

M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	FY 08 <u>Actual</u>	FY 09 <u>Working</u>	FY 10 <u>Allowance</u>	FY 09-10 <u>Change</u>	% Change <u>Prior Year</u>
Special Fund	\$123,687	\$131,658	\$169,231	\$37,573	28.5%
Contingent & Back of Bill Reductions	0	0	-43	-43	
Adjusted Special Fund	\$123,687	\$131,658	\$169,188	\$37,530	28.5%
Reimbursable Fund	201	0	0	0	
Adjusted Reimbursable Fund	\$201	\$0	\$0	\$0	
Adjusted Grand Total	\$123,888	\$131,658	\$169,188	\$37,530	28.5%

- The Governor's proposed budget for fiscal 2010 represents a \$37.5 million, or 28.5%, increase over the fiscal 2009 working appropriation.
- A change in the uncompensated care formula administered by the Health Services Cost Review Commission (HSCRC) has resulted in uncompensated care disbursements in the fiscal 2010 budget that are \$35.0 million above the fiscal 2009 level.

Personnel Data

	FY 08 <u>Actual</u>	FY 09 <u>Working</u>	FY 10 <u>Allowance</u>	FY 09-10 <u>Change</u>
Regular Positions	90.60	94.60	95.60	1.00
Contractual FTEs	<u>1.00</u>	<u>1.00</u>	<u>0.00</u>	<u>-1.00</u>
Total Personnel	91.60	95.60	95.60	0.00

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	3.82	4.00%
Positions and Percentage Vacant as of 12/31/08	8.00	8.46%

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

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- The fiscal 2010 allowance includes the addition of one regular position, the result of a contractual conversion within the Maryland Health Care Commission (MHCC).
- The projected fiscal 2010 turnover rate is 4%. In order to achieve the projected turnover rate, it will be necessary to maintain 3.82 vacancies. As of January 1, 2009, the Health Regulatory Commissions had 8.0 vacancies.

Analysis in Brief

Major Trends

Participation in the Small Group Market Remains Low: MHCC regulates the Comprehensive Standard Health Benefit Plan for employers with 2 to 50 employees. The cost of the basic, standard coverage is monitored annually to ensure that the average premium charged does not exceed 10% of the average annual wage in Maryland. While the cost of the plans is below the affordability cap, participation in the small group market remains low. MHCC estimates that 58% of small businesses currently do not offer health insurance to their employees. The Small Business Health Insurance Partnership, passed in the 2007 special session, has so far done little to change this trend.

Growth in Maryland Medicare Costs Lower than the National Average: Growth in Medicare costs in Maryland has remained consistently below the national average, a requirement of maintaining the Medicare waiver. Even though Maryland has maintained a slower rate of growth than the national average, it has slipped below the 10% cushion that HSCRC prefers to keep to maintain the waiver.

Issues

Small Business Health Insurance Partnership: Chapter 7 of the 2007 special session created a small business health insurance subsidy program to provide an incentive for small employers to offer and maintain health insurance to their employees; promote access to health services, particularly for preventive health services that may reduce emergency department utilization; and reduce uncompensated care in hospitals by covering previously uninsured individuals. Initial estimates projected 15,000 lives covered through the program; however, as of February 1, 2009, the program has only enrolled 628 individuals.

Revised Uncompensated Care Formula: In an effort to reduce Medicaid expenditures and more equitably share the burden of uncompensated care, the methodology by which uncompensated care in hospitals is assessed and distributed in Maryland was changed. Regulations were approved in December 2008 to change from a “partial pooling” system to a “full pooling” system that addresses uncompensated care funding in Maryland hospitals.

Operating Grant for R Adams Cowley Shock Trauma Center Disbursed through Maryland Health Care Commission: The operating grant subsidy for the R Adams Cowley Shock Trauma Center will be disbursed through MHCC. In previous years, the grant was disbursed directly to the agency. The Shock Trauma Center will receive the same level of support for the operating grant as in years past.

Recommended Actions

	<u>Funds</u>
1. Reduce funds for Small Business Health Partnership.	\$ 13,000,000
Total Reductions	\$ 13,000,000

Updates

Medicare Waiver Test: In 1977, HSCRC was granted a Medicare waiver by the federal government which allows HSCRC to set the Medicare reimbursement rate for hospitals. To maintain the waiver granted by the federal government, two conditions must be met: (1) the rate of growth in Medicare payments to Maryland hospitals from 1981 to the present is no greater than the rate of growth in Medicare payments to hospitals nationally over the same time period; and (2) all payors in the system must pay the same amount.

Task Force on Health Care Access and Reimbursement: Chapter 505 of 2007 established a task force to examine issues concerning access to and reimbursement of physicians and other health care professionals. Specifically, the task force was directed to make recommendations to the General Assembly on access to providers, payers' policies on participation, adequacy of current reimbursement levels, alternatives to the present system of payment, and the feasibility of linking reimbursement to quality. A final report containing findings and recommendations was submitted in December 2008.

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Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

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

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

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

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

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

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MCHRC was established 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.

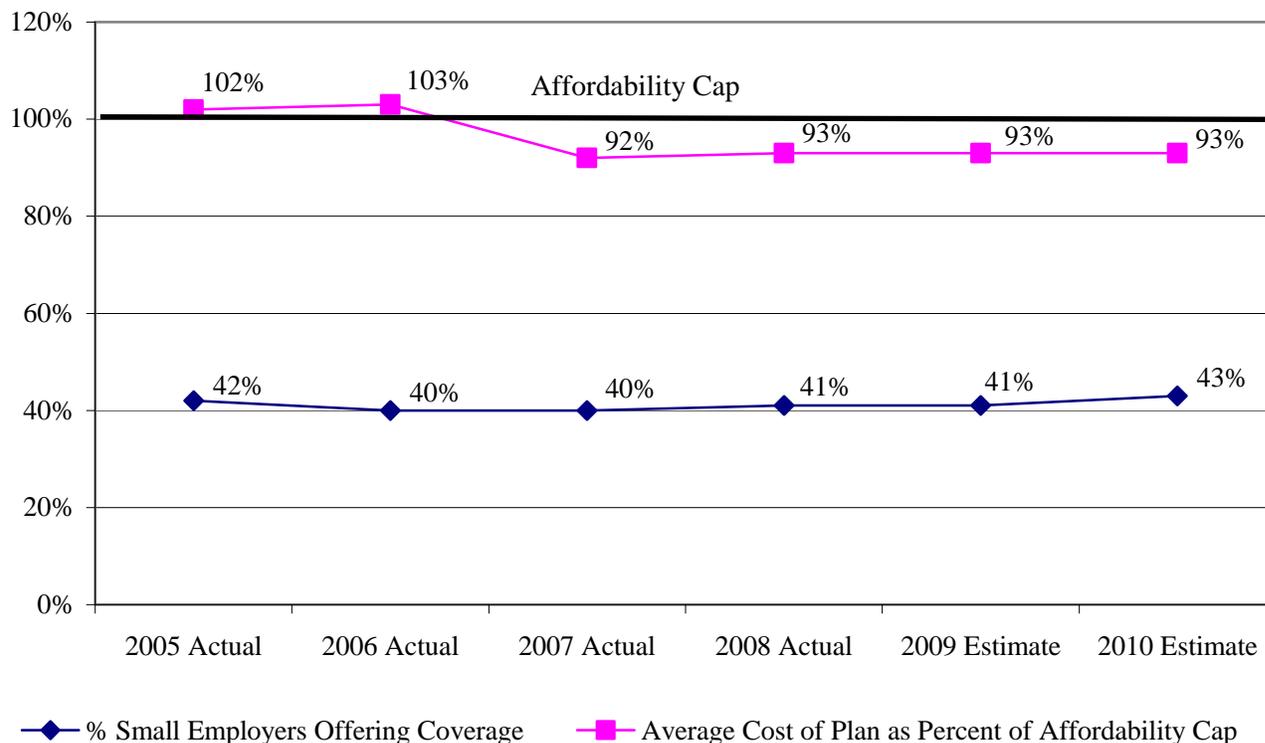
Performance Analysis: Managing for Results

Maryland Health Care Commission

One of the goals of MHCC is to improve access to, and affordability of, health insurance in the small group market. MHCC, along with the Maryland Insurance Administration, regulates a comprehensive standard health benefit plan (CSHBP) for the small group market (2 to 50 employees). Any carrier that sells health care coverage to the small group market can sell only the CSHBP, which consists of a broad set of covered services that can be offered as a Health Maintenance Organization (HMO), high deductible HMO, Point-of-Service Plan (POS), Preferred Provider Organization (PPO), or Health Savings Account (HSA)-compatible HMO and PPO plan. If small businesses want more coverage, they may purchase a "rider" to the CSHBP. Benefits are at least equal to those offered by a federally qualified HMO. The cost of the basic, standard coverage is monitored annually to ensure that the average premium charged does not exceed 10% of the average annual wage in Maryland, estimated to be \$48,239 in 2008. The affordability cap is set in statute.

