contract. This new contract will be discussed in Issue 1. Other large increases include $175,000 for special projects for MHCC as well as $139,000 in grants for MCHRC. However, for MCHRC, it should be noted that this increase is after the proposed contingent reduction of $3.0 million contained in the Budget Reconciliation and Financing Act (BRFA) of 2018. This reduction is made in order to utilize these special funds in lieu of general funds to support mental health services for the uninsured within

the Behavioral Health Administration (BHA) budget. However, the contingent actions are different since the source of this special fund, the CareFirst Premium Tax Credit, is anticipated to be declining due to changes in the premiums upon which it is based. Therefore, even without this contingent action, MCHRC would most likely not receive the $8.0 million that it would have anticipated without the BRFA action. Further, the BRFA proposes to permanently drop the MCHRC allotment to $4.0 million beginning in fiscal 2020, with the excess special funds continuing to support the BHA payments for uninsured mental health expenditures.

These increases are offset by various decreases, including $600,000 in grants for trauma services that comes from the Trauma Physicians Services (TPS) Fund. These grants are typically done on an every other year basis. However, it is worth noting that due to a large fund balance within the TPS fund, the BRFA also proposes to take $8.0 million of the fund balance and utilize the funds within the Medicaid program in lieu of general funds. More information on this fund swap can be found in the Medical Care Programs Administration analysis. Other notable decreases include $123,000 in data processing costs that were for one-time expenses in fiscal 2018 as well as $71,000 due to the elimination of 1 full-time equivalent contractual position that is no longer necessary within MCHRC.

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 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 five-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 100% 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, HSCRC has already met all of these goals.

Care Redesign Amendments

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 the 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 goals with the All-payer Model Contract and, in so doing, 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.

As of January 30, 2018, 18 hospitals are participating in one or both care redesign programs. These hospitals are presented in **Exhibit 4**. In total, 10 hospitals are participating in the HCIP only, 3 hospitals are participating in the CCIP only, and 5 are participating in both programs.

Exhibit 4
Care Redesign Programs
As of January 30, 2018

Hospital	HCIP	CCIP
Anne Arundel Medical Center	X	
Atlantic General Hospital	X	
Carroll Hospital	X	X
Doctors Community Hospital	X	
Frederick Memorial Hospital	X	
Garrett Regional Medical Center		X
Greater Baltimore Medical Center		X
Holy Cross Hospital	X	
Holy Cross Hospital – Germantown	X	
Mercy Medical Center	X	
Meritus Medical Center	X	
Northwest Hospital	X	X
Peninsula Regional Medical Center	X	
Shady Grove Medical Center	X	X
Sinai Hospital	X	X
St. Agnes Hospital		X
Washington Adventist Hospital	X	X
Western Maryland Health System	X	

CCIP: Chronic Care Improvement Program
HCIP: Hospital Care Improvement Program

Source: Health Services Cost Review Commission

The New Maryland Total Cost of Care Model

The All-payer Model Contract required Maryland to submit a proposal for a new model to limit Medicare beneficiary TCOC growth. The new "Maryland Enhanced All-payer Model" is designed to (1) improve population health; (2) improve outcomes for individuals; and (3) control growth of TCOC. To accomplish these goals, the model must move beyond hospitals to address Medicare patients' care in the community. Under the new model, the State will be required to address care delivery across the health care system with the objective of improving health and quality of care, while limiting State growth in Medicare spending to a level lower than the national rate.

The blueprint for this new model, also known as the Progression Plan, was submitted to the federal Centers for Medicare and Medicaid Services (CMS) in December 2016, with a substantial revision released in November 2017. The key themes of the plan are to (1) foster accountability by organizing hospitals, physicians, and other providers to take responsibility 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. **Exhibit 5** provides an overview of the goals and key elements of the new Progression Plan.

Exhibit 5

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: Progressively Plan and Implement Dual Eligible Care and Payment Alignment

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 the Medicare Access and CHIP Reauthorization Act

Strategy Three: Encourage and Develop Payment and Delivery System Transformation

Key Element 3a: Develop a Maryland Primary Care Program
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

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, TCOC metrics will still remain solely focused on Medicare spending and not necessarily on Medicaid spending if the Progression Plan as introduced is approved.

