M00R01
Health Regulatory Commissions
Maryland Department of Health

Executive Summary

The Health Regulatory Commissions are three independent agencies that separately regulate health care delivery, monitor price and affordability of service delivery, and expand access to care for Marylanders.

Operating Budget Data

($ in Thousands)

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change	% Change Prior Year
Special Fund	$149,348	$178,974	$166,332	-$12,643	-7.1%
Adjustments	0	71	404	332	
Adjusted Special Fund	**$149,348**	**$179,046**	**$166,735**	**-$12,311**	**-6.9%**
Reimbursable Fund	0	2,650	750	-1,900	-71.7%
Adjustments	0	0	0	0	
Adjusted Reimbursable Fund	**$0**	**$2,650**	**$750**	**-$1,900**	**-71.7%**
Adjusted Grand Total	**$149,348**	**$181,696**	**$167,485**	**-$14,210**	**-7.8%**

Note: The fiscal 2019 appropriation includes deficiencies, a one-time $500 bonus, and general salary increases. The fiscal 2020 allowance includes general salary increases.

- Significant budget decreases are due to lower than anticipated expenditures in major funds managed by the Health Regulatory Commissions.

- The Maryland Primary Care Program has moved from the Health Regulatory Commissions to the Maryland Department of Health, although it is still being funded through the Integrated Care Network fund.

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

For further information contact: Andrew C. Garrison Phone: (410) 946-5530

Personnel Data

	FY 18 Actual	FY 19 Working	FY 20 Allowance	FY 19-20 Change
Regular Positions	95.90	103.90	103.90	0.00
Contractual FTEs	0.79	0.00	7.57	7.57
Total Personnel	**96.69**	**103.90**	**111.47**	**7.57**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.45	4.50%
Positions and Percentage Vacant as of 12/31/18	9.00	8.66%

- Only significant personnel changes are a result of the April 1, 2019 general salary increases and the fiscal 2019 one-time employee bonus.

Key Observations

- The Health Services Cost Review Commission begins transition from a 5-year All-payer Model Contract into the new, 10-year total cost of care model, with aggressive Medicare savings targets.

- New program measures aim to improve hospital outcomes, patient satisfaction, and increased use of health information technology.

Operating Budget Recommended Actions

		Funds
1.	Reduce Integrated Care Network expenditures to reflect current spending authority.	$ 8,095,519
	Total Reductions	**$ 8,095,519**

M00R01
Health Regulatory Commissions
Maryland Department of Health

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are three independent agencies within the Maryland Department of Health: the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), and the Maryland Community Health Resource Commission (MCHRC). These commissions regulate health care delivery, monitor price and affordability of service delivery, and expand access to care for Marylanders, respectively. Each commission has its own separate goals and initiatives:

- MHCC develops quality and performance measures for health maintenance organizations, hospitals, and ambulatory care facilities; directs and administers State health planning functions; and conducts Certificate of Need evaluations for regulated entities. MHCC also issues grants to trauma centers through the Maryland Trauma Physicians Fund and operating grants to the Shock Trauma Center.

- HSCRC was established in 1971 to contain hospital costs, maintain fairness in hospital payments, and provide financial access for hospital care. HSCRC assures all purchasers of hospital health care services that the costs of the services are reasonable with rates set to be in relationship to the aggregate costs of the services provided. The Health Regulatory Commissions are also focused on the implementation of the total cost of care (TCOC) contract with the Center for Medicare and Medicaid Innovation (CMMI).

- MCHRC was established in 2005 to strengthen the safety net for uninsured and underinsured Marylanders. This safety net is made up of community health resources, ranging from federally qualified health centers to local health departments, community-based clinics, and providers. The Health Regulatory Commissions awards and monitors grants to these entities as well as developing, supporting, and monitoring strategies to strengthen viability and improve efficiency.

Performance Analysis: Managing for Results

1. Continued Utilization of 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 by eliminating unnecessary administrative expenses through the increased utilization of the State Health Information Exchange (HIE). The HIE for Maryland is the Chesapeake Regional Information System for our Patients (CRISP), which aims to make electronic health records

and other health information available in a secure environment to providers and patients. Another feature of CRISP is the Encounter Notification System (ENS) that delivers real-time alerts to providers whenever one of their patients visits an emergency room or is admitted and discharged from a hospital. ENS can also provide a summary of care and give readmission alerts. As of fiscal 2019, the Department of Budget and Management (DBM) added Managing for Results (MFR) metrics aimed at evaluating the utilization of HIE. The first three years of data are shown in **Exhibit 1**.

Exhibit 1
Utilization of HIE
Fiscal 2016-2018

	2016	2017	2018
Provider Queries	1,257,956	1,346,684	2,326,100
Unique Users	25,862	53,189	87,815
Encounter Notification System Alerts to Physicians	18,019,775	18,488,775	30,801,132

