

M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 10</u> <u>Actual</u>	<u>FY 11</u> <u>Working</u>	<u>FY 12</u> <u>Allowance</u>	<u>FY 11-12</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
Special Fund	\$150,083	\$161,298	\$162,677	\$1,379	0.9%
Contingent & Back of Bill Reductions	0	0	-7	-7	
Adjusted Special Fund	\$150,083	\$161,298	\$162,670	\$1,372	0.9%
Federal Fund	606	2,644	3,314	670	25.4%
Contingent & Back of Bill Reductions	0	0	-15	-15	
Adjusted Federal Fund	\$606	\$2,644	\$3,299	\$655	24.8%
Reimbursable Fund	117	1,879	285	-1,595	-84.9%
Contingent & Back of Bill Reductions	0	0	-1	-1	
Adjusted Reimbursable Fund	\$117	\$1,879	\$284	-\$1,596	-84.9%
Adjusted Grand Total	\$150,807	\$165,821	\$166,252	\$431	0.3%

- The Governor's proposed fiscal 2012 allowance for the Regulatory Commissions increases by \$0.4 million, or 0.3%, over the fiscal 2011 working appropriation. The budget is primarily special funded through fees and assessments collected and disbursed to the health care industry.
- Across-the-board reductions for health insurance, retiree prescription drug benefits, and pension changes included in the fiscal 2012 allowance decrease the budget by \$23,058.

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

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Personnel Data

	<u>FY 10 Actual</u>	<u>FY 11 Working</u>	<u>FY 12 Allowance</u>	<u>FY 11-12 Change</u>
Regular Positions	96.60	96.60	99.70	3.10
Contractual FTEs	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
Total Personnel	96.60	96.60	99.70	3.10

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	5.39	5.41%
Positions and Percentage Vacant as of 12/31/10	10.00	10.35%

- The fiscal 2012 allowance includes the addition of 3.10 full-time equivalents (FTEs). The Maryland Health Care Commission (MHCC) receives 0.1 FTEs to accommodate additional data collection required by the federal government. The Health Services Cost Review Commission (HSCRC) receives 3.0 FTEs for a Principal Deputy Director of Operations, responsible for management and oversight of both the Research and Methodology and Hospital Rate Setting divisions; an Associate Director of Data and Research, responsible for overseeing hospital cost and quality performance measures; and a Programmer Analyst, which will provide programming support for to various divisions within HSCRC.
- As of December 31, 2010, the commissions had 10.0 vacant positions for a vacancy rate of 10.35%.

Analysis in Brief

Major Trends

Maryland Moves Forward with Electronic Health Claims Submission: As a way to reduce the rate of growth in health care spending, MHCC certifies electronic health networks (EHNs) for providers and payors to receive and pay claims electronically. In fiscal 2010, the agency had certified 45 EHNs in the State. As a result of these networks, 79% 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. Repeated cost containment actions resulting in higher hospital charges threaten to erode the cushion, below the ideal minimum set by HSCRC, even further in fiscal 2011 and 2012.

Issues

Financing the State's Budget Deficit through Hospital Assessments: Amid recurring budget deficits, the State has searched for ways to reduce its general fund liability through the Medicaid program, specifically for payments that Medicaid makes for hospital costs. In fiscal 2011, the Medicaid budget was reduced by \$130 million to be backfilled with special funds collected through a hospital assessment. HSCRC is the regulatory body tasked with implementing the charges to the hospitals and voted to assign 30% as hospital remittance and 70% as additional hospital rates passed on to the payor/patient. The fiscal 2012 budget includes an even higher amount of unidentified reductions to Medicaid, roughly \$331.3 million. HSCRC is again authorized to devise a method of achieving savings to the Medicaid program through the hospital rate setting system.

Implications of the BRFA on Maryland's Medicare Waiver: The Budget Reconciliation and Financing Act of 2011 includes an annual assessment of 2.5% of net patient revenues to support the general operations of the Medicaid program. The inclusion of a permanent subsidy to Medicaid through the hospital rate system violates the all payor aspect of the system since one payor in the system (Medicaid) is subsidized by all others. Also, an increase of 2.5% to hospital rates threatens to violate the other provision needed to maintain the waiver – that 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.

Healthcare-associated Infections: Healthcare-associated infections (HAIs) are infections that patients acquire during the course of receiving medical treatment for other conditions. HAIs are the most common complication affecting hospitalized patients, with between 5 and 10% of patients acquiring one or more infections during their hospitalization. According to the Centers for Disease Control and Prevention (CDC), HAIs account for an estimated 1.7 million infections and 99,000 associated deaths annually. A recent CDC report showed that Maryland has the highest rate of central line-associated bloodstream infections of all states that are required to report.