Exhibit 1 shows the percent of small employers offering coverage and the average cost of the plan as a percent of the affordability cap. As the chart shows, in fiscal 2005 and 2006, the average cost of the CSHBP exceeded the affordability cap. In order to reduce the cost of the plans for small employers, MHCC changed the CSHBP by including a high deductible prescription drug benefit and a high deductible HMO plan in conjunction with an HSA. The result of these two changes, along with other minor modifications to the CSHBP, reduced the average cost below the affordability cap beginning in fiscal 2007.

Exhibit 1
Access and Affordability of Health Insurance for Small Businesses in Maryland
Fiscal 2005-2010



Source: Maryland Health Care Commission

Even with the changes made to the CSHBP, participation by employers remains around 40%. There was a slight increase in the number of employers offering coverage in fiscal 2008, as shown in Exhibit 1. However, long-term trends have pointed to a decline in employer and employee participation in the small group market. According to MHCC, employer participation has declined 9% overall since fiscal 1999; employee participation has declined 14% since fiscal 1998. Carriers in the small group market have also declined from 37 in 1995 to only 8 in 2007, due to mergers and departures. The top two insurers have a combined market share of 86% of the small group market, according to MHCC.

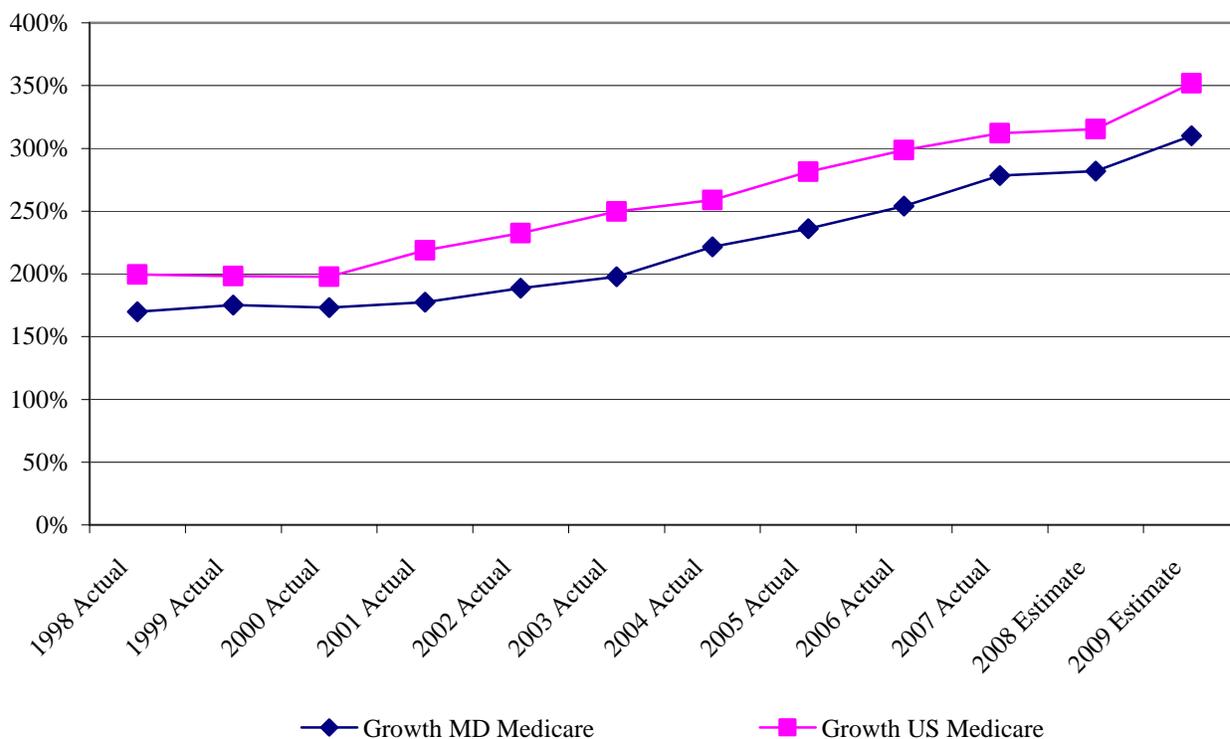
Due to the economic climate, small employers are not expected to increase health insurance coverage for their employees dramatically. Exhibit 1 shows a 2 percentage point increase in fiscal 2010 for participation in the small group market. The implementation of the Small Business Health Partnership, a premium subsidy program for qualified small businesses, has resulted in increased participation in the small group market. However, the number of businesses that are opting for the subsidy is lower than expected as a result of a slow economy. An in depth discussion of the program is included in the Issues section of this document.

Health Services Cost Review Commission

HSCRC was established to contain hospital costs, maintain fairness in hospital payments, provide for financial access to hospital care, and disclose information on the operation of hospitals in the State. In this role, one of the duties of HSCRC is to set standard rates that hospitals may charge for the purchase of care. This system encourages access to health care regardless of ability to pay and prevents cost shifting between payors. The commission’s ability to standardize rates for all payors, including Medicare and Medicaid, was established in 1980 by federal legislation, with continued regulation contingent on the commission’s ability to contain the rate of growth of Medicare hospital admissions costs.

In order to maintain an all-payor system, Maryland must contain the cost of health care such that the growth of Medicare payments does not surpass the growth of Medicare nationally. **Exhibit 2** illustrates the growth of Medicare between fiscal 1998 and 2009 and shows that the rate of growth in Maryland remains below the national average. As of September 2007, the cumulative growth of Maryland Medicare payments has been 282.00%, compared to national growth of 315.34%. A more in-depth discussion of the Medicare waiver is included in the Updates section of this document.