HIE: State Health Information Exchange

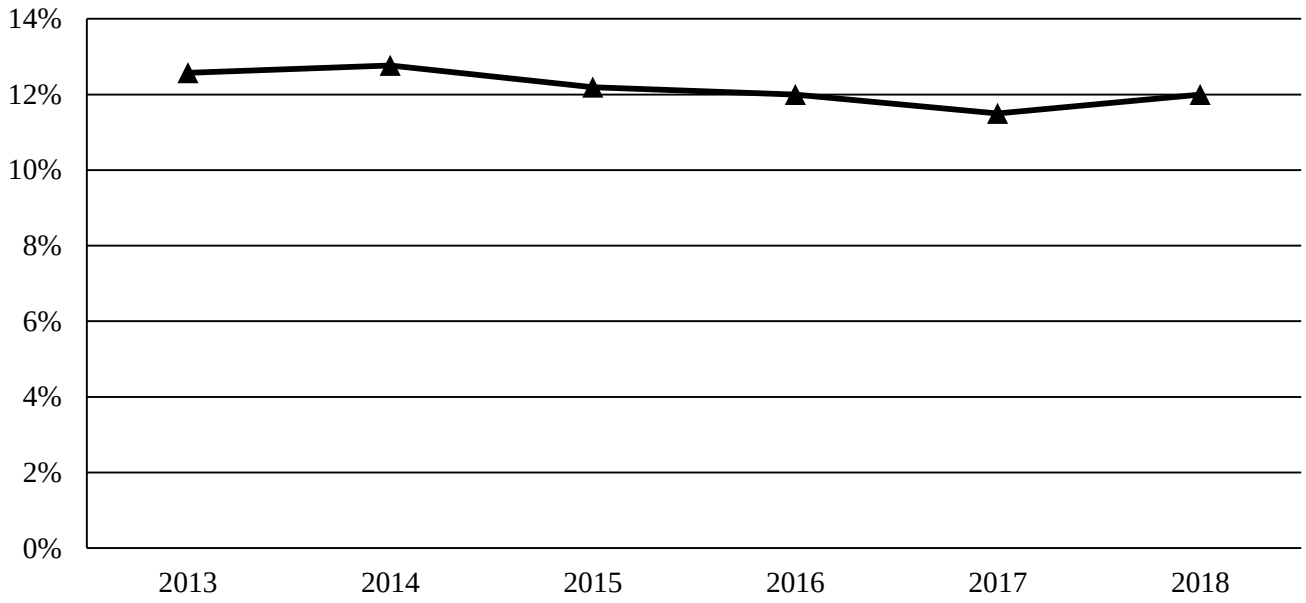
Source: Maryland Health Care Commission

In fiscal 2020, DBM and MHCC added another component to HIE metrics, percentage of Electronic Data Interchange/Electronic Health Network private payer electronic claims, and the stated overall goal for HIE is to increase the use of electronic claims to 85% by calendar 2021.

2. Health and Health Insurance Measures

HSCRC reports the 30-day, all hospital case-mix adjusted readmission rate. As shown in **Exhibit 2**, the all-cause readmission rate has been effectively flat in recent years.

Exhibit 2
30-day All-cause Readmission Rate
Fiscal 2013-2018



Source: Health Services Cost Review Commission

New Health Outcome and Telehealth Measures

The fiscal 2020 MFRs also include several new measures comparing the health outcomes at Maryland hospitals to the national average as well as tracking the use of telehealth in ambulatory care throughout the State. The new measures are listed in **Exhibit 3**.

Exhibit 3
New Health Outcome Performance Measures

75% of hospitals performing at, or above, the national average on preventing surgical site infections for hip procedures.

75% of hospitals performing at, or above, the national average on preventing surgical site infections for knee procedures.

75% of hospitals performing at, or above, the national average on preventing surgical site infections for CABG procedures.

75% of acute general hospitals at, or above, the national average on preventing CLABSIs in ICUs.

75% of acute general hospitals performing at, or above, the national average on preventing C. diff infections.

75% of acute general hospitals performing at, or above, the national average on preventing CAUTIs.

20 or more hospitals improving patient satisfaction, measured by a patient's saying he/she would recommend the hospital to family and friends.

20 or more hospitals improving patient satisfaction, measured by patients who would rate the hospital 9 or 10 on a scale of 1 to 10.

CABG: coronary artery bypass graft
CLABSI: central line-associated bloodstream infections
C. diff: clostridium difficile infections
CAUTI: catheter-associated Urinary Tract Infections
ICU: intensive care unit

Source: Governor's Fiscal 2020 Budget Books

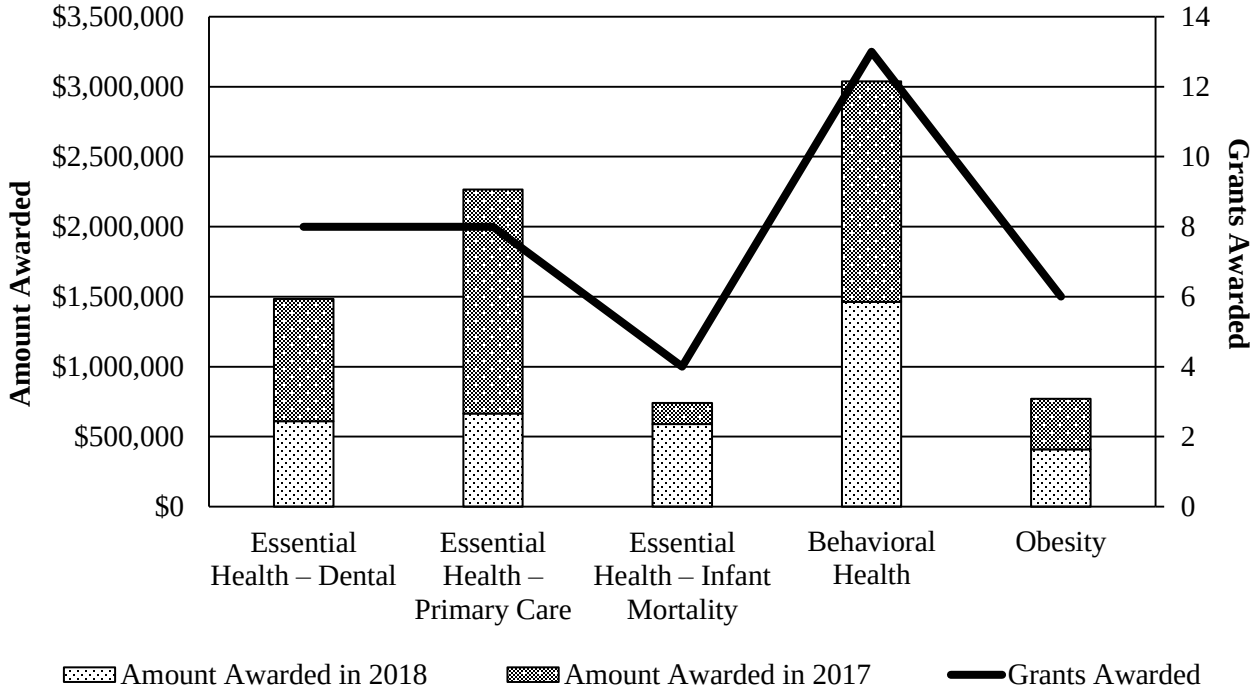
Additional new measures focusing on the quality of health care in Maryland are related to hospitals improving patient satisfaction and the likelihood that they would recommend the hospital. The Health Regulatory Commissions are also beginning to track the number of telehealth use cases and have set a goal to increase the use of telehealth by 20% from 2017 to 2021.