Recommended Actions

1. Concur with Governor's allowance.

Updates

Patient Centered Medical Homes Initiative: The General Assembly approved legislation in the 2010 session to create a Patient Centered Medical Homes (PCMH) pilot program which is designed to improve health outcomes and reduce the cost of health care by elevating the role of primary care in Maryland's health system. PCMHs involve a model of practice in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care to patients. The PCMH pilot program will provide primary care physicians and nurse practitioners with financial incentives and assistance to expand access to care, promote wellness and prevention, utilize multi-disciplinary teams to treat patients, and coordinate care to improve disease management and the overall health of patients.

Small Business Health Insurance Partnership: The Small Business Health Insurance Partnership, in its third year of operation, has provided a subsidy for 314 businesses and 1,495 covered lives. The total annual premium subsidy for the existing participants totals \$2.1 million as of November 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 2012 at \$3.2 million.

M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are independent agencies that operate within the Department of Health and Mental Hygiene (DHMH) 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 to and affordability of health insurance, especially for small employers;
- reducing the rate of growth in health care spending; and
- providing a framework for guiding the future development of services and facilities regulated under the certificate of need program.

HSCRC was established in 1971 to contain hospital costs, maintain fairness in hospital payment, and provide financial access to hospital care. The commission maintains responsibility for ensuring that the cost of health care is reasonable relative to the cost of 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.

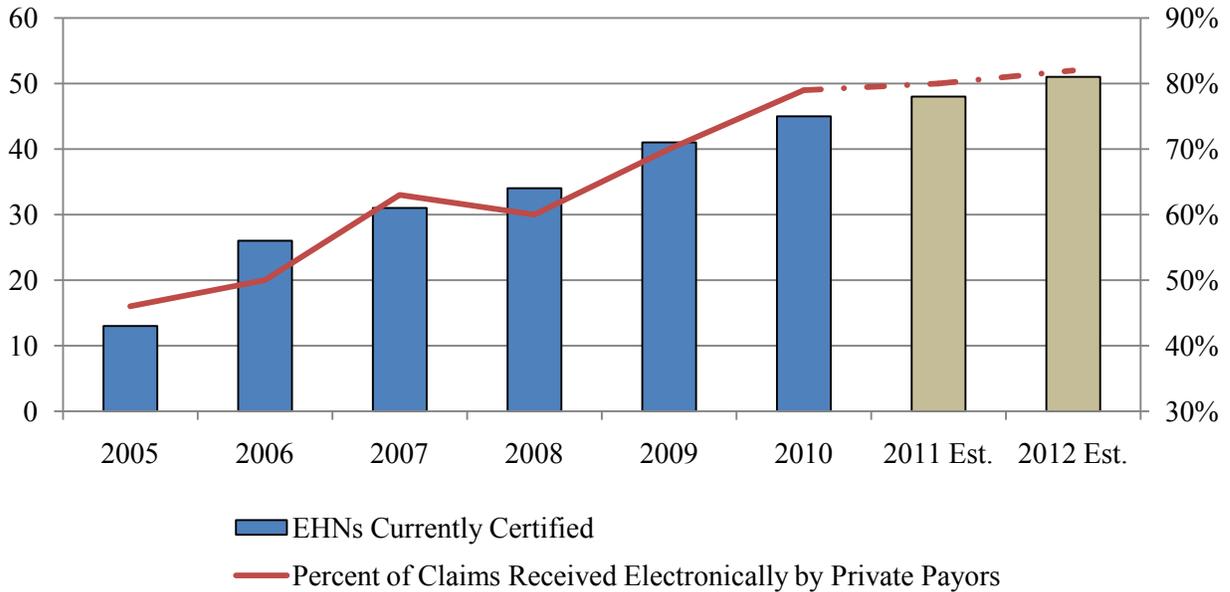
Performance Analysis: Managing for Results

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 (HIT); 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 79% in fiscal 2010. MHCC expects this trend to continue in the future as the use of HIT becomes more widely utilized in the State. In fact, Chapter 689 of 2009 directed MHCC and HSCRC to encourage the use of HIT by developing a Health Information Exchange (HIE) program to transmit electronic health records between approved providers. Many of the MHCC-certified EHNs may be able to connect to the statewide HIE once it is established.