Initial negotiations with CMMI were completed in May 2017. The federal government is currently engaged in an internal clearance process that should hopefully lead to final approval of the new contract. However, this approval has been delayed by changes in leadership at the federal level, resulting in the State missing its goal for having the new contract signed by the end of calendar 2017. On January 8, 2018, Governor Lawrence J. Hogan Jr.'s Administration along with CMS announced a one-year extension of the current contract through the end of calendar 2019, which the announcement stated will allow the federal government to complete its review and consider additional data through the end of calendar 2017 before finalizing the new contract. This extension, so far, only changes the end date of the current agreement and does not change any of the performance metrics or any other terms of the initial contract. However, since the extension has yet to be formally signed, there is still a remote possibility that terms could be amended.

While the State does have the extension option, this in no way precludes the final approval of the new contract, and therefore does not prevent the new contract from beginning on January 1, 2019, assuming that all final approvals and terms are in place. In due course, HSCRC and the State are already in an active engagement process with stakeholders and planning for the beginning of the new model. Core requirements and expectations of the new model, which are subject to federal approval, include the following:

- The new model will be for a 10-year term. Review of model performance will be ongoing with a significant reevaluation occurring at the 5-year mark.

- As with the current model contract, hospital cost growth per capita for all payers must not exceed 3.58% per year. The State has the opportunity to adjust this growth limit based on economic conditions, subject to federal review and approval.

- Maryland commits to saving $300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023. These savings will build off of the ongoing work of Maryland stakeholders, which began in 2014. Further, based upon the current model, the State is already saving an additional $118 million in Medicare TCOC in Year 4, which is less than halfway to the target.

- Federal resources will be invested in primary care and delivery system innovations, consistent with national and State goals, to improve chronic care and population health.

- The new model will help physicians and other providers leverage other voluntary initiatives and federal programs to align participation in efforts focused on improving care and care coordination, and participation in incentive programs that reward those results. These programs will be voluntary, and the State will not undertake setting Medicare and private fee schedules for physicians and clinicians.

- Maryland will also be held to a new range of population health goals, preliminarily including:

    - reducing deaths from opioid use;

    - reducing the incidence and prevalence of obesity and cigarette smoking;

    - reducing the prevalence and improving the control of diabetes and hypertension; and

    - reducing fall-related deaths.

The fact that a new contract has not been signed continues to bring uncertainty to the hospital system. If the agreement is not signed on time or at all, the entirety of the hospital financing system within the State will need to be changed within a relatively short timeframe. **HSCRC should provide an update on when both the extension and new expanded model contract will be signed, and further provide what contingency plans the commission has if the expanded contract is not signed.**

2. Hospital Profits Continue to Rise

Even under Year 4 of the global budgets under the All-payer Model Contract, hospital profits continue to rise. As reported at the January 2018 meeting of HSCRC, total profit margins for hospitals are up to 5.82% overall so far in fiscal 2018, compared to a margin of 4.42% over the same time period for fiscal 2017. In addition, as previously mentioned in this analysis, per capita revenues for all hospitals continues to climb. While not all hospitals in the State are posting a profit, there are a number of hospitals that have been at or above a 10% profit margin over the past year. Thus, the issue of profits at particular hospitals is going to require different tools and methodologies other than just adjusting the global rate increase. **HSCRC should comment on what plans, if any, it has to address particularly high profit rates at various hospitals.**

3. 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 Integrated Care Network (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.

As in previous years, work on the main CRISP 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. Further, on top of the main ICN projects, funding from the same sources is also being allocated to projects that seek to help the State with the next iteration of the All-payer Model Contract, including the accountable care organization for the dually eligible population as well as the Primary Care Program, both of which were explained in further detail within other analyses.

Funding Sources

Funding for these projects 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 the Maryland Health Insurance Program (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 6** 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.