3. MCHRC Grant Distribution

MCHRC is exclusively focused on improving the social safety net in the State through the provision of grants to improve a variety of health services statewide. MCHRC awards grants annually, generally for a two-year grant term. The grants awarded by MCHRC aim to support projects that are sustainable after the terms of the grant. A recent analysis of grants awarded in fiscal 2012 and 2014 by

MCHRC found that 78% of these programs that were awarded MCHRC had maintained core services at least one year after the terms of the grants had ended. Currently, MCHRC grants have been focusing on behavioral health, obesity, and essential health service provisions, namely, expanding access to dental and primary care and reducing infant mortality. **Exhibit 4** shows how many grants have been distributed across each focus area in the last two grant cycles and the amount of MCHRC funding that has been provided to each area.

Exhibit 4
Maryland Community Health Resource Commission and Grants and Funding Distribution
Fiscal 2017-2018



Source: Maryland Community Health Resource Commission

Fiscal 2019 Actions

Proposed Deficiency

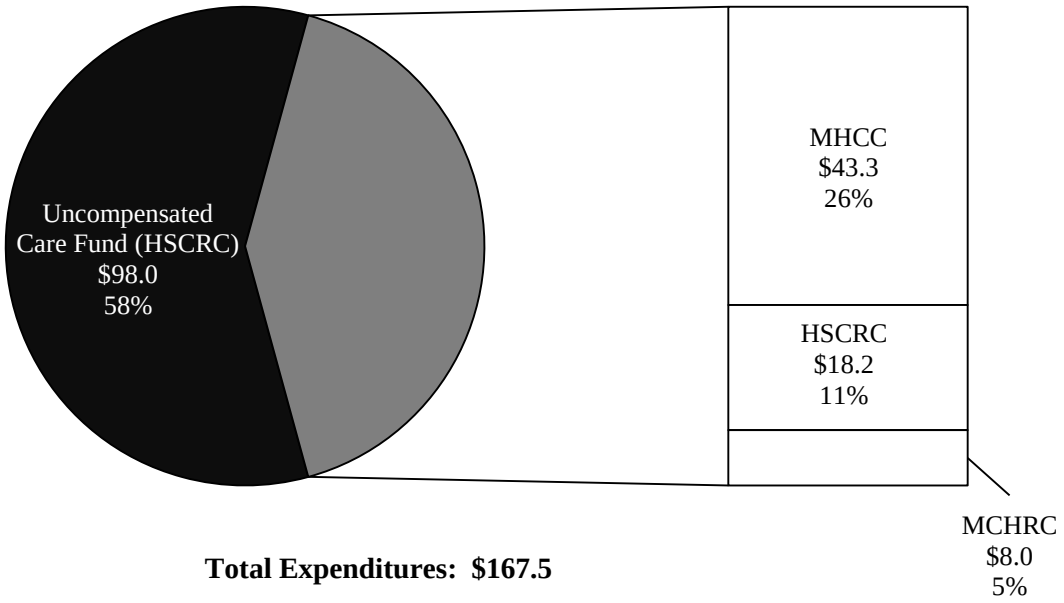
The fiscal 2020 budget – contains $55,848 and $15,538 to the Health Regulatory Commissions in fiscal 2019 for one-time employee bonuses and an annualization of the April 1, 2019 general salary increase, respectively.

Fiscal 2020 Allowance

Overview of Agency Spending

The fiscal 2020 allowance for the Health Regulatory Commissions totals $167,485,301 and is nearly entirely funded with special funds. As shown in **Exhibit 5,** nearly 60% of the total amount budgeted in the Health Regulatory Commissions are for the Uncompensated Care Fund (UCF), which is managed by HSCRC but paid out to the acute general hospitals for providing uncompensated care. This special fund derives revenues from the acute general hospitals that treat a disproportionately lower share of uncompensated care with payments made to those hospitals that have a higher share of uncompensated care.

Exhibit 5
Total Expenditures
Fiscal 2020
($ in Millions)