**Exhibit 1
Utilization of Electronic Health Networks in Maryland
Fiscal 2005-2012**



EHN: electronic health networks

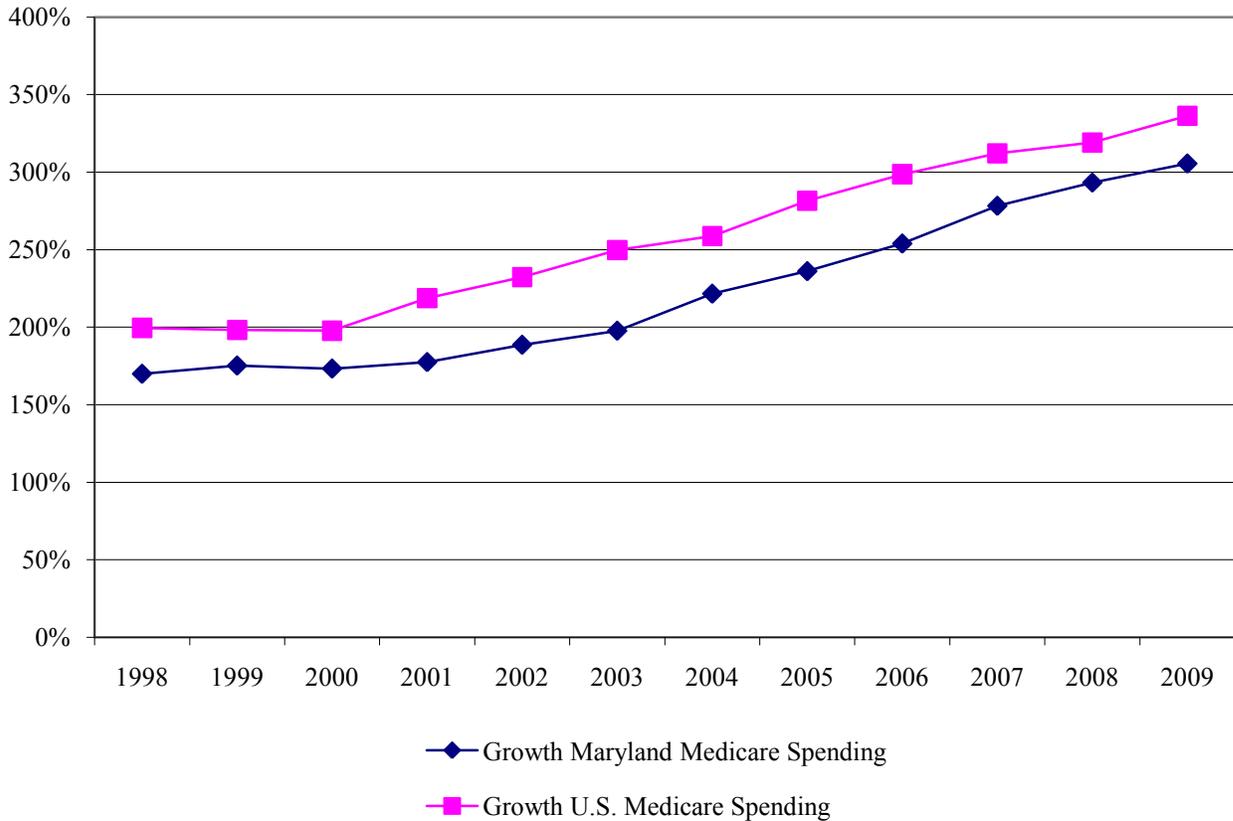
Source: Department of Health and Mental Hygiene

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 spending between fiscal 1998 and 2009 and shows that the rate of growth in Maryland remains below the national average. As of June 2009, the cumulative growth of Maryland Medicare payments has been 305.6%, compared to national growth of 336.3%. A more in-depth discussion of the Medicare waiver is included in the Issues section of this document.

