

**M00R**  
**Health Regulatory Commissions**  
**Department of Health and Mental Hygiene**

***Operating Budget Data***

(\$ in Thousands)

	<u>FY 09</u> <u>Actual</u>	<u>FY 10</u> <u>Working</u>	<u>FY 11</u> <u>Allowance</u>	<u>FY 10-11</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
Special Fund	\$134,261	\$155,911	\$161,332	\$5,421	3.5%
Contingent & Back of Bill Reductions	0	0	-303	-303	
<b>Adjusted Special Fund</b>	<b>\$134,261</b>	<b>\$155,911</b>	<b>\$161,029</b>	<b>\$5,119</b>	<b>3.3%</b>
Reimbursable Fund	0	189	331	143	75.6%
Contingent & Back of Bill Reductions	0	0	-3	-3	
<b>Adjusted Reimbursable Fund</b>	<b>\$0</b>	<b>\$189</b>	<b>\$328</b>	<b>\$139</b>	<b>73.8%</b>
<b>Adjusted Grand Total</b>	<b>\$134,261</b>	<b>\$156,099</b>	<b>\$161,357</b>	<b>\$5,258</b>	<b>3.4%</b>

Note: For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected across-the-board budget reductions. The actual allocations are to be developed by the Administration.

- The Governor's proposed fiscal 2011 allowance for the Health Regulatory Commissions increases by \$5.3 million, or 3.4%, over the fiscal 2010 working appropriation. The commissions' fund support is derived primarily from special funds, which increase by \$5.2 million, or 3.3%. Reimbursable fund income increases by \$0.1 million, or 73.8%.
- Back of the Bill reductions for furloughs and reductions to health insurance payments decrease the budget by \$0.3 million.

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

For further information contact: Kathleen K. Wunderlich

Phone: (410) 946-5530

***Personnel Data***

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	<b><u>FY 09 Actual</u></b>	<b><u>FY 10 Working</u></b>	<b><u>FY 11 Allowance</u></b>	<b><u>FY 10-11 Change</u></b>
Regular Positions	94.60	96.60	96.60	0.00
Contractual FTEs	<u>1.00</u>	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
<b>Total Personnel</b>	<b>95.60</b>	<b>96.60</b>	<b>96.60</b>	<b>0.00</b>

***Vacancy Data: Regular Positions***

Turnover and Necessary Vacancies, Excluding New Positions	3.47	3.59%
Positions and Percentage Vacant as of 12/31/09	6.00	6.21%

- The fiscal 2011 allowance does not include any increases to regular or contractual positions for the Health Regulatory Commissions.
- The projected turnover rate for the agency is 3.59% for fiscal 2011, which requires the agency to hold 3.47 positions vacant.

## ***Analysis in Brief***

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### **Major Trends**

***Maryland Moves Forward with Electronic Health Claims Submission:*** As a way to reduce the rate of growth in health care spending, the Maryland Health Care Commission (MHCC) certifies electronic health networks (EHNs) for providers and payors to receive and pay claims electronically. In fiscal 2009, the agency had certified 41 EHNs in the State. As a result of these networks, 70% of claims paid by private payors are done so electronically.

***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 Health Services Cost Review Commission (HSCRC) prefers to keep to maintain the waiver. Repeated cost containment actions resulting in higher hospital charges threatens to erode the cushion even further in fiscal 2010 and 2011.

### **Issues**

***Financing the State's Budget Deficit through Hospital Remittance and Hospital Payor/Patient Assessments:*** Amidst an annual budget deficit, the State has searched for ways to reduce its general fund liability through the Medicaid budget, specifically for payments that Medicaid makes for hospital costs. In fiscal 2010, the Medicaid budget was subject to several reductions that aim to lessen the State's general fund liability and reduce the State's budget deficit. The fiscal 2010 budget bill contained language that reduced the Medicaid budget by \$10 million in general funds to recognize savings on hospital payments. Other budget reductions have come through the Board of Public Works to reduce Medicaid payments to hospitals, totaling \$34.7 million in general funds in fiscal 2010. Additionally, the fiscal 2011 allowance includes unidentified reductions for Medicaid payments to hospitals. In place of these cuts, HSCRC is authorized to devise a method of achieving the same amount of savings to the Medicaid program through the hospital rate setting system.

***Statewide Health Information Exchange:*** Chapter 689 of 2009 required MHCC and HSCRC to designate a State Health Information Exchange (HIE) program to enable physicians, hospitals, and other health care professionals to share clinical information electronically, even if they operate on different systems. HSCRC approved a rate adjustment of up to \$10 million in seed funding over the next two to five years for the project. MHCC and HSCRC believe that the HIE can help improve health care quality, prevent medical errors, and reduce health care costs by providing essential information at the time and place of care. There are two principle tasks required to achieve this system: assuring that relevant clinical data and decision support are available at the time and place of care, and assuring that the information developed in the course of real-world treatment contributes to a provider's knowledge and shapes further practice.

***Fund Balance Transfers and Changes to the Funding Stream for The Maryland Community Health Resources Commission Limit Its Grant Making Abilities:*** The Maryland Community Health Resources Commission (MCHRC) was established by the Maryland legislature as an independent commission in 2005 and consists of 11 commissioners representing diverse interests in Maryland including, non-profit insurers, non-profit health maintenance organizations, hospitals, physicians, and others knowledgeable about health care issues. The purpose of the MCHRC is to increase access to care for low-income, under- and uninsured Marylanders by providing support to community health resources. The commission pursues this goal through various means, but primarily by awarding grants to community health resource centers. However, reductions to the appropriation of the commission in fiscal 2010 and those proposed in the fiscal 2011 budget severely limit the commission's ability to achieve its goal.

## **Recommended Actions**

1. Concur with Governor's allowance.

## **Updates**

***Update of Medicare Waiver Status:*** Maryland's Medicare waiver allows the State to establish an all payor system, in which every payor in the system pays the same rate. This includes Medicare payments to hospitals, which are higher in Maryland than in other states due to the all payor system. 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 growth rate nationally over the same time period; and (2) all payors in the system pay the same amount. Recent Board of Public Works reductions have resulted in higher hospital costs in fiscal 2010 as assessments replace lost State funds. Additionally, federal health care reform proposes to reduce Medicare payments as a budgetary cost containment measure. If that legislation is approved and there are also continued increases to hospital costs in Maryland, the first rule of the waiver may fail resulting in loss of the waiver and loss of up to \$1 billion in Medicare payments to Maryland hospitals.

***Small Business Health Insurance Partnership:*** The Small Business Health Insurance Partnership, in its second year of operation, has provided a subsidy for 218 businesses and 1,008 covered lives. The total annual premium subsidy for the existing participants totals \$1.3 million, as of January 1, 2010. The program was created 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.

***Support for the University of Maryland Medical System in the Operating Budget:*** State support for the University of Maryland Medical System is disbursed through the Maryland Health Care Commission for operating expenses at the R Adams Cowley Shock Trauma Center. Support for the Shock Trauma Center remains flat in fiscal 2011 at \$3.2 million.

**M00R**  
**Health Regulatory Commissions**  
**Department of Health and Mental Hygiene**

## ***Operating Budget Analysis***

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### **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.

### *M00R – DHMH – Health Regulatory Commissions*

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.