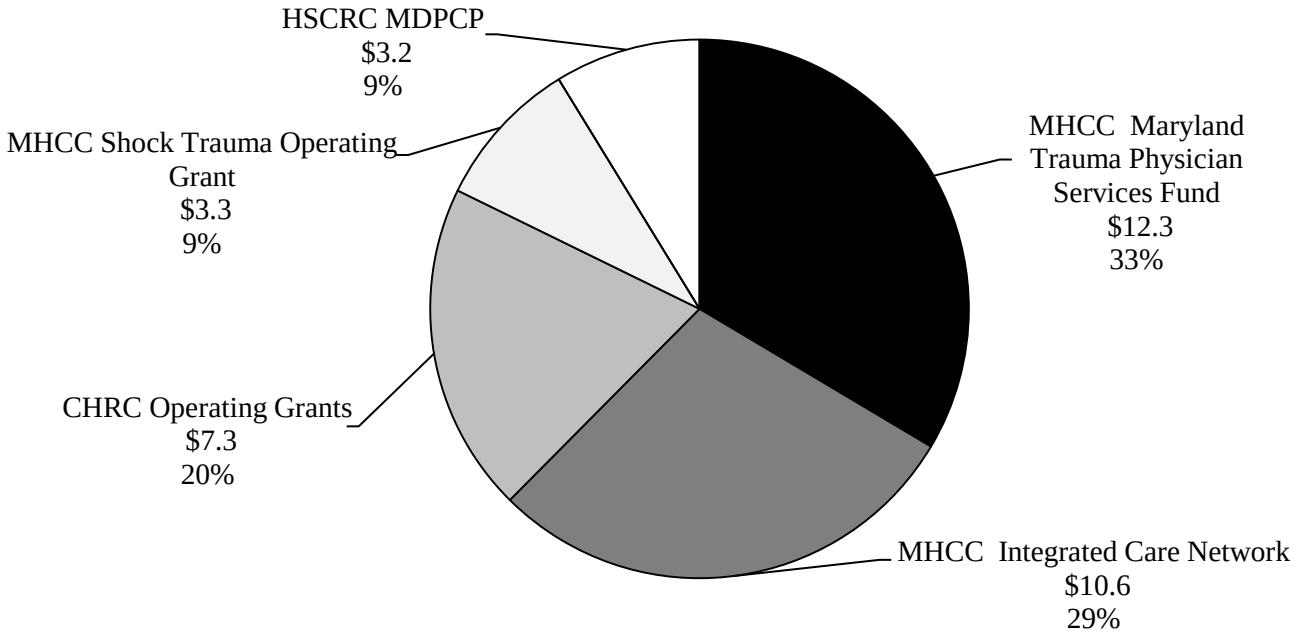
Total Expenditures: $167.5

HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resource Commission
MHCC: Maryland Health Care Commission

Source: Governor's Proposed Budget

Exhibit 6 highlights other grants and funds other than the UCF managed throughout the commissions, the amount budgeted in fiscal 2020, and the commission that has the responsibility over that particular fund or grant.

Exhibit 6
Funds Managed by Health Regulatory Commissions
Fiscal 2020
($ in Millions)



CHRC: Maryland Community Health Resource Commission
HSCRC: Health Services Cost Review Commission
MDPCP: Maryland Primary Care Program
MHCC: Maryland Health Care Commission

Source: Governor's Proposed Budget

Proposed Budget Change

As shown in **Exhibit 7**, the Health Regulatory Commissions budget is decreasing significantly from the 2019 working appropriation, which can be almost entirely attributed to a decrease in the amount budgeted for the Integrated Care Network (ICN) initiatives, from $25,000,000 in fiscal 2019 to $10,595,519 in fiscal 2020.

Exhibit 7
Proposed Budget
MDH – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	Special Fund	Reimb. Fund	Total
Fiscal 2018 Actual	$149,348	$0	$149,348
Fiscal 2019 Working Appropriation	179,046	2,650	181,696
Fiscal 2020 Allowance	166,735	750	167,485
Fiscal 2019-2020 Amount Change	-$12,311	-$1,900	-$14,210
Fiscal 2019-2020 Percent Change	-6.9%	-71.7%	-7.8%

Where It Goes:

Personnel Expenses	**$1,905**	
Employee and retiree health insurance		$825
Decrease in turnover expectancy		549
Fiscal 2020 3.0% general salary increase and annualization as of 0.5% April 1, 2019 general salary increase offset by fiscal 2019 April 1, 2019 salary increase		388
Estimated accrued leave payout based on fiscal 2017 and 2018 actuals		87
Reclassification, additional assistance, and other regular earnings adjustments		86
Employees' retirement, workers' compensation, and unemployment.		85
Increase in salaries, wages, and benefits for employees transferred within MHCC		45
One-time $500 State employee bonus in fiscal 2019		-56
Assistant Attorney General services paid for by HSCRC, used by the Health Professional Boards and Commissions.		-103
Overall Changes	**$247**	
Increase in MDH Administrative allocations		255
Statewide personnel system allocation		6
Department of Information Technology services allocation		-14
Maryland Community Health Resource Commission	**-$47**	
Unawarded MCHRC grants		1,357
End of various MCHRC grants		-1,409
Other		5
Health Services Cost Review Commission	**-$3,365**	
Contractual employee expenses for deputy director of medical economics and data analytics, a deputy director of special projects and auditing, 5 analysts assisting directors of the centers, and 0.5 chief of nurse support program		639

Where It Goes:

Increase in data processing repository contract	246
Decrease in payments made to hospitals from the Uncompensated Care Fund due to coverage expansion trends	-2,000
MDPCP budgeted in the deputy secretary of public health for fiscal 2020	-2,299
Other HSCRC expenditures	48
Maryland Health Care Commission	**-$12,951**
Supporting clinical practices moving from fee-for-service to value-based reimbursements through a Practice Transformation Network in Maryland	500
Funds award to vendors to integrate advance directives with CRISP	475
Maryland trauma physician services grant	300
The Health Information Exchange earned value assessment and EHR compliance	280
Telehealth grants and program development	275
Data processing contracts for the all-payer claims database and the Consumer Centric Price Transparency Initiative	200
Promotion, marketing, and other consumer engagement activities	200
Decrease in contracts for various special project expenses, including CON Study, cardiac performance, health care associated infectious diseases, value-based care models for specialists, and MDPCP	-850
Readjustment of the ICN expenditures	-14,404
Other MHCC expenditures	74
Total	**-$14,210**

CON: Certificate of Need
CRISP: Chesapeake Regional Information System for our Patients
EHR: electronic health record
ICN: Integrated Care Network
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resource Commission
MHCC: Maryland Health Care Commission
MDH: Maryland Department of Health
MDPCP: Maryland Primary Care Program

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

Contractual Full-time Equivalents with HSCRC

HSCRC is increasing their contractual employee expenditures in fiscal 2020 by $639,193. These positions include high-level staff such as deputy directors as well as several analysts. HSCRC notes that some of the new contractual employees will be working on additional special projects, such as an audit on hospital drug costs and population health credits. **HSCRC should comment on the use**

of contractual employees for high-level directorships, the status of recruitment for existing vacancies, and if the special projects being conducted by contractual employees will be on-going.

Integrated Care Network

As previously mentioned, the largest nonpersonnel change is in expenditures from ICN. **Exhibit 8** outlines programs and projects supported by ICN in fiscal 2019 and estimates for ICN expenditures in fiscal 2020. The amounts reflected for fiscal 2019 are recent expenditure estimates from MHCC and not the $25,000,000 in the 2019 budget.