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

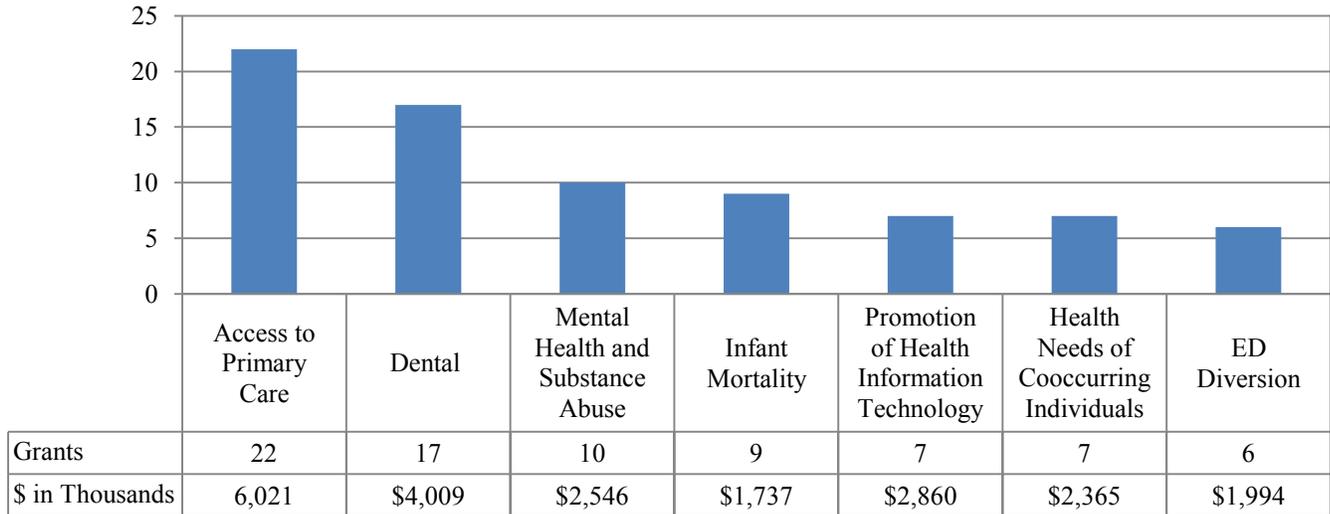


Source: Department of Health and Mental Hygiene

Maryland Community Health Resources Commission

MCHRC was established during the 2005 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 \$21.5 million in grant funding to 78 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 CHRCs, federally qualified health centers, and other community-based health clinics.

Exhibit 3
Grants Awarded by the Maryland Community Health Resources Commission
Fiscal 2007-2011
(\$ in Thousands)



ED: Emergency Department

Source: Maryland Community Health Resources Commission

Proposed Budget

The Governor's proposed fiscal 2012 allowance for the Health Regulatory Commissions increases by \$0.4 million, or 0.3%, over the fiscal 2011 working appropriation, as shown in **Exhibit 4**. The special fund allowance increases by \$1.4 million, or 0.9%, the federal fund allowance increases by \$0.7 million, or 24.8%, and the reimbursable fund allowance decreases by \$1.6 million, or 84.9%.

Impact of Cost Containment

The fiscal 2012 budget reflects several across-the-board actions. In fiscal 2012, the Health Regulatory Commission's share of the reduction is \$12,660 in federal funds, \$5,499 in special funds, and \$814 in reimbursable funds for changes in employee health insurance. Reductions contingent upon statutory changes include \$2,726 in federal funds, \$1,184 in special funds, and \$175 in reimbursable funds for retiree prescription drug benefits. To the extent that the Regulatory Commissions have positions abolished under the Voluntary Separation Program, additional reductions will be implemented by the Administration.

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

How Much It Grows:	<u>Special</u> <u>Fund</u>	<u>Federal</u> <u>Fund</u>	<u>Reimb.</u> <u>Fund</u>	<u>Total</u>
2011 Working Appropriation	\$161,298	\$2,644	\$1,879	\$165,821
2012 Allowance	<u>162,677</u>	<u>3,314</u>	<u>285</u>	<u>166,275</u>
Amount Change	\$1,379	\$670	-\$1,595	\$455
Percent Change	0.9%	25.4%	-84.9%	0.3%
Contingent Reductions	-\$7	-\$15	-\$1	-\$23
Adjusted Change	\$1,372	\$655	-\$1,596	\$431
Adjusted Percent Change	0.9%	24.8%	-84.9%	0.3%

Where It Goes:

Personnel Expenses

Increased salary expenses, including restoration of furlough reductions.....	\$249
New positions in HSCRC (3.0 FTE) and MHCC (0.1 FTE)	211
Reclassification of positions.....	177
Contributions to employee retirement.....	55
Turnover adjustments.....	-169
Personnel funds associated with Medicaid HIT project	-160
Employee and retiree health insurance (net of contingent and across-the-board reductions)...	-78
Other fringe benefit adjustments	22