Exhibit 2
Medicare Growth: Maryland vs. National Average
Fiscal 1998-2009

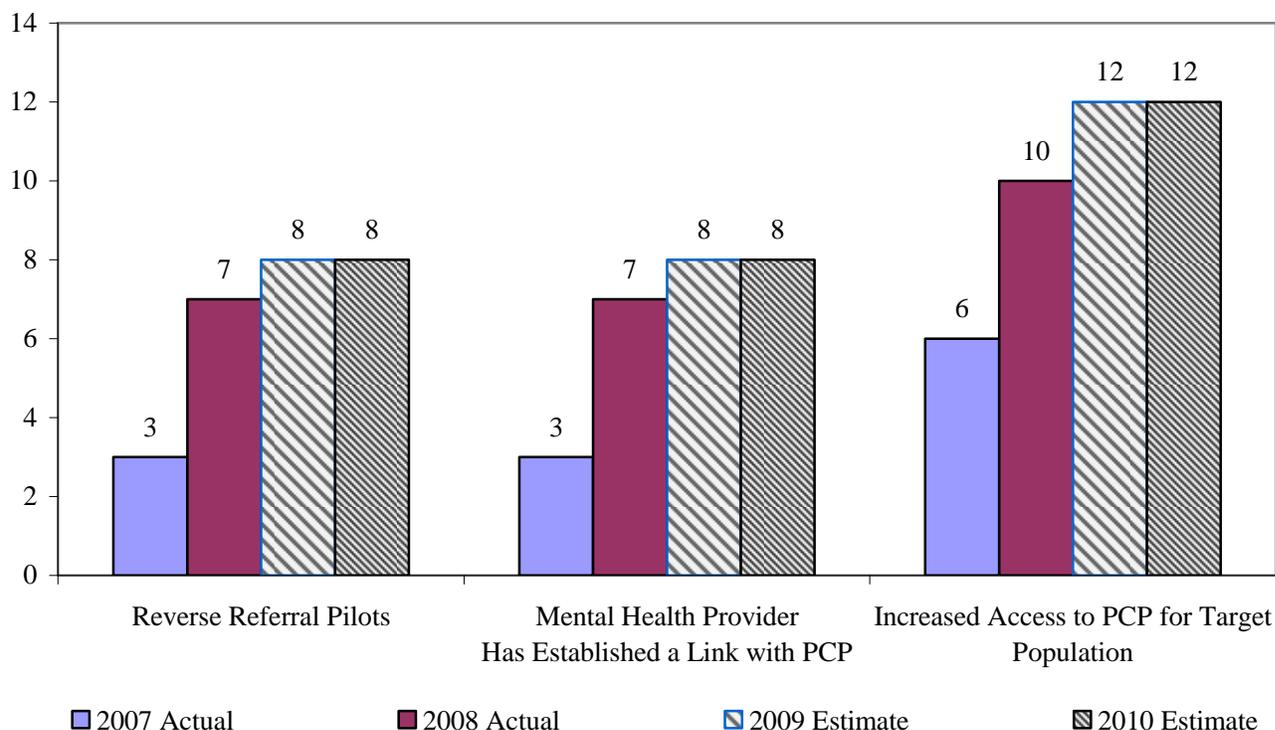


Source: Department of Health and Mental Hygiene

Maryland Community Health Resources Commission

MCHRC was established during the 2005 General Assembly to strengthen the safety net for low-income, uninsured, and underinsured Marylanders. Fiscal 2007 was the first full year that MCHRC was in operation and awarded grants to achieve its goals. **Exhibit 3** shows the initiatives undertaken by MCHRC in order to create greater access to affordable, coordinated, and integrated care for the target population. Grants are awarded to community health resource centers, federally qualified health centers, and other community-based health clinics.

Exhibit 3
Maryland Community Health Resources Commission Grants
Fiscal 2007-2010



PCP: Primary Care Physician

Source: Department of Health and Mental Hygiene

MCHRC has three main goals in awarding grants: (1) to decrease the use of hospital emergency departments for non-urgent care by utilizing reverse referral pilot programs; (2) to improve coordination of mental health and/or substance abuse treatment providers and primary care providers by encouraging the establishment of links between the two providers; and (3) to improve access to primary care for the targeted population. These three goals are shown in Exhibit 3 along

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with the respective achievement in each category. In fiscal 2009, the budget for MCHRC was cut from \$9.8 million to \$3.0 million. As a result, the number of reverse referral pilot programs, providers that link directly to the primary care physician (PCP), and programs that increase access to PCP is not expected to grow between fiscal 2009 and 2010.

A full list of grants disbursed by MCHRC in fiscal 2008 and 2009 is included in **Appendix 5**.

Fiscal 2009 Actions

Impact of Cost Containment

The Board of Public Works (BPW) met twice during the interim to reduce costs across the Executive agencies. In June 2008, actions taken by BPW reduced personnel expenses for the Regulatory Commissions by \$40,793 in special funds.

In October 2008, actions taken by BPW reduced the budget for the Maryland Community Health Resources Commission by \$6.8 million. The commission's fiscal 2009 working appropriation was reduced from \$9.8 million to \$3.0 million, diminishing the funds available to disburse community health and information technology grants in fiscal 2009.

Proposed Budget

The proposed budget for the Health Regulatory Commissions increases by \$37.6 million, or 28.5%, and is comprised solely of special funds as shown in **Exhibit 4**. A change in the uncompensated care formula administered by the Health Services Cost Review Commission provides the bulk of the change as the fiscal 2010 budget assumes a \$35.0 million increase in uncompensated care disbursements over the fiscal 2009 level.

Personnel

Personnel costs for the Health Regulatory Commissions increase by \$0.5 million in fiscal 2010. Increases include annualized expenses associated with base salary for employees (\$0.3 million); employee and retiree health insurance (\$0.2 million); State contribution to employee retirement (\$0.1 million); and the addition of 1.0 new regular position (contractual conversion) for MHCC (\$79,373). These increases are offset by the elimination of Other Post Employment Benefits funding (\$148,076), turnover adjustments (\$80,465), and the elimination of the deferred compensation match for State employees, contingent on passage of HB 101/SB 166 (\$42,746).

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

How Much It Grows:	<u>Special</u> <u>Fund</u>	<u>Total</u>
2009 Working Appropriation	\$131,658	\$131,658
2010 Allowance	<u>169,231</u>	<u>169,231</u>
Amount Change	\$37,573	\$37,573
Percent Change	28.5%	28.5%
Contingent Reductions	-\$43	-\$43
Adjusted Change	\$37,530	\$37,530
Adjusted Percent Change	28.5%	28.5%
 Where It Goes:		
Personnel Expenses		
Regular earnings		\$303
Employee and retiree health insurance		217
State contribution to retirement		126
New position (1.0)		79
Other fringe benefit adjustments.....		20
Elimination of Other Post Employment Benefits funding.....		-148
Turnover adjustments		-80
Elimination of deferred compensation match (HB 101/SB 166).....		-43
Maryland Health Care Commission		
Grant to Shock Trauma.....		3,000
Trauma equipment grants		200
Increased expenditure for contractual projects		68
Other		2
Reduced allowance for Trauma Physician Fund payments		-1,100
Contractual conversion		-73
Project in fiscal 2009 that studied professional reimbursement		-50
Health Services Cost Review Commission		
Revised uncompensated care formula and distribution		35,000
Purchase of data processing equipment in fiscal 2009		-25
Maryland Community Health Resources Commission		
Operating grants.....		86
Reduced allowance for special studies on improving access to care.....		-52
Total		\$37,530

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

MHCC

Nonpersonnel expenses for the Maryland Health Care Commission increase by roughly \$2 million in fiscal 2010. An annual operating grant, previously disbursed directly to the University of Maryland Medical System (UMMS), will be disbursed by MHCC in fiscal 2010 in the amount of \$3 million. A full discussion of the operating grant is included in the subsequent section.

In fiscal 2010, MHCC will begin to disburse trauma grants in accordance with Chapter 238 of 2008. The legislation directs MHCC and the Maryland Institute for Emergency Medical Systems Services (MIEMSS) to award grants to Level I and Level II trauma centers for the purpose of purchasing trauma equipment. The budget includes \$0.2 million for trauma equipment grants in fiscal 2010.

MHCC conducts studies each year on the state of quality and access to health care, including changes necessary to the CSHBP and advancing the use of health information technology. MHCC also publishes and disseminates comparative information on commercial managed care plans operating in the State to inform Marylanders. In fiscal 2010, costs associated with those studies increase by \$68,492.

The allowance for Trauma Physician Services Fund payments is reduced by \$1.1 million, due to lower anticipated revenues for the fund. The source of the fund is a surcharge on State driver's licenses. The trauma fund is intended to subsidize the cost of uncompensated care incurred by a trauma physician, maintaining trauma physicians on-call as required by MIEMSS, and for administrative expenses incurred by MHCC and HSCRC.

Other decreases to the MHCC budget include a contractual conversion, the savings of which are offset by the addition of a regular position, and a professional reimbursement study commissioned in fiscal 2009.