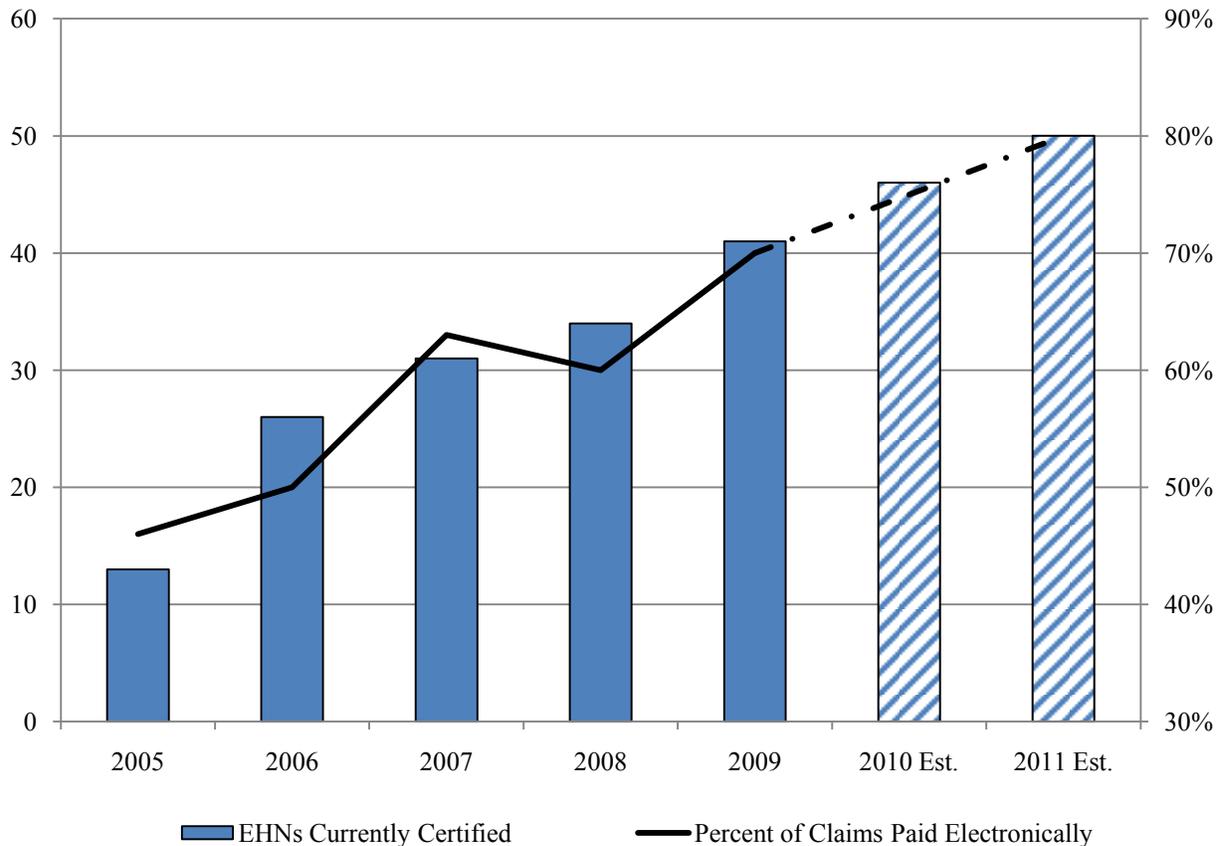
## **Performance Analysis: Managing for Results**

### **Maryland Health Care Commission**

One of the goals of MHCC, as stated above, is to reduce the rate of growth in health care spending in Maryland. One way that the commission has identified to lower costs is by eliminating unnecessary administrative expenses through the adoption of electronic data exchange. There are two main strategies used by the commission to achieve this goal: (1) developing programs that encourage the adoption of health information technology; and (2) certifying electronic health networks (EHNs) that provide for the electronic exchange of payment information between Maryland health care payors and providers. **Exhibit 1** shows the number of EHNs currently certified by MHCC and the percent of claims received electronically by private payors in Maryland.

As the exhibit demonstrates, the number of EHNs in the State has been steadily increasing since fiscal 2005, and as a result, the percent of claims paid electronically by private payors totaled 70% in fiscal 2009. MHCC expects this trend to continue in the future as the use of health information technology becomes more widely utilized in the State. In fact, Chapter 689 of 2009 directed MHCC and HSCRC to encourage the use of health information technology by developing a Health Information Exchange (HIE) program to transmit electronic health records between approved providers. Many of the MHCC-certified EHNs, cited in the chart above, may be able to connect to the statewide HIE once it is established.

**Exhibit 1**  
**Utilization of Electronic Health Networks in Maryland**  
**Fiscal 2005-2011**



EHN: Electronic Health Networks

Source: Department of Health and Mental Hygiene

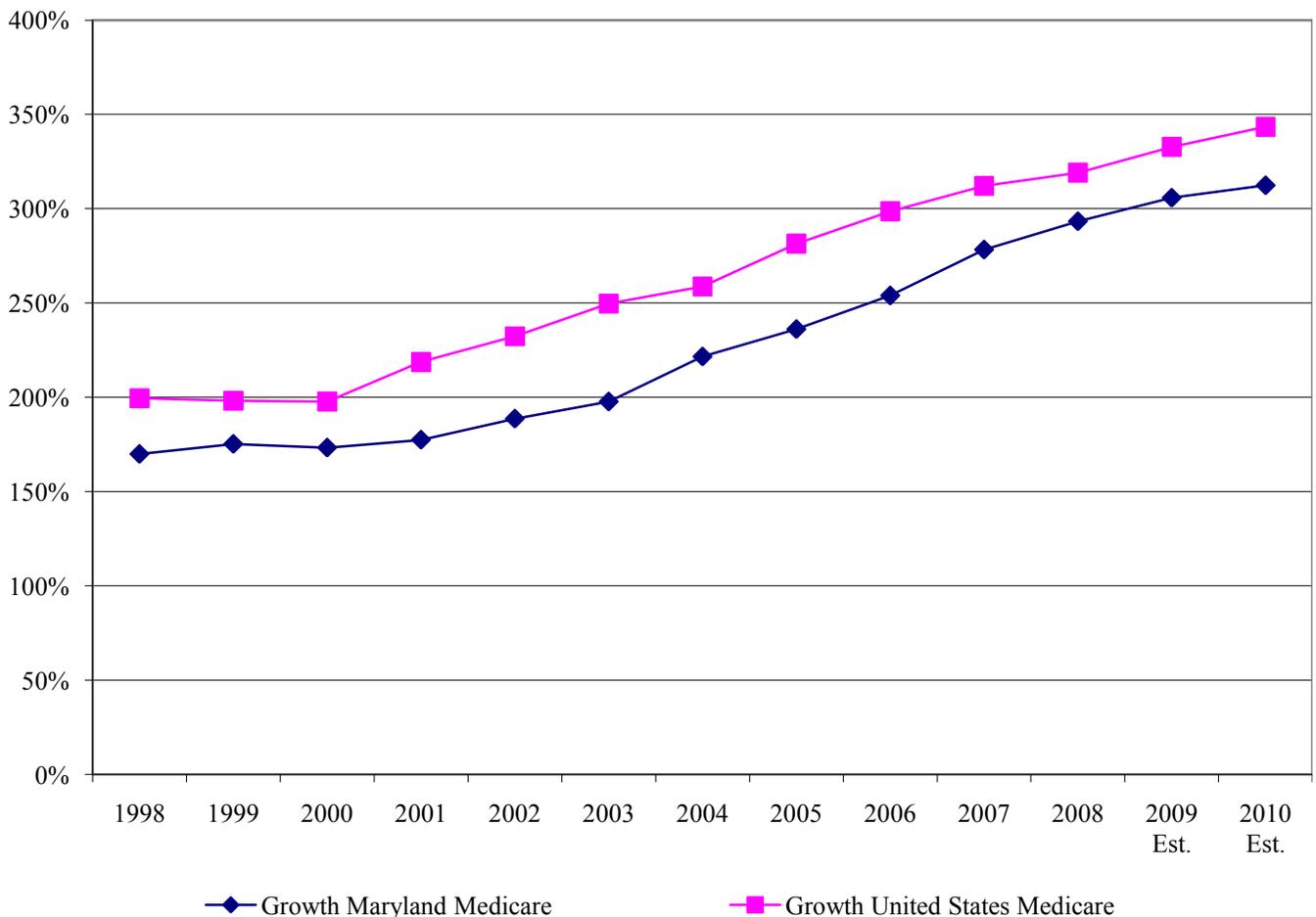
**Health Services Cost Review Commission**