Based on the data provided in Exhibit 6, there is a projected deficit of $1.3 million for the MHIP fund at the end of fiscal 2019 after the new special projects are taken into consideration. Unless some of the currently budgeted spending in fiscal 2018 is not realized, certain projects in fiscal 2019 will have to be removed from the plan or an alternative funding source will need to be identified. Further, the current allowance also contains more than enough special fund appropriation for what is currently projected to be spent from the MHIP fund balance as well as through hospital assessments that are provided for the operations of CRISP. Additionally, after discussions with MHCC, there is an excess in the allowance for this project of $6 million. **The commissions should comment on how they anticipate dealing with the projected fund balance deficit at the end of fiscal 2019. The Department of Legislative Services (DLS) also recommends that any excess in the appropriation be reduced.**

Exhibit 6
Integrated Care Networks Expenditures
Fiscal 2016-2019

	BRFA of 2014 Transfer				MHIP Fund Balance			
	2016	**2017**	**2018**	**2019**	**2016**	**2017**	**2018**	**2019**
Total Revenues and Expenditures								
Starting Balance	$0	$1,674,782	$1,266,885	$0	$0	$52,978,322	$34,821,278	$18,911,489
Revenues	11,500,884	0	0	0	52,978,322	0	90,211	0
Expenditures	9,826,102	407,897	1,266,885	0	0	18,157,044	16,000,000	20,250,000
Ending Balance	**$1,674,782**	**$1,266,885**	**$0**	**$0**	**$52,978,322**	**$34,821,278**	**$18,911,489**	**-$1,338,511**
Spending by Project								
HSCRC – ICN Special Projects	$0	$0	$0	$0	$0	$1,732,672	$4,000,000	$6,000,000
CRISP – ICN	9,779,252	0	0	0	0	16,424,372	11,000,000	11,250,000
IAPD	46,850	407,897	1,266,885	0	0	0	0	0
Dual ACO Project	0	0	0	0	0	0	500,000	500,000
Primary Care Program	0	0	0	0	0	0	500,000	2,500,000
Totals	**$9,826,102**	**$407,897**	**$1,266,885**	**$0**	**$0**	**$18,157,044**	**$16,000,000**	**$20,250,000**

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

Source: Maryland Health Care Commission

4. Uncompensated Care Fund

Within the HSCRC budget, there is an appropriation for payments made to hospitals for uncompensated care made from the Uncompensated Care Fund. This special fund derives revenues from hospitals that have a disproportionately lower share of uncompensated care, and the funds are then subsequently dispensed to those hospitals that have a disproportionately higher share of uncompensated care. As such, the special fund acts almost as a revolving fund, where payments in normally equate to payments out.

As has been stated in previous analyses, these payments have been declining over a number of years, as more and more individuals in the State receive health insurance coverage. Typically, any unused appropriation is canceled at the end of the fiscal year, as the revenues and expenditures match. In fiscal 2017, more than $40 million of the appropriation for the fund was canceled.

In recent years, MDH has been overestimating the appropriation needed for the Uncompensated Care Fund. As a result, MDH is able to use the additional special fund appropriation in order to raise special fund appropriations in other parts of the department's budget without having to process a budget amendment to independently increase the department's appropriation. It should be noted that the department is not taking funds from the Uncompensated Care Fund but rather just using the excess appropriation to circumvent the typical budget amendment process for raising special funds outside of the budget bill. **DLS recommends reducing the appropriation for the Uncompensated Care Fund to the appropriate level.**

Operating Budget Recommended Actions

		Amount Reduction	
1.	Reduce funding for the Integrated Care Networks to the appropriate level.	$ 6,000,000	SF
2.	Reduce payments from the Uncompensated Care Fund to the appropriate level based on the most recent actual. If the amount of uncompensated care rises beyond the level in the appropriation, the department is authorized to process a budget amendment to increase the appropriation.	20,000,000	SF
	Total Special Fund Reductions	**$ 26,000,000**	

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2017					
Legislative Appropriation	$0	$230,259	$0	$173	$230,431
Deficiency Appropriation	0	0	0	0	0
Cost Containment	0	0	0	0	0
Budget Amendments	0	-10,713	852	0	-9,861
Reversions and Cancellations	0	-59,109	-49	-173	-59,330
Actual Expenditures	**$0**	**$160,437**	**$803**	**$0**	**$161,240**
Fiscal 2018					
Legislative Appropriation	$0	$200,833	$0	$0	$200,833
Cost Containment	0	0	0	0	0
Budget Amendments	0	0	0	0	0
Working Appropriation	**$0**	**$200,833**	**$0**	**$0**	**$200,833**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. Numbers may not sum to total due to rounding.