Exhibit 8
Integrated Care Network Expenditures
Fiscal 2019-2020

	2019	**2020**
CRISP	$11,908,900	$2,694,322
HSCRC (non-CRISP) ICN Special Projects	3,000,000	3,000,000
10% State Share of the Federal IAPD Grant	1,000,000	1,000,000
Maryland Primary Care Program	2,848,436	3,211,197
MHCC for the Earned Value Assessment of CRISP Audit	190,000	190,000
Medicaid Duals Program	500,000	500,000
Total	**$19,447,336**	**$10,595,519**

CRISP: Chesapeake Regional Information Systems for our Patients
HSCRC: Health Services Cost Review Commission
IAPD: Implementation Advanced Planning Document
ICN: Integrated Care Network
MHCC: Maryland Health Care Commission

Note: Fiscal 2019 amounts are recent estimates of expenditures, not the fiscal 2019 budgeted amount of $25,000,000.

Source: Maryland Health Care Commission

ICN is currently funded through two sources. The first is through an HSCRC assessment on hospitals. These assessments are $2 million to $2.5 million annually and support the 10% share of the Implementation Advanced Planning Documents federal grant ($1 million annually) and CRISP operating expenses. The other funding source was authorized by the Budget Reconciliation and Financing Act of 2015, which authorized HSCRC to utilize the remaining fund balance of the Maryland Health Insurance Program (MHIP) through fiscal 2019. MHCC estimates that there will be $12 million in MHIP funds unspent at the end of fiscal 2019, and a portion of the balance is what supports the proposed fiscal 2020 spending. However, legislation will be required to expend these funds that, at the

time of writing, had not been introduced. **Therefore, the Department of Legislative Services (DLS) recommends reducing the fiscal 2020 allowance by $8,095,519 to reflect the current spending authority of MHCC with regards to funds supporting ICNs.**

Other Changes

While ICN continues to fund the Maryland Primary Care Program (MDPCP) in fiscal 2020, this program is budgeted in the Office of the Deputy Secretary of Public Health in fiscal 2020. DLS has been advised that a budget amendment will be submitted to move the reimbursable funds for the MDPCP into the HSCRC budget. However, in the current proposed budget, the MDPCP represents a signification reduction in the Health Regulatory Commissions budget and the cause of the drop in reimbursable funds. Additionally, the payments made from the UCF are expected to decrease in fiscal 2020. Several MHCC grants and contracts are ending in 2020, but they are more than offset by new and continuing contracts in telehealth, care transformation, and the increase in the Trauma Services Physicians Fund.

Issues

1. Maryland TCOC Contract

On July 9, 2018, Maryland and CMMI agreed to the terms of the new TCOC. This model, effective January 1, 2019, builds on the State's existing all-payer contract that was in effect from January 1, 2014, to December 31, 2018. The all-payer model (APM) replaced the State's 36-year-old Medicare wavier, which measured success primarily on the cumulative rate of growth in Medicare inpatient costs per admission. APM also called for Maryland to submit a proposal for a new model, no later than January 2017, which would limit, at a minimum, the Medicare beneficiary TCOC growth rate. To prepare this proposal, the State worked with a variety of stakeholders representing consumers, hospitals, physicians, skilled nursing facilities, post-acute care facilities, payers, experts, and State agencies. The TCOC model is set to continue for 10 years, provided that the State meets the requirements of the agreement. The TCOC model is framed around three goals: (1) improving population health; (2) improving care outcomes for individuals; and (3) controlling growth of TCOC for Medicare beneficiaries. In order to achieve these goals, the TCOC model is designed to move beyond hospitals to address Medicare patients' care in the community and address care provision throughout the entire health system.

The Maryland APM Contract

From January 1, 2014, until December 31, 2018, when the TCOC went into effect, Maryland was operating under APM. This model laid the foundation for the current TCOC and included the following major components:

- ***All-payer Total Hospital Cost Growth Ceiling:*** Maryland agreed to 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%). Over the term of APM, cost growth was held at 2.03%.

- ***Medicare Hospital Savings:*** Maryland agreed to produce $330 million in cumulative Medicare hospital savings over 5 years by holding the growth in Maryland Medicare fee-for-service (FFS) hospital spending below the national Medicare growth rate. Over the term of APM, Maryland ultimately saved over more than $1 billion in cumulative Medicare FFS spending.

- ***Population-based Revenue:*** Initially, HSCRC had agreed, under the contract, to shift 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 included 100% of all hospital revenue.

- ***Reduction of Hospital Readmissions:*** Maryland was to 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. Maryland achieved this goal by year 4 with a 30-day readmission rate in calendar 2017 of 15.24%, 0.2 percentage points below the national average.

- ***Reduction of Hospital-acquired Conditions:*** Maryland was tasked with a 30% reduction across all potentially preventable conditions measures that comprise Maryland's hospital acquired condition program, over the 5 years of the APM contract. Currently, Maryland has reduced hospital-acquired conditions by 53% from their 2013 levels. Hospital-acquired conditions have also been added to the MFR performance measures as of fiscal 2020.

- ***Medical Education Innovation:*** Maryland was to develop a 5-year plan for medical and health professional schools to serve as a nationwide model for transformation initiatives, which the HSCRC submitted in 2015.

- ***Regulated Revenue at Risk:*** Maryland was to ensure that the aggregate percentage of regulated revenue at risk for quality programs administered by the State was 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.

The Maryland TCOC Contract

The new 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 outcomes and quality of care, while limiting State growth in per capita FFS Medicare spending to a level lower than the national rate. **Exhibit 9** compares several components of the former APM contract to the incoming TCOC.

Exhibit 9
Differences between APM and TCOC

Performance Measures	All-Payer	TCOC
Hospital Financial Tests	Less than or equal to 3.58% compound annual growth per capita.	Less than or equal to 3.58% compound annual growth per capita.
Medicare Savings	Reduce Medicare hospital costs by $330 million cumulatively over five years.	Reduce Medicare TCOC by an annual rate of $300 million by 2023.
Population Health	No population Health Metrics Measured.	Improvement programs for chronic conditions, opioid deaths, senior health, and quality of life.
Reduction of Hospital Readmissions	Medicare readmission rate must be equal to or below the national readmission rate after five years.	Hospital Revenue at Risk with continuation of Readmission Reduction Incentive Program. The State must meet or exceed any reductions in the Readmissions rate that occur in the national program.
Reduction of Hospital-acquired Conditions	30% reduction over five years.	Hospital Revenue at Risk with continuation of Maryland Hospital-acquired Conditions Program. The State must meet or exceed any reductions in the Hospital-acquired Conditions rate that occur in the national program.