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

regulatory authority 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 June 2008, the cumulative growth of Maryland Medicare payments has been 293.3%, compared to national growth of 319.1%. 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 1998-2010**

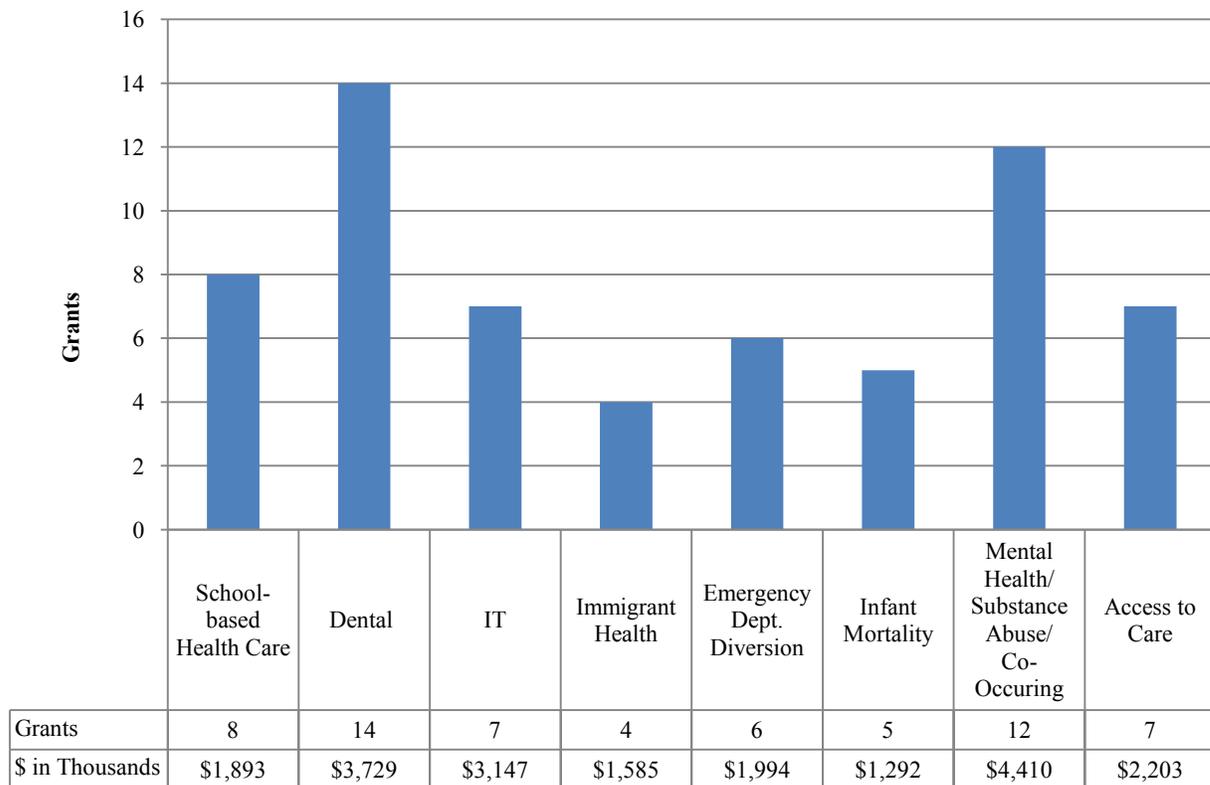


Source: Department of Health and Mental Hygiene

## Maryland Community Health Resources Commission

MCHRC was established during the 2005 legislative session 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. Since that time, it has awarded over \$20.2 million in grant funding to 63 community-based health centers. **Exhibit 3** shows the grants awarded and the total value of the grants by type. These grants aim 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**  
**Grants Awarded by the Maryland Community Health Resources Commission**  
**Fiscal 2007-2010**  
**(\$ in Thousands)**



IT: Information Technology

Source: Department of Health and Mental Hygiene

## **Fiscal 2010 Actions**

### **Impact of Cost Containment**

Cost containment actions taken by the Board of Public Works in August 2009 reduced personnel expenses by \$274,478 due to statewide employee furloughs affecting all three commissions.

### **Federal Stimulus Fund**

Reimbursable funds increased the budget of the Maryland Health Care Commission in fiscal 2010 by \$188,527 based on funds available from the Infectious Diseases and Environmental Health Administration (IDEHA) through an American Recovery and Reinvestment Act of 2009 (ARRA) grant. These funds are used for the infectious diseases cooperative agreement aimed to improve surveillance and response for infectious diseases. MHCC will play an active role in drafting the State Health-Associated Infectious (HAI) disease prevention plan and establishing the State's capacity to develop HAI prevention programs. The funding for this initiative continues in the fiscal 2011 allowance.

## **Proposed Budget**

The Governor's proposed fiscal 2011 allowance for the Health Regulatory Commissions increases by \$5.3 million, or 3.4%, over the fiscal 2010 working appropriation, as shown in **Exhibit 4**. The special fund allowance increases by \$5.1 million, or 3.3%, and the reimbursable fund allowance increases by \$0.1, million or 73.8%.

### **Personnel**

Personnel costs for the Health Regulatory Commissions increase by \$0.3 million in the fiscal 2011 allowance, which reflects several across-the-board actions to be allocated by the Administration. This includes a combination of employee furloughs and government shut-down days similar to the plan adopted in fiscal 2010; a reduction in overtime based on accident leave management; streamlining of State operations; hiring freeze and attrition savings; a change in the injured workers' settlement policy and administrative costs; and a savings in health insurance to reflect a balance in that account. For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected actions relating to employee furloughs and health insurance.

Regular earnings increase by \$0.2 million; however, that increase is negated by back of the bill language to implement employee furloughs in fiscal 2011, which decreases the budget for personnel expenses by \$0.3 million. The budget increases by \$0.2 million due to a lower turnover rate for the agency; the rate was lowered from 6.01% in fiscal 2010 to 3.59% in fiscal 2011.

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

<b>How Much It Grows:</b>	<b>Special Fund</b>	<b>Reimb. Fund</b>	<b>Total</b>
2010 Working Appropriation	\$155,911	\$189	\$156,099
2011 Allowance	<u>161,332</u>	<u>331</u>	<u>161,663</u>
Amount Change	\$5,421	\$143	\$5,564
Percent Change	3.5%	75.6%	3.6%
Contingent Reductions	-\$303	-\$3	-\$306
Adjusted Change	\$5,119	\$139	\$5,258
Adjusted Percent Change	3.3%	73.8%	3.4%

**Where It Goes:**

<b>Personnel Expenses</b>	<b>\$266</b>
Regular earnings .....	\$218
Decreased turnover rate from 6.01 to 3.59% .....	191
Contributions to employees' retirement system .....	141
Employee and retiree health insurance .....	38
Employee furloughs .....	-278
Other fringe benefits .....	-45
<b>Maryland Health Care Commission</b>	<b>-\$190</b>
Infectious Diseases Cooperative Agreement – audit to comply with ARRA law .....	100
Special projects to test methods for attributing services to a responsible care organization .....	100
Special project to examine incentives for primary care providers that function as effective medical homes .....	50
Electronic Health Information Exchange project.....	50
Other changes in MHCC budget.....	10
Decrease in Maryland Trauma Physician Services Fund Distribution .....	-300
Elimination of trauma equipment grants.....	-200
<b>Health Services Cost Review Commission</b>	<b>\$5,224</b>
Uncompensated Care Fund	5,000
Increase in contractual expenses .....	199
New utility server.....	25

*M00R – DHMH – Health Regulatory Commissions*

**Where It Goes:**

<b>Maryland Community Health Resources Commission</b>	<b>-\$43</b>
Lower rental expenses .....	-19
Reduction to in-state and out-of-state operations .....	-13
Per diem rate lowered-reimbursement for only 6 commissioners instead of 11 .....	-9
Other changes in MHCRC budget .....	-2
<b>Total</b>	<b>\$5,258</b>

ARRA: American Recovery and Reinvestment Act of 2009

MHCC: Maryland Health Care Commission

MHCRC: Maryland Community Health Resources Commission

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

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Contributions to the employees' retirement system increase by \$141,000 in the fiscal 2011 allowance. Finally, employee and retiree health insurance expenses increase by \$38,000, which includes the back of the bill reduction for health insurance expenses due to a balance in that account.