Fiscal 2017

Actual expenditures for the Health Regulatory Commissions were $69,191,064 below the legislative appropriation. Special funds decrease by $69,821,911 from the legislative appropriation, mainly due to decreased utilization of the Uncompensated Care Fund. Budget amendments decreased the appropriation for the Uncompensated Care Fund by almost $11 million, while an additional $41 million was canceled at the end of the year. Other large cancellations total approximately $18.1 million, including $9 million for the Integrated Care Network Project, $4 million in other contractual costs for the Health Services Cost Review Commission, $2.1 million in unspent funds from the Maryland Trauma Physicians Services Fund, $1.8 million in general expenses for the Maryland Health Care Commission (MHCC) to preserve their fund balance, and $1.2 million in grants from the Maryland Community Health Resources Commission. Additionally, budget amendments added $214,355 in special funds for the transfer of increment payments as well as $13,606 to realign funds for the implementation of Section 20 of the budget bill.

Federal funds increased by $702,426 above the legislative appropriation. This was due to the addition of $852,006 by budget amendment for MHCC to conduct Cycle IV of the Health Insurance Premium Rate Review under the federal Affordable Care Act. Subsequently, $48,660 was canceled at the end of the year, which is expected to roll into fiscal 2018.

While the legislative appropriation for reimbursable funds was $172,500, none of this was spent by MHCC, since there was no funding behind this appropriation.

Fiscal 2018

To date, the fiscal 2018 working appropriation is unchanged from the legislative appropriation.

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

Object/Fund	FY 17 Actual	FY 18 Working Appropriation	FY 19 Allowance	FY 18 - FY 19 Amount Change	Percent Change
Positions					
01 Regular	100.90	95.90	103.90	8.00	8.3%
02 Contractual	1.00	1.00	0.00	-1.00	-100.0%
Total Positions	**101.90**	**96.90**	**103.90**	**7.00**	**7.2%**
Objects					
01 Salaries and Wages	$ 12,475,021	$ 12,715,035	$ 12,928,156	$ 213,121	1.7%
02 Technical and Spec. Fees	54,523	109,278	48,791	-60,487	-55.4%
03 Communication	67,421	82,200	77,458	-4,742	-5.8%
04 Travel	131,526	236,100	231,252	-4,848	-2.1%
08 Contractual Services	138,459,344	178,895,774	180,269,316	1,373,542	0.8%
09 Supplies and Materials	63,723	60,359	64,625	4,266	7.1%
10 Equipment – Replacement	137,975	22,500	0	-22,500	-100.0%
11 Equipment – Additional	26,580	200,000	166,500	-33,500	-16.8%
12 Grants, Subsidies, and Contributions	9,392,137	7,973,468	10,612,928	2,639,460	33.1%
13 Fixed Charges	432,104	538,472	528,948	-9,524	-1.8%
Total Objects	**$ 161,240,354**	**$ 200,833,186**	**$ 204,927,974**	**$ 4,094,788**	**2.0%**
Funds					
03 Special Fund	$ 160,437,007	$ 200,833,186	$ 204,927,974	$ 4,094,788	2.0%
05 Federal Fund	803,347	0	0	0	0.0%
Total Funds	**$ 161,240,354**	**$ 200,833,186**	**$ 204,927,974**	**$ 4,094,788**	**2.0%**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.

Appendix 3
Fiscal Summary
MDH – Health Regulatory Commissions

Program/Unit	FY 17 Actual	FY 18 Wrk Approp	FY 19 Allowance	Change	FY 18 - FY 19 % Change
01 Maryland Health Care Commission	$ 47,018,400	$ 55,891,458	$ 60,809,628	$ 4,918,170	8.8%
02 Health Services Cost Review Commission	107,303,560	140,060,917	136,118,346	-3,942,571	-2.8%
03 Maryland Community Health Resources Commission	6,918,394	4,880,811	8,000,000	3,119,189	63.9%
Total Expenditures	**$ 161,240,354**	**$ 200,833,186**	**$ 204,927,974**	**$ 4,094,788**	**2.0%**
Special Fund	$ 160,437,007	$ 200,833,186	$ 204,927,974	$ 4,094,788	2.0%
Federal Fund	803,347	0	0	0	0.0%
Total Appropriations	**$ 161,240,354**	**$ 200,833,186**	**$ 204,927,974**	**$ 4,094,788**	**2.0%**

MDH: Maryland Department of Health

Note: The fiscal 2018 appropriation does not include deficiencies, targeted reversions, or across-the-board reductions. The fiscal 2019 allowance does not include contingent reductions or cost-of-living adjustments.