APM: all-payer model
TCOC: total cost of care

Source: Health Service Cost Review Commission

The TCOC model started on January 1, 2019, and will continue for 10 years, providing that Maryland continues to meet the requirements outlined in the contract with CMMI. Under the new TCOC model, Maryland commits to reaching an annual Medicare savings target of $300 million from the 2013 base year by 2023 (program year 5) in Medicare FFS. Prior to the end of 2022 (program year 4), CMMI and Maryland will assess the progress of the TCOC model and determine if the State is on track to meet its savings goal. By the end of 2023 (program year 5), CMMI and Maryland will establish the formula for the allowable Medicare cost growth rate for the remaining 5 years of the TCOC. These savings goals or annual savings targets, as outlined by the model contract, are shown in **Exhibit 10.**

Medicare savings will be measured per beneficiary in the State, for Medicare FFS, against the 2013 per Medicare beneficiary amount trended forward by the national average growth rate for each year of the model. Maryland will be expected to meet the $300 million Medicare FFS savings goal regardless of national trends.

Exhibit 10
TCOC Annual Savings Targets
($ in Millions)

Year	Program Year	Compound Medicare TCOC Savings Target	Estimated Cumulative Savings to Medicare from APM and TCOC
2018			$599
2019	1	$120	719
2020	2	156	875
2021	3	222	1,097
2022	4	267	1,364
2023	5	300	1,664
Estimated Net TCOC Model Savings		**$1,065**	

APM: all-payer model
TCOC: total cost of care

Note: Excludes savings from changing the hospital differential, includes savings from the Medicaid Deficit Assessment.

Source: Health Service Cost Review Commission

Under the APM contract, hospital revenue growth was limited to under 3.58% compounded annual growth per capita. The TCOC model maintains this per capita cap. However, HRCSC has the discretion to review and adjust the overall cap, based on future trends and other factors, subject to prior approval by CMMI.

CMMI and the State expect that the targets established under APM, which will continue into the TCOC model, are achievable without changes to the hospital differential, the discounted rate paid by Medicare and Medicaid. In December 2018, HSCRC increased the hospital differential from 6.0% to 7.7% effective July 1, 2019. Medicare savings resulting from the higher differential are not to be factored into hospitals' performance under the TCOC model. The goal of the TCOC model is to improve care and, therefore, the differential should not be used to control costs. However, the model contract outlines when the State can change the differential with CMMI approval:

- if hospital expenditures are below the all-payer revenue limit, but the State is unable to meet the annual savings target outlined in Exhibit 10; and

- to effectuate changes in hospital overhead allocations or other factors used in Maryland's rate setting system that may be necessary to adjust, recalibrate, or modernize the rate setting structure while avoiding shifting costs.

Savings to Medicare FFS resulting from the planned decrease in the Medicaid deficit assessment will be credited toward Maryland's savings in the TCOC.

Medicare Performance Adjustments and Revenues at Risk

In an effort to bring accountability for the TCOC model to the hospitals, HSCRC will use Medicare Performance Adjustment (MPA). MPA is a scaled positive or negative adjustment to each hospital's Medicare payments relative to a per capita TCOC benchmark. For calendar 2018 and 2019, the hospital Medicare revenue at risk from MPA is 0.5% and 1%, respectively, which HSCRC determines the share of revenue at risk for 2020 and beyond. The MPA adjustments are based on the all-cause readmissions rates and the hospital-acquired conditions quality programs. **HSCRC should comment on the use of the MPA in the TCOC model and potential programs that incorporate nonhospital providers.**

Care Redesign Programs

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 APM 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' TCOC growth.

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 is implemented by hospitals in collaboration with community providers, as a forerunner program to the MDPCP, to link hospitals' resources for managing the care of individuals with severe and chronic health issues, or rising needs, with primary care providers' efforts to care for the same populations. 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 TCOC model and, in so doing, improve health outcomes while lowering the TCOC.

Physicians and other providers are incentivized to participate in the State's care redesign programs with federal quality payment programs that increase Medicare provider payments for high value and quality care. 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.

A third care redesign program, Episode Care Improvement Program (ECIP), started January 1, 2019, and is intended to complement the two existing Care Redesign Programs. ECIP aims to facilitate care for 23 different clinic episodes across all care settings for a 90-day global period.

As of January 1, 2019, the HCIP has 40 participants, the CCIP has 2 hospital participants, and the ECIP has 9. **Exhibit 11** shows that 42 hospitals are participating in at least one care redesign program, with 8 hospitals participating in two programs. Currently, no hospitals are participating in all three programs. The care redesign programs are currently structured to span the continuum of care, in the community, hospital, and post-acute settings. The State can expand opportunities for further care redesign programs after 2019.

Exhibit 11
Hospital Participation in Care Redesign Programs
As of January 1, 2019

Hospitals	HCIP	ECIP	CCIP
Anne Arundel Medical Center	X	X	
Washington Adventist Hospital	X		
Atlantic General Hospital	X		
CalvertHealth Medical Center	X		
Carroll Hospital	X	X	
Charles Regional Medical Center	X		
Doctors Community Hospital	X		
Frederick Memorial Hospital	X		
Garrett Regional Medical Center			X
Greater Baltimore Medical Center	X	X	
Harford Memorial Hospital	X		
Holy Cross Hospital	X	X	
Holy Cross Hospital – Germantown	X		
Howard County General Hospital	X		
Johns Hopkins Bayview Medical Center	X		
The Johns Hopkins Hospital	X		
MedStar Franklin Square Medical Center	X		
MedStar Good Samaritan Hospital	X		
MedStar Harbor Hospital	X		
MedStar Montgomery Medical Center	X		
MedStar Southern Maryland Hospital Center	X		
MedStar St. Mary's Hospital	X		