HSCRC

The budget for the Health Services Review Commission increases by \$35 million based on a revised uncompensated care formula for equitably sharing uncompensated care costs across all hospitals. HSCRC moved from a partial pooling system where each hospital paid a set rate of 0.75% into the fund to a full pooling system where each hospital remits payment according to its uncompensated care costs compared to the State average. HSCRC also now includes the R Adams Cowley Shock Trauma Center in the uncompensated care pool. The result of the change in formula results in a \$35 million increase in collection and disbursement from the pool. A full discussion of the uncompensated care formula change is included in the Issues section of this document.

MCHRC

The fiscal 2010 allowance for MCHRC remains at virtually the same level as the fiscal 2009 working appropriation. Although the budget is unchanged from the working appropriation, the fiscal 2010 allowance is \$6.8 million less than the original fiscal 2009 legislative appropriation, due to cost containment actions in October 2008.

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In fiscal 2010, MCHRC will spend approximately \$2.5 million on community health and information technology grants, \$85,747 more than is designated in the fiscal 2009 working appropriation.

MCHRC also commissions special studies on public health issues and ways to improve access to primary care, specialty care, mental health, dental health, and substance abuse. Due to budget constraints, expenses associated with these studies decrease by \$51,750 in the fiscal 2010 allowance.

Transfers and Changes Per Budget Reconciliation and Financing Act of 2009

The Governor’s fiscal 2010 budget is balanced by using special funds in place of general funds in certain circumstances. HB 101/SB 166, the Budget Reconciliation and Financing Act of 2009, is the vehicle by which funds from certain special funds are transferred to the general fund to support State activities. HB 101/SB 166 directs the following transfers to the general fund to occur before the end of fiscal 2009:

- \$17,000,000 from the Maryland Trauma Physicians Services Fund;
- \$14,000,000 from the Community Health Resources Commission Fund; and
- \$2,000,000 from the Maryland Health Care Commission Fund.

Exhibit 5 shows the fund balance for each before and after the transfer in fiscal 2009. As the chart shows, each fund will be solvent in fiscal 2009 after the transfer.

Exhibit 5
Fund Balances Affected by HB 101/SB 166
Fiscal 2009

<u>Fund</u>	<u>Original 2009 Ending Balance</u> ¹	<u>Transfer to General Fund</u>	<u>New 2009 Ending Balance</u> ¹
Maryland Trauma Physicians Fund	\$20,726,121	\$17,000,000	\$3,726,121
Community Health Resources Commission Fund	15,102,678	14,000,000	1,102,678
Maryland Health Care Commission Fund	4,901,229	2,000,000	2,901,229

¹The ending balance for fiscal 2009 is an estimate only.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

Community Health Resources Commission Fund

In addition to the fund transfers indicated in HB 101/SB 166, language is included that changes the distribution of funds from the Community Health Resources Commission Fund. The bill as introduced caps the funding for the Community Health Resources Commission at \$3.0 million, which includes money to be used for unified data system grants. Additionally, the bill adds funding support for the Primary Adult Care Program (PAC) equal to the value of CareFirst’s premium tax exemption less the subsidy for the Senior Prescription Drug Assistance Program (SPDAP), set at \$14 million in fiscal 2009 and \$17 million in fiscal 2010 and beyond, and less funding for MCHRC, set at \$3.0 million in fiscal 2010 and annually thereafter.

Exhibit 6 shows the distribution of the healthcare premium tax exemption revenue before and after the changes outlined in HB 101/SB 166. Under the current law, MCHRC receives the balance of the revenue from the premium tax exemption, less the funding for the SPDAP program. Annually, the balance after the SDAP subsidy equaled between \$8.3 and \$10.7 million which MCHRC used for administrative expenses, health grants, and the unified data system grants.

Under the proposal offered in HB 101/SB 166, the subsidy for SPDAP will remain, but the funding for MCHRC will be capped at \$3 million. The remaining balance will go to fund the PAC program.

Exhibit 6
Premium Tax Exemption Revenue for
Community Health Resources Commission Fund
Fiscal 2007-2011

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
<u>Current Law</u>					
Senior Prescription Drug Assistance Program (SPDAP)	\$14,000	\$14,000	\$14,000	\$14,000	\$14,000
New SPDAP Coverage Gap Subsidy (2008 Legislation)			3,000	3,000	3,000
Maryland Community Health Resources Commission	8,300	9,031	10,700	12,100	13,600
<i>plus interest</i>	353	742	913	100	100
Total	\$22,653	\$23,773	\$28,613	\$29,200	\$30,700
<u>HB 101/SB 166 Proposal</u>					
Senior Prescription Drug Assistance Program	\$14,000	\$14,000	\$14,000	\$14,000	\$14,000
SPDAP Coverage Gap Subsidy			3,000	3,000	3,000
Maryland Community Health Resources Commission	8,300	9,031	10,700	3,000	3,000
Primary Adult Care (DHMH)				9,100	10,600
<i>plus interest</i>	353	742	913	100	100
Total	\$22,653	\$23,773	\$28,613	\$29,200	\$30,700

DHMH: Department of Health and Mental Hygiene

Source: Department of Budget and Management

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The agency should comment on whether the focus of the community health grants will change now that MCHRC has only \$3 million to spend. The agency should also comment on the financial viability of local community health centers now that the State will not be able to provide financial support.

Issues

1. Small Business Health Insurance Partnership

Chapter 7 of the 2007 special session established a Small Employer Health Benefit Plan Premium Subsidy Program, referred to as the Small Business Health Insurance Partnership, and tasked MHCC with administering the program and promulgating regulations that will govern the program. The purpose of the program is to provide an incentive for small employers to offer and maintain health insurance to their employees, promote access to health services, particularly for preventive health services that may reduce emergency department utilization, and reduce uncompensated care in hospitals and other health care settings by covering previously uninsured individuals.

The plan will provide a premium subsidy of up to 50% of both the employer and employee contribution, or a contribution limit set by MHCC, for businesses that employ between two and nine employees who have not offered health insurance to their employees for the previous 12 months. In order to qualify for the premium subsidy, the coverage must include a wellness benefit. Regulations were developed by MHCC to clarify eligibility requirements, to set State subsidy amounts, and to develop the wellness benefit required by law.

The program subsidizes a variety of current small group market health plans rather than contracting with a single carrier. Premium subsidies are administered directly to small group market carriers as opposed to payment to employers and employees that participate in the program. The total subsidy is passed through to the employer as a reduced group premium. Employers must then agree to pass through the employee's share of the subsidy in the form of lower payroll deductions for health insurance.

Outreach and Enrollment

The primary sources of outreach for the Health Insurance Partnership have been statewide meetings between small businesses, health insurance agents and brokers, as well as outreach through the partnership's web site, <http://mhcc.maryland.gov/partnership/>. MHCC has partnered with State and local business associations, county health departments, local chapters of health underwriters, State agencies, and members of the General Assembly to promote the partnership.

Although initial estimates placed enrollment for the program at 15,000 previously uninsured individuals, MHCC has only enrolled 628 total individuals since the program began, as shown in **Exhibit 7**. Outreach campaigns are currently underway with private partners such as the Baltimore Association of State Underwriters and the Maryland Association of Health Underwriters. Even with the public-private efforts at outreach, enrollment has been slow due in large part to the economic downturn.

Exhibit 7
Small Business Health Insurance Partnership

<u>Small Business Subsidy Program</u>	<u>Nov-08</u>	<u>Dec-08</u>	<u>Jan-09</u>	<u>Feb-09</u>
# of Participating Employers	48	79	105	121
# of Participating Employees	151	246	329	384
# of Covered Individuals	245	404	547	628
Average Annual Premium Subsidy per Covered Individual	\$1,165	\$1,135	\$1,130	\$1,136
Total Annual Subsidy for Existing Participants	\$285,457	\$458,534	\$618,597	\$713,119

Source: Maryland Health Care Commission

Chronic Care Management and Wellness Component for Small Group Market

As part of the Small Business Health Insurance Partnership, carriers will be required to include a wellness program as part of the total benefit package. A qualifying wellness benefit must include a health risk assessment¹, education in the form of written feedback based on the risk assessment results for covered individuals, and financial incentive for prevention, health promotion, or disease management. Financial incentives for covered individuals could include direct financial reward or reduced cost sharing.