## **MHCC**

Nonpersonnel expenses for the Maryland Health Care Commission decrease by \$0.2 million in the fiscal 2011 allowance. Increases to the commission result from the following: an audit requirement for the infectious disease cooperative agreement with the Infectious Disease and Environmental Health Administration (\$0.1 million); a special project to test methods for attributing services to a responsible care organization in order to evaluate the use of patient-centered medical homes (\$0.1 million); a special project to examine how the State and private payors can combine a number of different purchasing and reimbursement strategies to encourage primary care providers to function as effective medical homes (\$50,000); and expenses associated with the Health Information Exchange project, per Chapter 689 of 2009 (\$50,000).

There are two major decreases to the MHCC budget pertaining to the Maryland Trauma Physician Services Fund. The special funds for this account are derived from a surcharge on motor vehicle registrations in the State and are projected to decrease from \$12.2 million in fiscal 2010 to \$11.7 million in fiscal 2011. First, distribution of funds from the Maryland Trauma Physician Services Fund intended to offset the cost of uncompensated care for physicians in trauma care settings decreases by \$0.3 million in fiscal 2011. Also, trauma equipment grants funded by the Maryland Physician Services Fund are eliminated from the 2011 allowance, resulting in a decrease of \$0.2 million. The Small Business Health Insurance Partnership is level-funded at \$2.0 million for fiscal 2011.

## **HSCRC**

Nonpersonnel expenses for the Health Services Cost Review Commission increase by \$5.2 million in the fiscal 2011 allowance. The driving force in the budget for HSCRC is an increase in the amount of uncompensated care funds collected and distributed to hospitals, which is estimated to increase by \$5.0 million in fiscal 2011. The budget also increases by \$0.2 million for increased contractual expenses to provide data requested by the federal government related to alleged fraudulent coding practices and other violations in hospitals in Maryland. Lastly, a new utility server will be purchased as part of an upgrade to the current HSCRC network, which will cost \$25,000.

## **MCHRC**

The fiscal 2011 allowance for MCHRC remains at virtually the same level as the fiscal 2010 working appropriation. Grants awarded by the commission for information technology projects at community health resource centers remain level funded at \$600,000, and those for regular operating grants to community health resource centers remain level funded at \$1.9 million in fiscal 2011. The changes to the MCHRC budget occur in the administrative budget and decrease only slightly from the fiscal 2010 working appropriation. The decreases in the budget include lower rent costs due to moving the office to a smaller location (\$19,228), a decrease for in-state and out-of-state travel (\$12,768), and lower per-diem costs for the 11 commissioners due to an accounting error (\$9,000).

## **Transfers and Changes Per Budget Reconciliation and Financing Act of 2010**

Senate Bill 141/House Bill 151, the Budget Reconciliation and Financing Act of 2010, authorizes the transfer of \$472,026 from the special fund balance of MHCC and \$1.8 million from the special fund balance of MCHRC, as approved by the Board of Public Works in 2009. In addition, Section 28 of SB 141/HB 151 authorizes the transfer of interest earned on certain special fund balances during fiscal 2010 and 2011 to the general fund. Both special funds for MHCC and MCHRC are affected by this provision, as well as the Maryland Trauma Physicians Services Fund maintained by MHCC. **Exhibit 5** shows the fund balance for each before and after the transfers in fiscal 2010. As the exhibit shows, each fund will be solvent in fiscal 2010 after the transfers.

In addition to the fund transfers indicated in SB 141/HB 151, language is included that creates a permanent \$3.0 million cap for the MCHRC based on transfers from nonprofit health service plans in Maryland. The bill as introduced would permanently change the distribution of funds, as stated in Insurance Article §14-106. According to SB 141/HB 151, payments from nonprofit health service plans would go to fulfill the subsidy requirements for the Senior Prescription Drug Assistance Program and MCHRC. The remaining balance of the funds would be awarded to the Kidney Disease Program. Additionally, the bill authorizes the Secretary of DHMH to transfer any amounts received but not spent by the Kidney Disease Program in a given year to the MCHRC fund.

**Exhibit 5**  
**Fund Balances Affected by SB 141/HB 151**  
**Fiscal 2010**

	<u>Maryland Health Care Commission</u>	<u>Maryland Trauma Physician Services Fund</u>	<u>Community Health Resources Commission Fund</u>
FY 2009 ending balance	\$3,418,712	\$3,831,632	\$1,889,880
FY 2010 award	10,214,513	11,700,000	12,445,217
FY 2010 expenditures	10,860,809	11,700,000	3,009,027
Transfers to GF in FY 2010 (per 2010 BRFA)	472,026		1,800,000
Transfer to PAC program (per 2009 BRFA)			9,100,000
Less interest transferred to GF (per 2010 BRFA)	67,090	125,480	214,141
FY 2010 ending balance	\$2,233,300	\$3,706,152	\$211,929

PAC: primary adult care  
BRFA: Budget Reconciliation and Financing Act  
GF: general fund

Source: Department of Health and Mental Hygiene

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## ***Issues***

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### **1. Financing the State's Budget Deficit through Hospital Remittance and Hospital Payor/Patient Assessments**

Amidst an annual budget deficit, the State has searched for ways to reduce its general fund liability through the Medicaid budget, specifically for payments that Medicaid makes for hospital costs. In fiscal 2010, the Medicaid budget was subject to several reductions that aim to lessen the State's general fund liability and reduce the State's budget deficit. The fiscal 2010 budget bill contained language that reduced the Medicaid budget by \$10 million in general funds to recognize savings on hospital payments. Other budget reductions have come through the Board of Public Works to reduce Medicaid payments to hospitals, totaling \$34.7 million in general funds.

#### **Medicaid Day Limits**

One way that the State has achieved savings in the past is through the implementation of Medicaid Day Limits (MDLs). MDLs cap the number of days that Medicaid will pay for a hospital stay at a percentage of the average length of stay by diagnosis-related group. A hospital would not be paid for additional days beyond this limit; thus, any losses incurred become uncompensated care. Although MDLs achieve cost savings to the general fund budget, they increase health care costs in the State and are detrimental to the all payor hospital system.

The policy of Medicaid hospital day limits ended in fiscal 2009, but the fiscal 2010 budget reinstated the policy on a temporary basis by reducing the Medicaid budget by \$10 million to recognize savings from the continued use of MDLs. Subsequent cost containment actions taken by the Board of Public Works would also reinstate MDLs if HSCRC could not come up with alternate financing strategies to account for the needed reduction in the Medicaid budget. In both cases, HSCRC was granted the authority to devise an alternate financing mechanism so as not to implement MDLs again. The continuation of the Medicaid hospital day limits policy is troubling because the policy could negatively impact the State's Medicare waiver.

To maintain the waiver, HSCRC must ensure all payors in the system pay the same amount for similar services and that 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. The MDL policy impacts the Medicare waiver because the general fund savings accrued to the Medicaid program from the hospital day limits policy are redistributed through the system, which increases hospital rates for all payors (including Medicare) and drives up the cost of health care in the State.

Additionally, the MDL policy also causes the State to lose the federal fund match associated with Medicaid's hospital charges. If the number of days that Medicaid will pay for hospital stays are capped, the amount of federal funds that can be leveraged will also be capped. By not implementing MDLs, the State is able to continue to maximize the federal fund match for the Medicaid program.