Hospitals	HCIP	ECIP	CCIP
MedStar Union Memorial Hospital	X		
Mercy Medical Center	X	X	
Meritus Medical Center	X		
Northwest Hospital	X	X	
Peninsula Regional Medical Center	X		
Shady Grove Medical Center	X		
Sinai Hospital	X	X	
St. Agnes Hospital		X	X
Suburban Hospital	X		
University of Maryland Rehabilitation and Orthopaedic Institute	X		
University of Maryland Prince George's Hospital Center	X		
University of Maryland Shore Medical Center – Easton	X	X	
University of Maryland Shore Medical Center – Dorchester	X		
University of Maryland St. Joseph Medical Center	X		
University of Maryland Baltimore Washington Medical Center	X		
University of Maryland Shore Medical Center – Chestertown	X		
University of Maryland Upper Chesapeake Medical Center	X		
University of Maryland – Midtown Campus	X		
University of Maryland Medical Center	X		
Western Maryland Health System	X		

CCIP: Complex and Chronic Care Improvement Program
ECIP: Episode Care Improvement Program
HCIP: Hospital Care Improvement Program

Source: Health Service Cost Review Commission

Maryland Primary Care Program

The MDPCP will also be implemented during the first model year of TCOC and will continue through 2026 (model year 8). The MDPCP will accept primary care providers and care transformation organizations into the program to move Medicare FFS beneficiaries into advanced primary care. The MDPCP is an important part of meeting the commitments in TCOC by providing management of care and reducing unnecessary hospital and emergency department utilization.

The MDPCP aims to integrate behavioral health, improve patient access, provide care management, and improve other health outcomes for Medicare beneficiaries and reduce hospital utilization through this coordination. The MDPCP is a voluntary program open to all qualifying Maryland primary care providers. Practices must apply to, and be approved by, CMMI for participation in the program. Practices participating in the program must undertake five functions: (1) access to care

and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver experience; and (5) planned care for health outcomes.

The program includes two tracks with the second track having additional advance care delivery requirements and experiencing changes to the payment structure for practices.

Patients in participating practices are expected to receive a number of benefits including enhanced services (including case management), expanded office hours, alternative care options, and linkages to support services. Practices are expected to benefit through changes in payment structure, an ability to provide care management support, an ability to provide care based on need (without focus on volume), improved health status of beneficiaries, and improved satisfaction.

Participating practices can be in a number of specialties: family medicine; general practice; geriatric medicine; internal medicine; obstetrics/gynecology; pediatric medicine; and co-located psychiatry. Practices may provide care management themselves or partner with a Care Transformation Organization (CTO). CTO is an organization that hires and manages a care management team capable of providing care coordination services to Medicare beneficiaries. CTOs must apply to, and be approved by, CMMI for participation in the program. Practices select and sign business agreements with their chosen CTO.

Providers are encouraged to enroll in the MDPCP through prospective additional per beneficiary per month payments (PBPM) for Medicare FFS. These payments and a performance bonus are based on a provider's progress through the MDPCP, either Track One or Track Two. On the first track, monthly care management fees payments range from $6 to $50 PBPM, and $9 to $100 on Track Two. The MDPCP also includes a performance-based incentive of up to $2.50 and $4 PBPM. These PBPM incentives are fully funded through Medicare. Practices may choose which track to apply for, but after the third year in the program, Track One practices must transition to Track Two. **Exhibit 12** provides information on the requirements for each function by track.

While the MDPCP aligns primary care providers with the goal of the TCOC model, the payment incentives associated with the MDPCP will also count toward Medicare FFS spending for TCOC, potentially creating a challenge for the State in meeting the annual savings targets for Medicare spending.

Outcome and Population Based Measures

The TCOC model also includes a process to develop outcome-based credits aimed at improving general population health. Initially, the TCOC model identified three potential population health priorities:

- behavioral health, measured by a reduction of deaths from opioid use;
- chronic condition prevention, measured by rates of diabetes, obesity, hypertension, and hepatitis C; and
- senior health and quality of life, measured through fall-related death prevention.

Exhibit 12
Requirements of Participating Practices by Track

Function	Track One Requirements	Additional Track Two Requirements
Access and Continuity	Empanel patients to care team. Provide access to care team or practitioner 24/7.	Ensure patients have regular access through at least one alternative strategy (telemedicine, group visits, *etc*.)
Care Management	Ensure beneficiaries are risk stratified. Ensure all beneficiaries identified as increased risk and likely to benefit, receive targeted, proactive, long term care management. Ensure beneficiaries receive timely follow-up after hospital or emergency department (ED) discharges (or other triggering events) and short-term care management.	Ensure beneficiaries in longitudinal care management are engaged in personalized care planning processes. Ensure beneficiaries in longitudinal care have access to comprehensive medication management.
Comprehensiveness and Coordination	Ensure coordinated referral management for beneficiaries seeking care from high-volume and/or high-cost specialists, EDs, and hospitals. Ensure beneficiaries with behavioral health needs have access to integrated behavioral health care supplied by the practice.	Provide referrals to community resources for beneficiaries with identified health-related social needs.
Beneficiary and Caregiver Experience	Convene, at least annually, a Patient-Family/Caregiver Advisory Council and integrate recommendations into care and quality improvement activities.	Engage beneficiaries and caregivers in a collaborative advance care planning process.
Planned Care for Health Outcomes	Improve performance on key outcomes (*e.g.*, cost of care, beneficiary experience, and utilization rates).	

Source: Maryland Primary Care Program

The State can develop and propose additional population health priorities, pending CMMI approval, providing that they meet three criteria:

- specifications for appropriate population health measures and applicable performance targets;
- methodologies to assess the State's performance on each measure and target; and
- an estimated savings to Medicare that could be expected with an improvement by the State in each measure and target.

Maryland can apply outcome-based credits to offset primary care spending or other approved investment costs due to overall healthcare savings that can be credited to achieving the population measures.

HSCRC should comment on how the Medicare focused TCOC model will benefit other public and private payers in Maryland. The commission should also comment on how it will monitor and mitigate potential cost shifting from Medicare to other payers. Additionally, HSCRC should comment on other population-based outcome measures being considered and the implementation of the MDPCP.