Due to the low level of participation in the Small Business Health Insurance Partnership Initiative in fiscal 2009, DLS recommends reducing the fiscal 2010 allowance to \$2 million. The balance will revert to the Health Care Coverage Fund for the use of Medicaid enrollment and the future need of the Small Business Health Insurance Partnership. The reduction will allow for the continuation of the subsidy for the 628 existing enrollees as well for enrollment of 1,133 additional individuals in fiscal 2010.

2. Revised Uncompensated Care Formula

Background

As part of its mission, HSCRC attempts to quantify the reasonable cost of uncompensated care as part of a hospital's full financial requirements. In the past, HSCRC utilized a "partial pooling" method that assessed all hospitals a flat rate to offset the cost of uncompensated care across hospitals in the State.

¹ In the context of public health, a risk assessment is the process of quantifying the probability of a harmful effect to individuals or populations from certain activities.

In 1992, the General Assembly passed HB 924 which instructed the HSCRC to study alternative methodologies to “promote the equitable distribution of the cost of uncompensated care among hospitals” and gave the HSCRC authority for implementing a financing mechanism for uncompensated care. In September 1996, the HSCRC approved a methodology that spread the costs evenly among all hospitals in the State by imposing an assessment against acute care hospitals equal to 0.75% of gross revenues. The funds collected are deposited into the Uncompensated Care Fund and subsequently distributed to those Maryland hospitals that treat the higher proportion of uninsured patients.

This system was called “partial pooling” as all hospitals, regardless of the amount of uncompensated care provided, paid the same amount into the system, and the total burden of uncompensated care was only partially subsidized by the assessment. This system was in place until December 2008 when a change in the formula was instituted to assess uncompensated care not by a flat rate, but rather based on each hospital’s level of uncompensated care relative to the State average. Full pooling refers to the fact that all expenses associated with uncompensated care are shared equally among the hospitals in the system.

Full Pooling

Regulatory changes enabled HSCRC to make a special adjustment to the uncompensated care provision of each hospital’s “mark-up” (the mechanism used to increase hospital rates to allow for payor differentials and the cost of providing uncompensated care) which will bring the hospital’s uncompensated care provision included in its mark-up to the statewide uncompensated care average, currently set at 6.91%. Hospitals with uncompensated care rates lower than 6.91% will be assessed an amount that will represent an equitable share of statewide uncompensated care costs up to the State average. Likewise, hospitals with rates higher than 6.91% will be awarded payment sufficient to bring their costs down to the average.

Hence, hospitals with high levels of uncompensated care will receive higher payments from the fund, and those with lower levels of uncompensated care will remit more into the fund. **Exhibit 8** demonstrates the difference between the partial pooling and full pooling system for hospitals depending on their level of uncompensated care.

A hospital with high uncompensated care costs, such as Hospital A in the example, would receive a higher level of payment under full pooling to offset a greater share of its uncompensated care costs. Similarly, a hospital with low uncompensated care costs, such as Hospital K, would remit a greater payment into the fund under full pooling than it did previously under partial pooling. In the end, all of the hospitals in the system will equitably share the costs associated with uncompensated care in the State.

**Exhibit 8
Partial Pooling vs. Full Pooling**

	<u>Total UC</u>	<u>Remittance Under Partial Pooling</u>	<u>Remittance Under Full Pooling</u>	<u>Payment Under Partial Pooling</u>	<u>Payment Under Full Pooling</u>
High UC Hospitals					
Hospital A	14.00%	0.75%	0.00%	5.50%	7.00%
Hospital B	12.00%	0.75%	0.00%	3.50%	5.00%
Hospital C	10.00%	0.75%	0.00%	1.50%	3.00%
Hospital D	9.00%	0.75%	0.00%	0.50%	2.00%
Hospital E	8.70%	0.75%	0.00%	0.20%	1.70%
Low UC Hospitals					
Hospital F	5.00%	0.75%	2.00%	0.00%	0.00%
Hospital G	4.00%	0.75%	3.00%	0.00%	0.00%
Hospital H	3.50%	0.75%	3.50%	0.00%	0.00%
Hospital J	3.00%	0.75%	4.00%	0.00%	0.00%
Hospital K	2.00%	0.75%	5.00%	0.00%	0.00%

UC: Uncompensated Care

Note: The State average, 6.91%, is rounded to 7.0% for purposes of this chart.

Source: Health Services Cost Review Commission

Inelastic Demand for Services at Hospitals

Under the full pooling system, the mark-up for a hospital with a low amount of uncompensated care will be higher than under the partial pooling system as they are taking on a greater amount of the total uncompensated care costs in the State. The practical result of this is a higher rate for payors – private insurance, Medicaid, and Medicare. The hospital does not lose any money since the mark-up is in addition to the cost of services. Payors will pay a higher rate at hospitals that experience lower uncompensated care and pay a lower rate at hospitals that tend to have higher uncompensated care populations. Savings to Medicaid are realized under this system due to lower rates at hospitals that serve Medicaid populations.

Hospitals have found that the demand for services at hospitals is inelastic and that a slight increase or decrease in price will not sway consumers’ or insurance companies’ decision to patronize a certain hospital. The decision is more likely to be based on the proximity of the hospital and the services that are offered. Thus, neither hospitals nor payors have opposed the change to full pooling.

Summary

Additionally, the R Adams Cowley Shock Trauma Center, previously excluded from the uncompensated care fund, has been added to the list of hospitals that are included in the system. Shock Trauma historically experiences a high level of uncompensated care; in fiscal 2009, HSCRC calculated the uncompensated care rate to be 14.17% higher than the State average. In 2009, the payment from the uncompensated care fund to Shock Trauma is estimated to be \$20.7 million. Including Shock Trauma in the pool will lower the hospital's rate as it will receive payment from the fund. Consequently, this action will result in savings to Medicaid as 26.79% of patients at Shock Trauma are Medicaid patients, according to HSCRC.

The HSCRC estimates that total annual Medicaid savings associated with the two changes would be approximately \$10.9 million, including \$5.1 million in general funds.

3. Operating Grant for R Adams Cowley Shock Trauma Center Disbursed through Maryland Health Care Commission

The University of Maryland Medical System, a private nonprofit corporation, was created by legislation in 1984 to provide governance and management over the operation of the formerly State-run University of Maryland Hospital. The mission of the medical system is to provide tertiary care to the State and surrounding areas, to provide comprehensive care to the local community, and to serve as the primary site for health care education and research for the University System of Maryland. The system includes the James Lawrence Kernan Hospital, the Marlene and Stewart Greenebaum Cancer Center, University Hospital, R Adams Cowley Shock Trauma Center, and University Specialty Hospital.

Direct State support is provided to the Shock Trauma Center utilizing special funds from the Maryland Emergency Medical System Operations Fund (MEMSOF). MEMSOF was established in 1992 to provide support to State providers of emergency medical services and generates approximately \$50 million each year from a surcharge on vehicle registrations.

In previous years, the subsidy for the Shock Trauma Center was disbursed directly to the UMMS for operating and educational grants. Beginning in fiscal 2010, the operating grant from MEMSOF will be disbursed through MHCC and the Maryland Institute of Emergency Medical Services System (MIEMSS).

Exhibit 9 shows State support of the Shock Trauma Center between fiscal 2007 and 2010 in the operating budget only. Support for the Shock Trauma Center is also included in the annual capital budget, not shown on Exhibit 9. The operating subsidy for the Shock Trauma Center aids the center in its standby costs, homeland security requirements, and research and education expenditures.