## Alternate Financing Mechanisms

Due to concerns over the State's Medicare waiver, HSCRC believed that the re-imposition of MDLs was not an optimal choice and chose to finance the budget cuts through alternate means. **Exhibit 6** shows the reductions made to the Medicaid budget for which HSCRC approved alternate financing mechanisms to achieve the required savings. The financing mechanisms developed and approved by HSCRC include two types of actions: (1) a remittance from hospitals, which comes directly from the operating budgets of Maryland hospitals; and (2) an assessment on hospital rates, which is an extra amount paid by payors and patients built into the rates that hospitals charge. In this way, HSCRC sought to develop a strategy that split the financial burden between both payors and hospitals. The alternative mechanism also aimed to minimize further increases in the cost of health care; avoid further erosion of the Medicare waiver performance by not reinstating MDLs as a cost saving measure; and lower, to the extent possible, the financial liability of hospitals given the fact that hospitals already received a lower than normal update factor in 2010.

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### Exhibit 6 Alternate Financing Mechanisms to Account for Fiscal 2010 Medicaid Reductions

	<u>Total Reduction</u>	<u>Hospital Portion (Remittance)</u>	<u>Payor Portion (Assessment)</u>	<u>Total Paid to Medicaid by Hospitals</u>
<b>Contingent Reduction in Fiscal 2010 Budget Bill</b>	<b>\$10,000,000</b>	<b>\$10,000,000</b>	<b>\$0</b>	<b>\$10,000,000</b>
<b>BPW Reductions</b>				
July 2009	8,897,720	0	8,897,720	
August 2009	4,532,380	4,532,380	0	
November 2009	21,279,382	12,822,361	8,457,021	
<b>Subtotal BPW Action</b>	<b>\$34,709,482</b>	<b>\$17,354,741</b>	<b>\$17,354,741</b>	<b>\$34,709,482</b>
<b>Feedback Effect on Rates</b>				
Payor Portion of BPW Action	17,354,741			
Medicaid Fee for Service Percent	6.1%			
<b>Subtotal Feedback Effect</b>	<b>\$1,058,639</b>	<b>\$529,320</b>	<b>\$529,320</b>	<b>\$1,058,639</b>
<b>Total Financing by Hospitals and Payors for Budget Reductions</b>		<b>\$27,884,061</b>	<b>\$17,884,061</b>	<b>\$45,768,121</b>

BPW: Board of Public Works

Source: Health Services Cost Review Commission

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## **Reductions to the Budget**

- **Supplemental Budget No. 2 to HB 100 of 2009 (\$10.0 Million Reduction):** Language included in the fiscal 2010 budget bill authorized a \$10 million general fund reduction to the Medicaid program to recognize savings from MDLs contingent on the failure of legislation implementing a Maryland False Claims Act. Instead of implementing MDLs, HSCRC chose to finance the \$10 million cut through a remittance on hospitals. This means that hospitals alone would bear the cost of the reduction.
- **BPW Actions (\$34.7 Million Reduction):** The Board of Public Works reductions in July, August, and November 2009 specify a \$34.7 million general fund reduction in Medicaid payments to hospitals. HSCRC was again granted the flexibility to adopt an alternative approach to achieve these savings. In December 2009, HSCRC approved the final funding mechanism for the reduction, which called for hospitals and payors to equally share the total cost of the reduction. First, there is an assessment on hospital rates for the period of January - June, 2010 sufficient to generate \$17.4 million. Second, hospitals will directly remit a payment of \$17.4 million to Medicaid from each hospital's respective operating budget.
- **Feedback Effect on Medicaid:** Because rates increase as a result of the \$17.4 million assessment noted above, the savings to Medicaid is actually slightly less than the target since Medicaid is also paying higher rates for hospital stays. Medicaid's payment increases by \$1.06 million as indicated in Exhibit 6 above. HSCRC approved a strategy where hospitals and payors provide payments to Medicaid equally to erase the \$1.06 million gap. Hospitals will remit \$0.5 million and an assessment on payors will result in an additional rate increase in the amount of \$0.5 million.

## **Ongoing Issues**

While the State has been able to use reductions to the Medicaid program to balance past budgets, the approach, as a long-term strategy, presents a number of issues detrimental to the cost of health care in Maryland and the stability of the State's Medicare waiver that allows for the all payor system currently in place.

First, the reliance on an assessment on payors and patients at hospitals to finance Medicaid reductions is equivalent to a tax on Maryland citizens that use the hospital system. Insurance companies will have to increase premiums in order to account for the increased cost of hospital care as a result of higher hospital rates. Given the fact that health care costs continue to increase, the extra assessment/rate increase only serves to increase the total cost borne by patients. Maryland hospitals also have to contribute funds from their bottom line to finance the State's deficit.

Second, Maryland's Medicare waiver is also in jeopardy if continued cuts are passed through to the hospital payment system. Even if MDLs are never reinstated, the constant increase of rates/assessments will lead to higher Medicare payments per case. If rates are constantly increased to

achieve savings for the Medicaid program, Medicare payments will increase thereby eroding the waiver cushion.

Finally, the Governor's fiscal 2011 allowance for the Medicaid program includes unidentified reductions for Medicaid payments to hospitals, amounting to \$123 million in general funds. If the budget is approved as submitted, HSCRC will again have to devise a strategy for achieving savings to the Medicaid program, either through implementation of MDLs, the elimination of the Medically Needy program, or by alternate methods of assessments and remittance similar to those approved in fiscal 2010. **The agency should comment on future strategies to achieve savings to Medicaid and the impact those may have on payors, patients, hospitals, and the health care system in Maryland.**

## **2. Statewide Health Information Exchange**

Broad use of health information technology has the potential to improve health care quality, prevent medical errors, increase efficiency, reduce unnecessary health care costs, decrease paperwork, expand access to affordable care, and improve population health. Developing a statewide health information system has been a priority of the State and federal government over the past several years. Chapter 689 of 2009 required the Maryland Health Care Commission and the Health Services Cost Review Commission to designate a State Health Information Exchange and to promulgate regulations instructing payors to provide incentives to providers to promote the adoption and meaningful use of electronic health records. The HIE will provide physicians, hospitals, and other health care providers the capability to electronically share clinical information, even if their electronic health records systems are different.

To that end, MHCC and HSCRC have been working to develop a health information exchange system that has the ability to achieve efficiencies in the health care delivery system by:

- enabling patient information to be shared between providers of different organizations and different regions in real-time;
- supporting the use of evidence-based medicine;
- storing and transmitting sensitive health information privately and securely;
- providing patient access to clinical records to help engage patients in their own care;
- providing a means for the patient to exercise appropriate control over the flow of private health information;
- providing a method of securely transmitting electronic claims and bills;

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- contributing to public health initiatives in biosurveillance and disease tracking; and
- preparing for emergency preparedness efforts that will positively impact health outcomes by providing greater access to secure and accurate information;

Providers who wish to connect to the HIE can either use their own system or can tap into an electronic health record system hosted by a Management Services Organization (MSO). In the case of the MSO, the software necessary to implement an electronic health record system would be accessed via the Internet, and the stored data would be hosted offsite in a secure network operating center.

### **Accessing Federal ARRA funds**

The federal government included provisions in the American Recovery and Reinvestment Act of 2009 to stimulate the adoption of health information technology by providing Medicare and Medicaid payment incentives to health care providers for the adoption and meaningful use of electronic health record technology. The statewide HIE being developed by MHCC and HSCRC will allow providers to maximize incentive funding under the ARRA provisions. Additionally, MHCC submitted a request in October 2009 to the Office of National Coordinator for Health Information Technology for a cooperative agreement grant of \$9.4 million in ARRA funding for the development of the HIE.

### **Status Update**

In August 2009, MHCC selected the Chesapeake Regional Information System for our Patients (CRISP), a nonprofit collaborative effort among the Johns Hopkins Health System, MedStar Health, University of Maryland Medical System, Erickson Retirement Communities, and Erickson Foundation, to implement the HIE statewide. HSCRC approved a rate adjustment of up to \$10 million in seed funding over the next two to five years for the project, which will be funded through the all payor hospital system. Funding for the project is expected to decrease over time due to the availability of ARRA funding for Health IT projects as well as private funding for the system.