Operating Budget Recommended Actions

		Amount Reduction	
1.	Reduce the fiscal 2020 special fund allowance by $8,095,519, currently budgeted as Integrated Care Network (ICN) expenditures. Funds supporting some of the ICN programs are derived with funds remaining from the Maryland Health Insurance Program. Expenditures from these funds were authorized to be expended by the Budget Reconciliation and Financing Act of 2015 through fiscal 2019. Currently, the Maryland Health Care Commission does not have the authority to spend these funds without new legislation.	$ 8,095,519	SF
	Total Special Fund Reductions	**$ 8,095,519**	

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2018					
Legislative Appropriation	$0	$200,833	$0	$0	$200,833
Deficiency/Withdrawn Appropriation	0	-124	0	0	-124
Cost Containment	0	0	0	0	0
Budget Amendments	0	-4,841	0	0	-4,841
Reversions and Cancellations	0	-46,519	0	0	-46,519
Actual Expenditures	**$0**	**$149,348**	**$0**	**$0**	**$149,348**
Fiscal 2019					
Legislative Appropriation	$0	$178,861	$0	$0	$178,861
Budget Amendments	0	113	0	2,650	2,763
Working Appropriation	**$0**	**$178,974**	**$0**	**$2,650**	**$181,624**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. Numbers may not sum to total due to rounding.

Fiscal 2018

Actual expenditures for the Health Regulatory Commissions were $51,484,749, all special funds, below the legislative appropriation. Section 19 of the fiscal 2019 Budget Bill withdrew $124,256, due to a surplus in the health insurance account.

Budget amendments reduced the appropriation by $4,841,073. All of the budget amendments that reduced the special fund appropriation were related to a decrease in the use and need of the Uncompensated Care Fund (UCF). The remaining $46,519,420 reduction from the legislative appropriation was due to cancellation of special funds. Of these special fund cancellations, $15,566,734 were from the Maryland Health Care Commission, most of which was a cancellation of Integrated Care Network funds related to lower spending for the Chesapeake Regional Information System for our Patients and other special projects. The largest cancellation was $30,713,902 by the Maryland Health Services Cost Review Commission (HSCRC), $26 million of which was related to the UCF. The remaining $238,782 was canceled by the Maryland Community Health Resource Commission.

Fiscal 2019

The fiscal 2019 working appropriation is $2,762,756 over the legislative appropriation. This increase is predominately due to the allocation of $2,649,720 in unappropriated reimbursable funds to HSCRC to support the funding for the Maryland Primary Care Program. The remaining $113,036 special fund increase is to distribute the fiscal 2019 general salary increase effective January 1, 2019, that was centrally budgeted.

Appendix 2
Object/Fund Difference Report
Maryland Department of Health – Health Regulatory Commissions

Object/Fund	FY 18 Actual	FY 19 Working Appropriation	FY 20 Allowance	FY 19 - FY 20 Amount Change	Percent Change
Positions					
01 Regular	95.90	103.90	103.90	0.00	0%
02 Contractual	0.79	0.00	7.57	7.57	N/A
Total Positions	**96.69**	**103.90**	**111.47**	**7.57**	**7.3%**
Objects					
01 Salaries and Wages	$ 11,985,053	$ 13,330,009	$ 14,902,614	$ 1,572,605	11.8%
02 Technical and Special Fees	111,876	414,383	693,322	278,939	67.3%
03 Communication	103,810	79,958	87,141	7,183	9.0%
04 Travel	118,543	241,252	274,294	33,042	13.7%
08 Contractual Services	128,374,969	156,120,231	139,449,804	-16,670,427	-10.7%
09 Supplies and Materials	86,560	67,125	72,196	5,071	7.6%
10 Equipment – Replacement	223,702	5,000	0	-5,000	-100.0%
11 Equipment – Additional	107,631	190,060	200,000	9,940	5.2%
12 Grants, Subsidies, and Contributions	7,799,350	10,612,928	10,861,589	248,661	2.3%
13 Fixed Charges	436,943	563,268	540,625	-22,643	-4.0%
Total Objects	**$ 149,348,437**	**$ 181,624,214**	**$ 167,081,585**	**-$ 14,542,629**	**-8.0%**
Funds					
03 Special Fund	$ 149,348,437	$ 178,974,494	$ 166,331,585	-$ 12,642,909	-7.1%
09 Reimbursable Fund	0	2,649,720	750,000	-1,899,720	-71.7%
Total Funds	**$ 149,348,437**	**$ 181,624,214**	**$ 167,081,585**	**-$ 14,542,629**	**-8.0%**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.

Appendix 3
Fiscal Summary
Maryland Department of Health – Health Regulatory Commissions

Program/Unit	FY 18 Actual	FY 19 Wrk Approp	FY 20 Allowance	Change	FY 19 - FY 20 % Change
01 Maryland Health Care Commission	$ 40,251,184	$ 54,825,309	$ 43,081,523	-$ 11,743,786	-21.4%
02 Health Services Cost Review Commission	104,459,027	118,797,393	116,000,062	-2,797,331	-2.4%
03 Maryland Community Health Resources	4,638,226	8,001,512	8,000,000	-1,512	0%
Total Expenditures	**$ 149,348,437**	**$ 181,624,214**	**$ 167,081,585**	**-$ 14,542,629**	**-8.0%**
Special Fund	$ 149,348,437	$ 178,974,494	$ 166,331,585	-$ 12,642,909	-7.1%
Total Appropriations	**$ 149,348,437**	**$ 178,974,494**	**$ 166,331,585**	**-$ 12,642,909**	**-7.1%**
Reimbursable Fund	$ 0	$ 2,649,720	$ 750,000	-$ 1,899,720	-71.7%
Total Funds	**$ 149,348,437**	**$ 181,624,214**	**$ 167,081,585**	**-$ 14,542,629**	**-8.0%**

Note: The fiscal 2019 appropriation does not include deficiencies, a one-time $500 bonus, or general salary increases. The fiscal 2020 allowance does not include general salary increases.