Exhibit 9
Subsidy to the R Adams Cowley Shock Trauma Center
Fiscal 2007-2010
(\$ in Thousands)

	<u>2007</u> <u>Actual</u>	<u>2008</u> <u>Actual</u>	<u>2009 Working</u> <u>Appropriation</u>	<u>2010</u> <u>Allowance</u>	<u>2009-2010</u> <u>Change</u>	<u>2009-2010</u> <u>% Change</u>
Operating Subsidy	\$3,200	\$3,264	\$3,361	\$3,200	-\$161	-4.8%
Capital Subsidy	\$3,500	\$3,500	\$0*	\$0*	n/a	n/a

* The capital subsidy for the Shock Trauma Center was included in the capital budget beginning in fiscal 2009.

Source: Department of Budget and Management

The total State support for UMMS, as shown in Exhibit 9, is \$3.2 million in fiscal 2010, including \$3.0 million in the MHCC allowance and \$0.2 million in the MIEMSS allowance. The operating subsidy in fiscal 2010 represents a 4.8% decrease over the fiscal 2009 working appropriation.

Capital funding support for the Shock Trauma Center was eliminated from the operating budget in fiscal 2009 and replaced with funds in the capital budget. The level of support for the Shock Trauma Center was set at \$3.5 million in fiscal 2009; language in Chapter 336 of 2008, the 2008 capital budget bill, directed the State to include \$3.5 million in each fiscal 2010 and 2011 to replace the MEMSOF capital budget subsidy. The fiscal 2010 capital budget submitted by the Governor reflects the additional capital subsidy.

Recommended Actions

	<u>Amount Reduction</u>
1. Reduce funds for the Small Business Health Partnership Initiative. Based on current projections, less than \$1,000,000 of \$15,000,000 available for the subsidy program will be utilized in fiscal 2009. The Maryland Health Care Commission may request additional funding for this program through budget amendments should enrollment increase in fiscal 2010.	\$ 13,000,000 SF
Total Special Fund Reductions	\$ 13,000,000

Updates

1. Medicare Waiver Test

On July 1, 1977, HSCRC was granted a Medicare waiver by the federal government. The waiver exempts Maryland hospitals from Medicare’s prospective payment system that reimburses hospitals on a diagnosis-based method. Under the waiver, Medicare agrees to reimburse hospitals at the rates set by HSCRC. The waiver allowed Maryland to establish an “all payor” system, in which every payor for hospital care pays the same rates for hospital services. As a result, hospitals annually realize an estimated \$800 million in Medicare reimbursements above that which would be received absent the all payor system. Currently, Medicare services in Maryland cost more than they would in other states.

To maintain the waiver, HSCRC must ensure that two conditions are met: (1) the rate of growth in Medicare payments to Maryland hospitals from 1981 to the present is no greater than the rate of growth in Medicare payments to hospitals nationally over the same time period; and (2) all payors in the system must pay the same amount.

As a condition of the health care expansion efforts, Medicaid day limits were lifted in fiscal 2009. The HSCRC believed that the existence of Medicaid day limits threatened the validity of the waiver as it allowed other payors besides Medicaid to share the cost of Medicaid patients, hence violating the second condition of the waiver. Even with cost containment measures looming for fiscal 2009 and fiscal 2010, there are currently no plans to reinstate Medicaid day limits.

Medicare Growth

The HSCRC must ensure that Maryland’s cumulative rate of growth is equal to or less than the national growth in Medicare payments per discharge. If it fails to do so, the all payor system will enter a three-year corrective period. During that time, HSCRC must reduce hospital rates to bring payment growth below Medicare nationally and return Medicare “overpayments” back to the federal government. As of September 2007, the latest quarter for which there is available data, the Maryland Medicare charge per case has increased by 282.00% since the waiver was awarded in 1980. Nationally, Medicare charge per case has increased by 315.34% since 1980. **Exhibit 10** shows the change in charge per case for Maryland and for the national average. As the table illustrates, the cost of Medicare services in Maryland is higher than the national average, but it is growing at a slower rate.

Exhibit 10
Medicare Growth
Maryland vs. National Average

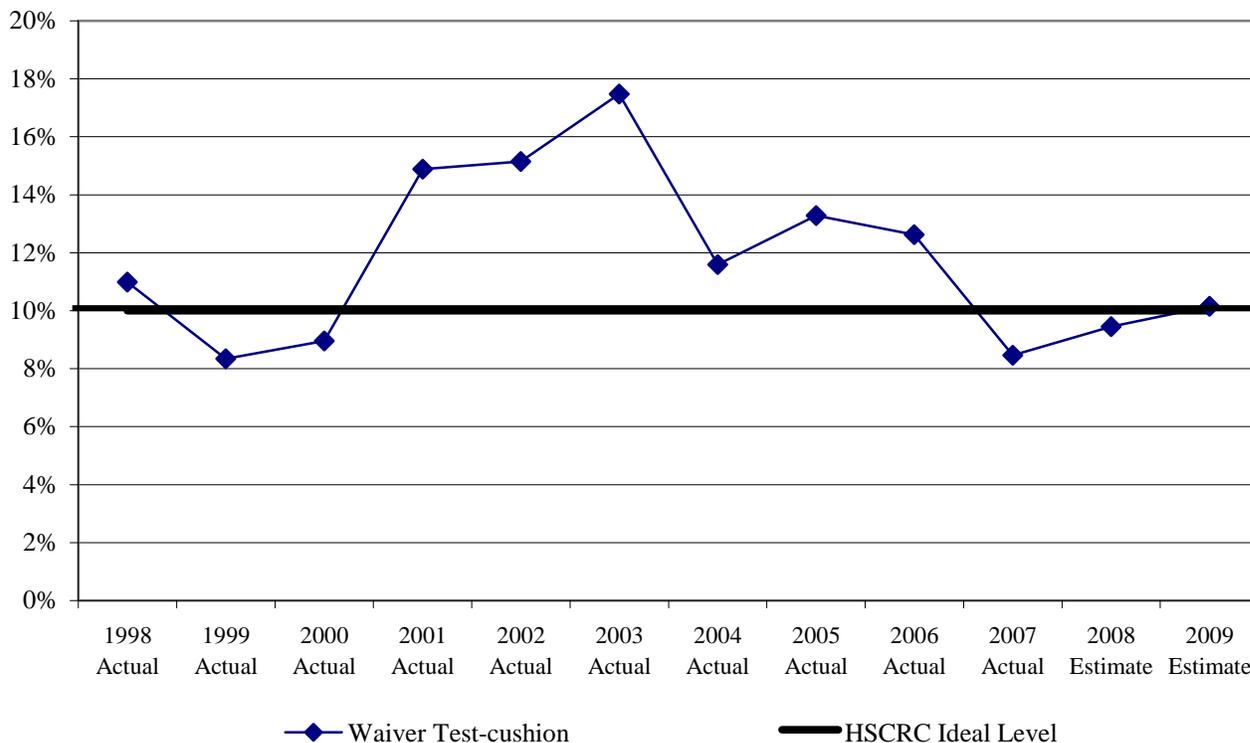
	<u>CY 1980</u>	<u>CY 2007</u>	<u>% Change</u>
Maryland	\$2,972	\$11,352	282.00%
National Average	\$2,293	\$9,524	315.34%

Source: Health Services Cost Review Commission

The primary measure used to monitor waiver performance is the relative waiver margin calculation, a test performed using an independent economic model that assumes a flat rate of growth in Medicare payments per case. The result of the test is the relative waiver margin or “waiver cushion,” which represents the amount Medicare payments to Maryland could grow, assuming zero growth in Medicare payments nationally, before the State failed to meet its waiver requirements. HSCRC has determined that 10% is the lowest desirable level for the waiver margin; however, a margin between 12 to 15% is ideal. The larger the margin, the more flexibility HSCRC has to adjust rates while simultaneously weathering Medicare payment trends.

As shown in **Exhibit 11**, over the past decade, the waiver cushion has fluctuated below and above the 10% absolute minimum level. Information on the national average has an 18-month lag, so the most current actual data is from fiscal 2007 when there was a cushion of 8.44%. HSCRC estimates that the cushion will continue to improve to 9.45% in fiscal 2008 and 10.15% in fiscal 2009.