There are two principle tasks required to achieve this system: assuring that relevant clinical data and decision support are available at the time and place of care, and assuring that the information developed in the course of real-world treatment contributes to a provider's knowledge and shapes further practice.

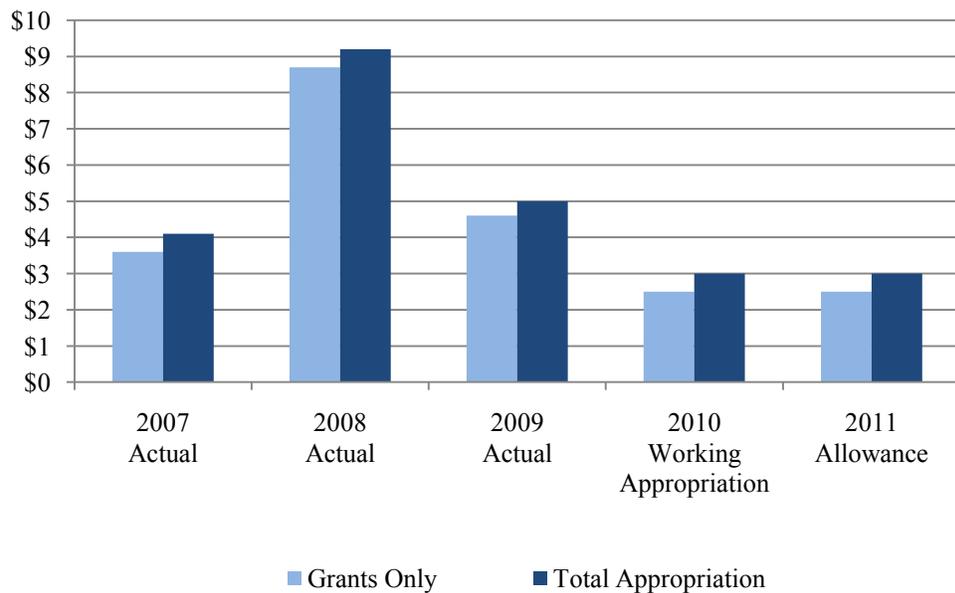
**The agency should comment on the status of development of the HIE and provide an estimated date when providers will be able to connect to the HIE. The agency should also comment on the status of the grant application for ARRA funding for the exchange.**

### 3. Fund Balance Transfers and Changes to the Funding Stream for MCHRC Limit Its Grant Making Abilities

The Maryland Community Health Resources Commission was established by the Maryland legislature as an independent commission in 2005 and consists of 11 commissioners representing diverse interests in the State including, non-profit insurers, non-profit health maintenance organizations, hospitals, physicians, and others knowledgeable about health care issues in Maryland. The purpose of MCHRC is to increase access to care for low-income, under- and uninsured Marylanders by providing support to community health resources. The commission pursues this goal through various means, chiefly by the awarding of grants to community health resources. However, reductions to the appropriation of the commission in fiscal 2010 and those proposed in the fiscal 2011 budget severely limit the commission’s ability to achieve its goal.

Since fiscal 2007, the commission awarded over \$20.2 million in grants to 63 community health resource centers, as cited in the Managing for Results section of this document. Funding for the commission has not been stable from year to year due to the inability to award grants on a timely basis and repeated budget cuts and transfers from the MCHRC fund balance. **Exhibit 7** shows the total appropriation level for the MCHRC as well as the amount targeted specifically for grants.

**Exhibit 7**  
**Funding Levels for the Community Health Resource Commission**  
**Fiscal 2007-2011**  
**(\$ in Millions)**



Source: Department of Legislative Services

## **Fund Balance Transfers and Changes to the Funding Stream for MCHRC**

There have been numerous transfers from the fund balance of MCHRC and changes to the funding stream for the commission that have been approved by legislation since fiscal 2009, as shown in **Exhibit 8**. These changes have been authorized by the enactment of legislation in 2009 (Chapter 487 of 2009, the Budget Reconciliation and Financing Act of 2009) and proposed legislation in the 2010 session (SB 141/HB151, the Budget Reconciliation and Financing Act of 2010).

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### **Exhibit 8 Changes to the MCHRC Balance and Funding Stream Fiscal 2009-2011**

<b>Fiscal 2009</b>	Transfer of \$12.1 million from the fund balance of the MCHRC fund to the general fund, leaving slightly more than \$1.0 million in the fund, per Chapter 487 of 2009.
<b>Fiscal 2010</b>	One-year cap of \$3.0 million in funding for MCHRC activities, per Chapter 487 of 2009. Transfer of \$1.8 million from the fund balance of the MCHRC fund to the general fund, pending passage of SB 141/HB 151. If approved, this would leave just over \$200,000 in the fund.
<b>Fiscal 2011</b>	Permanent cap of \$3.0 in funding per year for MCHRC activities, pending passage of SB 141/HB 151.

MCHRC: Maryland Community Health Resources Commission

Source: Department of Legislative Services

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### **Future of Commission**

Given limited resources, the commission may need to partner more closely with other parts of DHMH to achieve the stated mission. Additionally, one of the goals that MCHRC has identified in fiscal 2010 is to reduce infant mortality in Maryland. The commission has already awarded five grants to community organizations to reduce infant mortality in fiscal 2010. The Family Health Administration (FHA) and the Office of Minority Health and Health Disparities (MHHD) are also working on initiatives to reduce infant mortality, some of which involve making grants to community organizations.

**The commission should comment on ways that it can partner with FHA and MHHD to maximize limited State resources to reduce infant mortality, so as not to duplicate efforts. It should also comment on ways that it can partner with these agencies to increase access to care for low-income, under-insured individuals in other identified areas such as dental health, emergency room diversion, and school-based health care.**

## ***Recommended Actions***

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1. Concur with Governor's allowance.

## Updates

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### 1. Update of Medicare Waiver Status

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, which is higher than that of the prospective payment system used nationally. 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 \$1 billion in Medicare reimbursements above that which would be received absent the all payor system.

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.

#### Medicare Cost Growth

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 June 2008, the Maryland Medicare charge per case has increased by 293% since the waiver was awarded in 1980. Nationally, the Medicare charge per case has increased by 319% since 1980. **Exhibit 9** shows the change in charge per case for Maryland and for the national average. As the exhibit illustrates, the cost of Medicare services in Maryland is higher than the national average, but it is growing at a slower rate.

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**Exhibit 9**  
**Medicare Cost Growth**  
**Maryland vs. National Average**

	<u>1980</u>	<u>2008</u>	<u>% Change</u>
Maryland	\$2,972	\$11,675	293%
National Average	2,293	9,600	319%

Source: Health Services Cost Review Commission

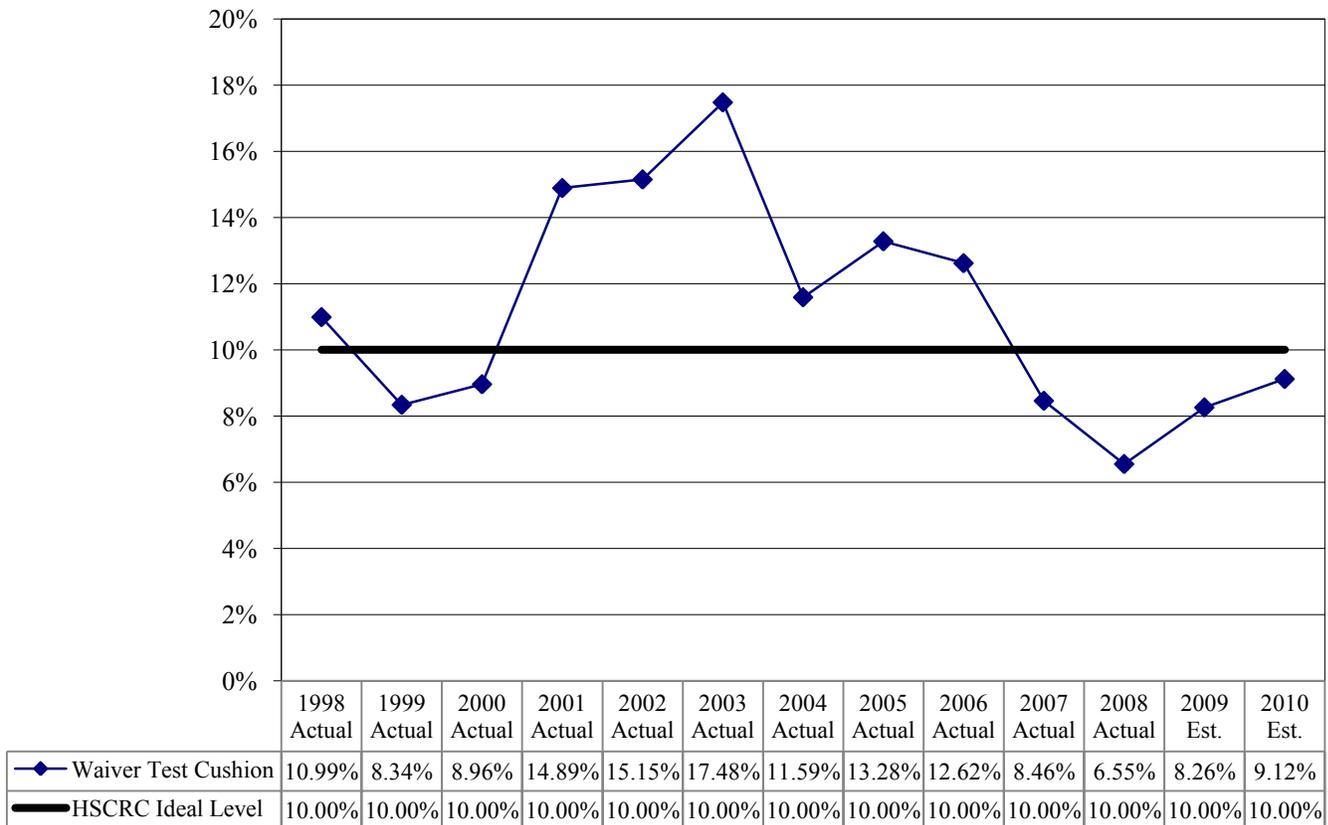
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The primary measure used to monitor waiver performance is the relative waiver margin calculation, a test performed using an independent economic model that assumes a flat rate of growth in Medicare payments per case. The result of the test is the relative 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 10**, over the past decade, the waiver cushion has fluctuated below and above the 10% minimum level. Information on the national average has an 18-month lag, so the most current actual data is from fiscal 2008 when there was a cushion of 6.55%. HSCRC estimates that the cushion will improve to 8.26% in fiscal 2009 and to 9.12% in fiscal 2010.

**Exhibit 10**  
**Medicare Waiver Cushion**  
**Fiscal 1998-2010**



Source: Health Services Cost Review Commission

## **All Payor System**

As a condition of the health care expansion efforts, Medicaid day limits were lifted in fiscal 2009. 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. Subsequent cuts to the Medicaid program have threatened to reimplement Medicaid day limits, as mentioned in the Issues section of this document. So far, HSCRC has been able to approve alternate financing mechanisms that preserve the all payor system.

## **2. 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. 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.

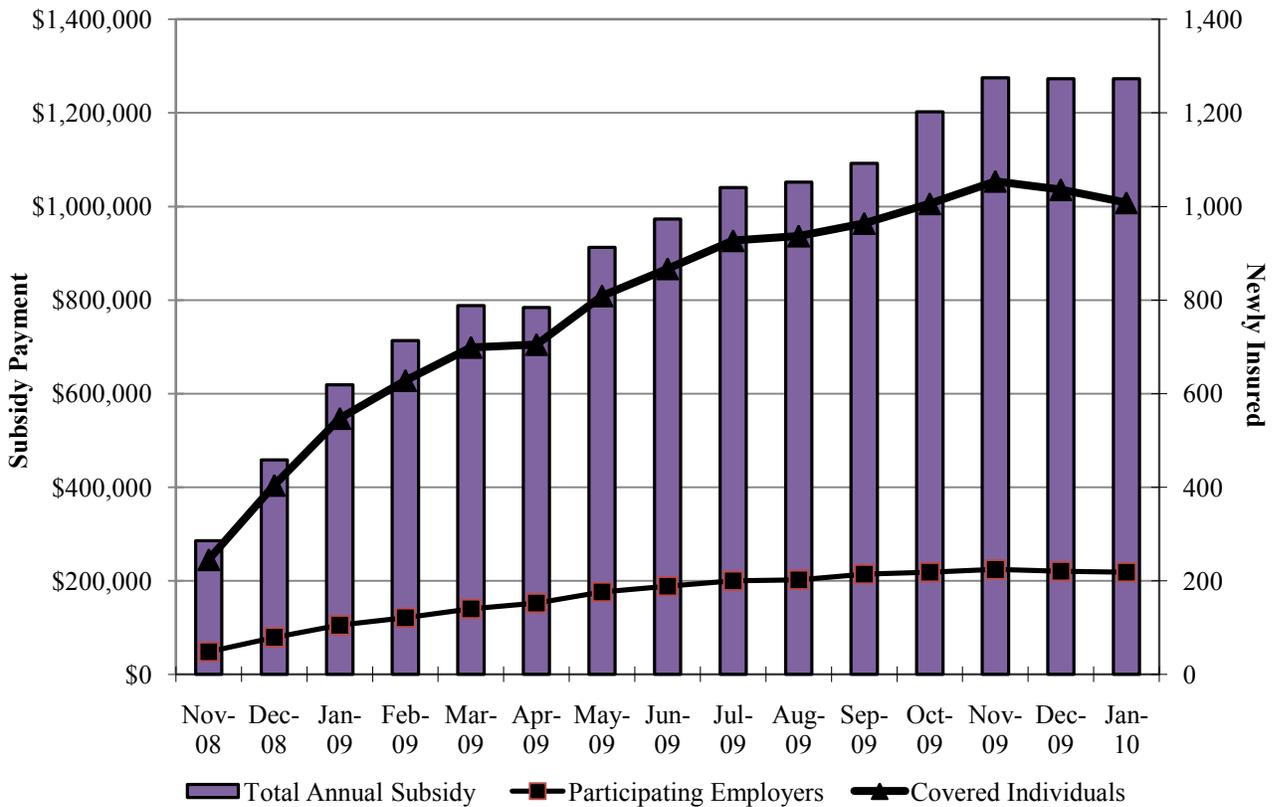
The plan provides a premium subsidy of up to 50% of both the employer and employee contribution, or a contribution limit set by MHCC, for businesses that employ between two and nine employees who have not offered health insurance to their employees for the previous 12 months. In order to qualify for 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.

### **Status Update**

Now in its second year of operation, the Health Insurance Partnership has provided a subsidy for 218 businesses to offer health insurance coverage to its employees, resulting in coverage for over 1,000 new individuals, as shown in **Exhibit 11**. Although initial estimates placed enrollment for the program at 15,000 previously uninsured individuals, a downturn in the economy has hampered utilization of the program.

**Exhibit 11**  
**Small Business Health Insurance Partnership**  
**Cost and Enrollment**  
**November 2008 – January 2010**



Source: Maryland Health Care Commission

**3. Support for the University of Maryland Medical System in the Operating Budget**

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.

## R Adams Cowley Shock Trauma Center

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 University of Maryland Medical System for operating and educational grants. Beginning in fiscal 2010, the operating grant from MEMSOF was disbursed through MHCC and the Maryland Institute for Emergency Medical Services System (MIEMSS).

**Exhibit 12** shows State support of the Shock Trauma Center between fiscal 2007 and 2011 in the operating budget only. The operating subsidy for the Shock Trauma Center aids the center in its standby costs, homeland security requirements, and research and education expenditures. Annually, \$3.0 million is disbursed through MHCC, and \$0.2 million is disbursed through MIEMSS.