**Exhibit 11
Medicare Waiver Cushion
Fiscal 1998-2009**



HSCRC: Health Services Cost Review Commission

Source: Health Services Cost Review Commission

All Payor System

The second condition of the waiver is that all payors in the system – Medicaid, Medicare, private insurance, or uninsured individuals – be charged the same amount. As a one-time cost containment measure, Medicaid day limits (MDLs) were established to limit the number of days that Medicaid is required to pay for an individual in the hospital. Any days above that limit were considered uncompensated care. While MDLs were intended to be a one-time cost containment measure, budgetary pressures prolonged the use of MDLs.

In fiscal 2008, MDLs were finally abolished in conjunction with the implementation of the Working Families Act of 2007. Although MDLs were estimated to provide approximately \$68 million in savings to the Medicaid program, they were also detrimental to waiver performance in that these costs are shifted to other payors, thereby violating the all payor system. Also, the growth of Medicare is artificially inflated based on the cost shift from MDLs. Since the abolition of MDLs, the waiver cushion improved by almost 1%.

2. Task Force on Health Care Access and Reimbursement

Chapter 505 of 2007 established a task force to examine issues concerning access to and reimbursement of physicians and other health care professionals. Specifically, the task force was directed to make recommendations to the General Assembly on access to providers, payors' policies on participation, adequacy of current reimbursement levels, alternatives to the present system of payment, and the feasibility of linking reimbursement to quality.

Findings on the Maryland Health Care Environment

The task force found that physician fees for services were lower in Maryland than the national average, but per capita spending for health services was closer to national levels than fee levels would suggest. Also, Maryland's rate of uninsured individuals was below the national average, but above 16 other states. Health care premiums for family policies in Maryland have been near the national averages for both HMO and non-HMO insurance products.

In 2008, a study by the Maryland Hospital Association and MedChi found that a physician shortage currently exists in Maryland. The report claims that the State has 179 practicing physicians for every 100,000 residents, 16% below the national average of 212. The shortage is most pronounced in rural areas and is predicted to worsen by 2015.

Recommendations

The task force issued eight recommendations that address access to services including the physician workforce shortage that currently exists, and changes to the reimbursement system. **Exhibit 12** lists each recommendation and describes the type of action required for implementation. The first recommendation expands loan programs in the State and promotes practice development, particularly in primary care (Recommendation 1). The task force also recommends that State agencies permit a single organization to conduct primary and secondary source verification on behalf of health plans and hospitals in order to make the credentialing process less expensive and less time-consuming (Recommendation 2).

The task force formulated the third recommendation to resolve the long-standing problem of reimbursement for noncontracting providers that treat HMO enrollees (Recommendation 3). The fourth recommendation establishes requirements on insurance carriers and plans for physician performance measures (Recommendation 4).

Consensus was reached within the task force on the importance of promoting new models of care that incorporate a medical home model where primary care physicians and other professionals provide conventional diagnostic and therapeutic services. The primary care physicians serve as advocates for patients and are paid to coordinate their care, thus avoiding unnecessary tests and procedures, hospital admissions, and other complications. The recommendation focuses on building a coalition that can develop, promote, test, and fund the medical home model (Recommendation 5). While the medical home model still needs to be tested, the task force did recommend that one component of the medical home model be implemented – payment for after-hours and weekend care (Recommendation 6).

Exhibit 12
Task Force on Health Care Access and Reimbursement Recommendations

<u>Recommendations</u>	<u>Action Required</u>
1. Recommendation on approaches to promote practice formation in Maryland	Amend Education Article § 18-1501 – 18-1502
2. Recommendation for simplifying the credentialing of physicians by hospitals and health plans	Amend Health General Article § 15-103.4 and Health General Article § 19-319
3. Recommendation for changing the formula for reimbursing nonparticipating providers that treat HMO patients	Amend Health General Article § 19-710.1
4. Recommendation that health insurance plans must agree to use common nationally recognized measures in performance plans	Amend Insurance and Health General Articles depending on implementation
5. Recommendation for enhancing delivery of primary care and development of the medical home model	No legislation required
6. Recommendation on elevated payment for after-hours and weekend care	Yes, if stakeholders wish to mandate
7. Recommendation for reimbursing primary care providers that provide mental health services	No legislation required
8. Recommendation on improving data on physician supply	Changes to Code of Maryland Regulations 10.25.14

Source: Department of Health and Mental Hygiene

Recommendation 7 instructs health plans and MedChi to develop guidance and training for primary care providers requesting information on billing for mental health services. The last recommendation is to expand data collection on the physician workforce in Maryland in order to provide State policymakers with high-quality information on workforce issues (Recommendation 8).

Current and Prior Year Budgets

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

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2008					
Legislative Appropriation	\$0	\$118,162	\$0	\$0	\$118,162
Deficiency Appropriation	0	10,098	0	0	10,098
Budget Amendments	0	1,404	0	201	1,605
Cost Containment	0	-231	0	0	-231
Reversions and Cancellations	0	-5,746	0	0	-5,746
Actual Expenditures	\$0	\$123,687	\$0	\$201	\$123,888
Fiscal 2009					
Legislative Appropriation	\$0	\$138,350	\$0	\$0	\$138,350
Cost Containment	0	-6,843	0	0	-6,843
Budget Amendments	0	151	0	0	151
Working Appropriation	\$0	\$131,658	\$0	\$0	\$131,658

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

Fiscal 2008

In fiscal 2008, the budget for the Health Regulatory Commissions closed at \$123.9 million, an increase of \$5.7 million over the original legislative appropriation. The budget for the Health Regulatory Commissions is primarily special funded with all but \$0.2 million of the change occurring in special funds. The major changes in the special fund appropriation are as follows:

- \$7.0 million deficiency appropriation for HSCRC for increased uncompensated care fund payments;
- \$3.1 million deficiency appropriation for MCHRC for community health grants;
- \$1.25 million increase to cover the cost of administrative support provided by DHMH;
- \$154,429 increase for cost-of-living adjustments (COLA) for MHCC, HSCRC, and MCHRC;
- \$221,653 decrease associated with 8.8 positions abolished by the Board of Public Works in February 2008; and
- \$9,331 decrease due to cost containment action taken by BPW in July 2007. This action reduces the appropriation for supplies and materials across the three regulatory commissions.

A total of \$5.7 million in the special fund appropriation was cancelled for fiscal 2008. For MHCC, \$2.4 million was cancelled due to realized operating savings, indirect cost savings associated with vacancies and lost positions, delayed projects, savings on contracts that came in lower than expected, and funds associated with the abolished positions. For HSCRC, \$1.1 million was cancelled due to lower than expected Uncompensated Care Fund awards and two delayed contracts. For MCHRC, \$2.2 million was cancelled due to awards that were not processed in time. Those grants were awarded in fiscal 2009.

Reimbursable funds increased by \$0.2 million due to a transfer of funds from the Mental Hygiene Administration to MHCC to develop a plan to guide the future role and capacity of Maryland Psychiatric Hospitals.

Fiscal 2009

The fiscal 2009 working appropriation has decreased by \$6.7 million over the original legislative appropriation. Cost containment actions taken by the Board of Public Works in June 2008 reduced personnel expenses by \$40,793. BPW action in October 2008 reduced the budget for the Maryland Community Health Resources Commission by \$6.8 million, depleting the amount of grants that can be disbursed through MCHRC. The fiscal 2009 COLA increases the budget for the commissions by \$0.2 million.

Audit Findings

Audit Period for Last Audit:	September 26, 2005 – April 30, 2008
Issue Date:	November 2008
Number of Findings:	1
Number of Repeat Findings:	1
% of Repeat Findings:	100%
Rating: (if applicable)	n/a

Finding 1: **The Maryland Health Care Commission did not assess fiscal 2002 user fees in accordance with a new State law, resulting in an improper allocation of fees among regulated industries.**

*Bold denotes item repeated in full or part from preceding audit report.