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**Exhibit 12**  
**Operating Budget Subsidy for Shock Trauma Center**  
**Fiscal 2007-2011**  
**(\$ in Thousands)**

	<u>2007</u> <u>Actual</u>	<u>2008</u> <u>Actual</u>	<u>2009</u> <u>Actual</u>	<u>2010 Working</u> <u>Appropriation</u>	<u>2011</u> <u>Allowance</u>
Operating Subsidy for Shock Trauma Center	\$3,200	\$3,264	\$3,361	\$3,200	\$3,200

Source: Department of Legislative Services

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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. However, the fiscal 2011 capital budget submitted by the Governor defers the final installment of \$3.5 million to fiscal 2012.

***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>
<b>Fiscal 2009</b>					
Legislative Appropriation	\$0	\$141,711	\$0	\$0	\$141,711
Deficiency Appropriation	0	16,000	0	0	16,000
Budget Amendments	0	1,251	0	0	1,251
Cost Containment	0	-6,978	0	0	-6,978
Reversions and Cancellations	0	-17,723	0	0	-17,723
<b>Actual Expenditures</b>	<b>\$0</b>	<b>\$134,261</b>	<b>\$0</b>	<b>\$0</b>	<b>\$134,261</b>
<b>Fiscal 2010</b>					
Legislative Appropriation	\$0	\$156,185	\$0	\$0	\$156,185
Cost Containment	0	-274	0	0	-274
Budget Amendments	0	0	0	189	189
<b>Working Appropriation</b>	<b>\$0</b>	<b>\$155,911</b>	<b>\$0</b>	<b>\$189</b>	<b>\$156,099</b>

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

## **Fiscal 2009**

In fiscal 2009, the budget for the Health Regulatory Commissions closed at \$134.3 million, a decrease of \$7.5 million below the original legislative appropriation. The budget for the commissions was solely special funded in fiscal 2009.

First, a deficiency appropriation was issued to accommodate the new uncompensated care formula for hospitals (\$16.0 million). The uncompensated care formula was changed from a partial pooling system to a full pooling system where hospitals share more equitably the financial burden of uncompensated care, consequently collecting and dispensing a greater share of uncompensated care funds.

Next, budget amendments account for an increase of \$1.3 million in fiscal 2009 due to a cost-of-living adjustment for all commissions (\$0.2 million) and to cover the increased cost of grants disbursed by the Maryland Community Health Resources Commission to eligible health resource centers (\$1.1 million).

Three cost containment actions taken by the Board of Public Works reduced the budget by \$7.0 million. In June 2008, BPW reduced personnel expenses for all three commissions (\$40,793). In October 2008, the budget for the Maryland Community Health Resources Commission was further reduced by \$6.8 million, depleting the amount of grants that may be disbursed through MCHRC. In March 2009, BPW reduced personnel expenses as a result of statewide employee furloughs for all three commissions (\$135,118).

Finally, \$17.7 million of special fund appropriation was cancelled at the end of fiscal 2009. The bulk of the cancellation was from the Maryland Health Care Commission, which cancelled \$16.6 million in special fund appropriation due to lower than expected participation in the Small Business Health Insurance Partnership (\$14.5 million), lower collections for the Maryland Trauma Physician Fund (\$1.2 million), and \$0.3 million for delay of contractual expenses related to the hospital guide. Additionally, \$1.1 million of special fund appropriation was cancelled by the Health Services Cost Review Commission due to an overestimate of the collections of uncompensated care funds.

## **Fiscal 2010**

The fiscal 2010 working appropriation for the Health Regulatory Commissions has decreased by just under \$0.1 million over the original legislative appropriation. Cost containment actions taken by the Board of Public Works in August 2009 reduced personnel expenses by \$274,478 as a result of statewide employee furloughs affecting all three commissions.

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Reimbursable funds increased the budget of the Maryland Health Care Commission in fiscal 2010 by \$188,527 based on funds available from the Infectious Diseases and Environmental Health Administration (IDEHA) through an ARRA grant. These funds are used for the infectious diseases cooperative agreement aimed to improve surveillance and response for infectious diseases. MHCC will play an active role in drafting the State Health-Associated Infectious (HAI) disease prevention plan and establishing the State's capacity to develop HAI prevention programs.

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

<u>Object/Fund</u>	<u>FY09 Actual</u>	<u>FY10 Working Appropriation</u>	<u>FY11 Allowance</u>	<u>FY10 - FY11 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	94.60	96.60	96.60	0	0%
02 Contractual	1.00	0	0	0	0.0%
<b>Total Positions</b>	<b>95.60</b>	<b>96.60</b>	<b>96.60</b>	<b>0</b>	<b>0%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 8,867,868	\$ 9,212,179	\$ 9,784,547	\$ 572,368	6.2%
02 Technical and Spec. Fees	66,992	48,200	42,050	-6,150	-12.8%
03 Communication	259,096	101,872	115,545	13,673	13.4%
04 Travel	76,645	108,056	72,245	-35,811	-33.1%
08 Contractual Services	117,362,707	140,354,268	145,579,403	5,225,135	3.7%
09 Supplies and Materials	85,999	75,279	81,343	6,064	8.1%
10 Equipment – Replacement	70,910	33,863	12,000	-21,863	-64.6%
11 Equipment – Additional	21,824	8,391	25,000	16,609	197.9%
12 Grants, Subsidies, and Contributions	7,007,430	5,700,000	5,500,000	-200,000	-3.5%
13 Fixed Charges	441,767	457,310	451,171	-6,139	-1.3%
<b>Total Objects</b>	<b>\$ 134,261,238</b>	<b>\$ 156,099,418</b>	<b>\$ 161,663,304</b>	<b>\$ 5,563,886</b>	<b>3.6%</b>
<b>Funds</b>					
03 Special Fund	\$ 134,261,238	\$ 155,910,891	\$ 161,332,234	\$ 5,421,343	3.5%
09 Reimbursable Fund	0	188,527	331,070	142,543	75.6%
<b>Total Funds</b>	<b>\$ 134,261,238</b>	<b>\$ 156,099,418</b>	<b>\$ 161,663,304</b>	<b>\$ 5,563,886</b>	<b>3.6%</b>

Note: The fiscal 2010 appropriation does not include deficiencies.

**Fiscal Summary**  
**DHMH – Health Regulatory Commissions**

<u>Program/Unit</u>	<u>FY09 Actual</u>	<u>FY10 Wrk Approp</u>	<u>FY11 Allowance</u>	<u>Change</u>	<u>FY10 - FY11 % Change</u>
01 Maryland Health Care Commission	\$ 22,238,508	\$ 28,249,336	\$ 28,324,726	\$ 75,390	0.3%
02 Health Services Cost Review Commission	104,568,757	124,841,055	130,334,192	5,493,137	4.4%
03 Maryland Community Health Resources Commission	4,092,586	3,009,027	3,004,386	-4,641	-0.2%
01 Aid to University of Maryland Medical System	3,361,387	0	0	0	0%
<b>Total Expenditures</b>	<b>\$ 134,261,238</b>	<b>\$ 156,099,418</b>	<b>\$ 161,663,304</b>	<b>\$ 5,563,886</b>	<b>3.6%</b>
Special Fund	\$ 134,261,238	\$ 155,910,891	\$ 161,332,234	\$ 5,421,343	3.5%
<b>Total Appropriations</b>	<b>\$ 134,261,238</b>	<b>\$ 155,910,891</b>	<b>\$ 161,332,234</b>	<b>\$ 5,421,343</b>	<b>3.5%</b>
Reimbursable Fund	\$ 0	\$ 188,527	\$ 331,070	\$ 142,543	75.6%
<b>Total Funds</b>	<b>\$ 134,261,238</b>	<b>\$ 156,099,418</b>	<b>\$ 161,663,304</b>	<b>\$ 5,563,886</b>	<b>3.6%</b>

Note: The fiscal 2010 appropriation does not include deficiencies.