**Object/Fund Difference Report
DHMH – Health Regulatory Commissions**

<u>Object/Fund</u>	<u>FY08 Actual</u>	<u>FY09 Working Appropriation</u>	<u>FY10 Allowance</u>	<u>FY09 - FY10 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	90.60	94.60	95.60	1.00	1.1%
02 Contractual	1.00	1.00	0	-1.00	-100.0%
Total Positions	91.60	95.60	95.60	0	0%
Objects					
01 Salaries and Wages	\$ 8,204,182	\$ 8,926,172	\$ 9,446,037	\$ 519,865	5.8%
02 Technical and Spec. Fees	87,810	135,062	48,200	-86,862	-64.3%
03 Communication	113,139	107,641	104,628	-3,013	-2.8%
04 Travel	73,140	118,116	106,895	-11,221	-9.5%
08 Contractual Services	106,100,869	119,377,444	153,254,268	33,876,824	28.4%
09 Supplies and Materials	66,404	78,618	75,279	-3,339	-4.2%
10 Equipment – Replacement	81,390	28,960	33,863	4,903	16.9%
11 Equipment – Additional	51,144	32,017	4,391	-27,626	-86.3%
12 Grants, Subsidies, and Contributions	8,688,162	2,414,253	5,700,000	3,285,747	136.1%
13 Fixed Charges	421,961	439,452	457,310	17,858	4.1%
Total Objects	\$ 123,888,201	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%
Funds					
03 Special Fund	\$ 123,687,274	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%
09 Reimbursable Fund	200,927	0	0	0	0.0%
Total Funds	\$ 123,888,201	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

<u>Program/Unit</u>	<u>FY08 Actual</u>	<u>FY09 Wrk Approp</u>	<u>FY10 Allowance</u>	<u>Change</u>	<u>FY09 - FY10 % Change</u>
01 Maryland Health Care Commission	\$ 22,018,419	\$ 38,891,789	\$ 41,256,391	\$ 2,364,602	6.1%
02 Health Services Cost Review Commission	92,666,616	89,765,946	124,955,074	35,189,128	39.2%
03 Maryland Community Health Resources Commission	9,203,166	3,000,000	3,019,406	19,406	0.6%
Total Expenditures	\$ 123,888,201	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%
Special Fund	\$ 123,687,274	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%
Total Appropriations	\$ 123,687,274	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%
Reimbursable Fund	\$ 200,927	\$ 0	\$ 0	\$ 0	0.0%
Total Funds	\$ 123,888,201	\$ 131,657,735	\$ 169,230,871	\$ 37,573,136	28.5%

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Operating Grants Awarded to Community Health Resource Centers Fiscal 2008

Operating Grants Awarded for Dental Health Initiatives

<u>Community Health Resource Center</u>	<u>Amount</u>	<u>Description</u>	<u>Date Awarded</u>
Choptank Community Health System (FQHC)	\$300,000	Dental Health Expansion	Sep-07
Allegany County Health Department	200,000	Dental Health Expansion	Sep-07
Baltimore City Health Department	70,750	Dental Health Expansion	Sep-07
Carroll County Health Department	29,030	Dental Health Expansion	Sep-07
Garrett County Health Department	173,660	Dental Health Expansion	Sep-07
Harford County Health Department	435,564	New Dental Health Clinic	Sep-07
Wicomico County Health Department	300,000	Dental Health Expansion	Sep-07
Allegany Health Right, Inc.	82,350	Improve Access to Dental Health Care	Mar-08
Family Health Centers of Baltimore	300,000	Dental Health Expansion	Mar-08
Kernan Hospital	287,410	Kernan Dental Services Expansion Project	Mar-08
Prince George's County Health Department	299,164	Improving access to dental care in Prince George's County	Mar-08
Subtotal	\$2,477,928		

Operating Grants Awarded for Information Technology Initiatives

<u>Community Health Resource Center</u>	<u>Amount</u>	<u>Description</u>	<u>Date Awarded</u>
Allegany County Health Department	\$99,731	Document Storage, Retrieval and Management System for the Behavioral Health Division	Nov-07
Baltimore Medical System, Inc.	397,304	Extend Electronic Health Network for Health Centers and School-based Health Clinics	Nov-07
Choptank Community Health System	400,000	Implement Electronic Health and Dental Records	Nov-07
St. Luke's House, Inc.	350,000	Implement Electronic Medical Record and Billing System	Nov-07
Walnut Street Community Health Center	400,000	Update Practice Management System and Implement Electronic Medical Record Component	Nov-07
Community Health Integrated Partnership	1,000,000	Implement Electronic Health Records System	Nov-07
Subtotal	\$2,647,035		

All Other Operating Grants Awarded

<u>Community Health Resource Center</u>	<u>Amount</u>	<u>Description</u>	<u>Date Awarded</u>
Anne Arundel Mental Health Agency, Inc.	\$355,000	Access to Care Service Integration Project – Treatment of co-occurring disorders	Mar-08
Harford County Health Department	484,237	Integrating Services for Patients with Co-occurring Mental Illness and Substance Abuse; Partnering with the Criminal Justice System for Optimal Outcomes	Mar-08
Junction, Inc. – Adolescents and Young Adults	104,800	Integrated Treatment for Chemically Involved Adolescents and Young Adults with Co-occurring Disorders	Mar-08
Way Station	500,000	Functionally Integrating Services for Individuals with Co-occurring Mental Illness and Substance Abuse Disorders	Mar-08
Atlantic General Hospital	355,000	Out of the Emergency Room, Into the Worcester County Public Safety Net	Mar-08
Total Health Care	100,000	Redirecting Non-emergency Use of Hospital Departments to Community Health Resources	Mar-08
University of Maryland Department of Family Medicine	499,749	Providing a Medical Home to Decrease Emergency Department Use, Enhance Access to Care, and Reduce Health Disparities in Baltimore	Mar-08
Upper Chesapeake Health System	485,743	Redirecting Non-emergency Use of Hospital Emergency Departments to Upper Chesapeake HealthLink Primary Care Clinics	Mar-08
Greater Baden Medical Services	500,000	Access to Care for Immigrants	Mar-08
Mobile Medical Care	500,000	Upcounty Montgomery Immigrant Health Initiative	Mar-08
Queen Anne’s County Health Department	82,597	Mom Movers	Mar-08
Subtotal	\$3,967,126		
Fiscal 2008 Total	\$9,092,089		

Operating Grants Awarded to Community Health Resource Centers Fiscal 2009

Operating Grants Awarded for School-based Health Centers

<u>Community Health Resource Center</u>	<u>Amount</u>	<u>Description</u>
Baltimore City Health Department	\$200,000	Technical Assistance to all existing SBHCs statewide
Coppin State University Helene Fuld School of Nursing	201,962	Enhances nurse-managed SBHC at St. Francis Academy in Baltimore City
Washington County Health Department	270,000	Increasing mental health services at SBHCs in Washington County
Baltimore County Health Department	55,450	Enhance IT capability and open a new SBHC in Dundalk Elementary School
Frederick County Health Department	500,000	Creation of SBHC at Hillcrest Elementary School
Dorchester County Health Department	220,000	Service expansion for existing SBHCs
Harford County Health Department	221,897	Increases the presence of a Nurse Practitioner and Social Worker at SBHCs
Montgomery County Health Department	224,100	Establishes a preventive dental program at nine existing SBHCs
Subtotal	\$1,893,409	

All Other Operating Grants Awarded – Multi-year Grants (Fiscal 2009 portion only)

<u>Community Health Resource Center</u>	<u>Amount</u>	<u>Description</u>
Howard County Health Department	\$250,000	Two-year grant for Howard County's electronic eligibility enrollment system – \$250,000 in fiscal 2009 and \$250,000 in fiscal 2010
University of Maryland Department of Family Medicine	183,251	Three-year grant for diversion of non-urgent care from emergency departments distributed as: \$183,251 in fiscal 2009; \$183,251 in fiscal 2010; and \$91,625 in fiscal 2011
Subtotal	\$433,251	
Fiscal 2009 Working Appropriation	\$2,326,660	

FQHC: Federally Qualified Health Center
SBHC: School-based Health Center