MHCC

Development of Health Information Exchange	670
Increased collection to and disbursement from the Maryland Trauma Physician Services Fund	600
Continuation of contract for medical care database	112
Healthcare Associated Infection prevention initiative	-150
Expenses related to PCMH	-350
Medicaid HIT project in fiscal 2011	-1,082

M00R – DHMH – Health Regulatory Commissions

Where It Goes:

HSCRC

Increased contractual costs 161

MCHRC

Development of a State Public Health Needs Plan 500

PCMH initiative -150

Fewer funds available for grants -200

Other changes..... 14

Total **\$431**

FTE: full-time equivalent

HIT: health information technology

HSCRC: Health Services Cost Review Commission

MHCC: Maryland Health Care Commission

MCHRC: Maryland Community Health Resources Commission

PCMH: Patient Centered Medical Homes

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

Personnel Expenses

Personnel expenses for the Regulatory Commissions increase by \$0.3 million in the fiscal 2012 allowance, as shown in Exhibit 4. The major increases for personnel include salary expenses, including the restoration of furlough reductions, which adds \$0.2 million. Also, the fiscal 2012 allowance includes 3.0 full-time equivalent (FTE) new positions for HSCRC and 0.1 FTE position for MHCC (\$0.2 million). These positions include the following: a Principal Deputy Director of Operations, responsible for management and oversight of both the Research and Methodology and Hospital Rate Setting divisions; an Associate Director of Data and Research, responsible for overseeing hospital cost and quality performance measures; and a Programmer Analyst, which will provide programming support for to various divisions within HSCRC. The position increase within MHCC is required to perform additional data collection and analysis for the Home Health Survey required by the federal government. Position reclassification for 25 of the 31 existing positions in HSCRC results in an increase of \$0.2 million. The reclassification and new positions for HSCRC resulted from recommendations by a consultant hired to evaluate the wages and benefits of staff. The commission has independent salary setting authority and can increase salaries even though other State agencies have been directed to constrain personnel costs. Finally, contributions to employee retirement adds \$54,781, which accounts for across-the-board reductions and changes to the pension system.

The decreases in personnel expenses includes \$0.2 million for turnover adjustments, \$0.2 million for personnel funds associated with the Medicaid HIT initiative, and \$0.1 million for employee and retiree health insurance, including across-the-board reductions mentioned above.

Operating Expenses

Collectively, the operating expenses for all three commissions increase by \$0.1 million in the fiscal 2012 allowance. The major changes for each commission are described below.

MHCC

Operating expenses for the Maryland Health Care Commission decrease by \$0.2 million over the fiscal 2011 working appropriation. The majority of the decrease is the result of funds associated with the Medicaid HIT project start up funds in fiscal 2011.

The major increases to the budget include activities related to the HIE for interstate and intrastate expansion (\$0.7 million). In fiscal 2010, MHCC was awarded a four-year grant from the federal government to fund Maryland's HIE both within and across states. In August 2009, MHCC selected the Chesapeake Regional Information System for our Patients, a nonprofit collaborative effort among the Johns Hopkins Health System, MedStar Health, University of Maryland Medical System (UMMS), Erickson Retirement Communities, and Erickson Foundation, to implement the HIE statewide. The statewide HIE will support high-quality, safe, and effective health care; ensure the privacy and security of health information; be financially sustainable; and support connectivity nationally and regionally.

Also, increased collection to and disbursement from the Maryland Trauma Physician Services Fund account for an increase of \$0.6 million. The Trauma Fund was established to subsidize documented costs of physician uncompensated care to trauma patients in trauma centers in Maryland, as well as to provide equipment grants for trauma centers. The funds are collected through the Motor Vehicle Administration through a \$5.00 surcharge on every vehicle registered in Maryland.

MHCC is mandated to establish and maintain the medical care database based on claims data for health care services rendered by providers in the State. The contract to maintain this database is in its third year and increases the budget by \$0.1 million. The database allows the commission to report annually on the variations in the fees charged and utilization of health care practitioner data.

The main source of the decrease in MHCC's budget relate to activities in fiscal 2011 to assist the Maryland Medical Assistance Program in implementing the HIT authorized by the American Recovery and Reinvestment Act of 2009 (ARRA). MHCC received reimbursable funds for this project in fiscal 2011. Thus, the fiscal 2012 allowance decreases by \$1.1 million.

Other decreases include fewer resources for the Patient Centered Medical Homes pilot project (\$0.4 million); the majority of the funding for this project was budgeted in fiscal 2011. Also, activities related to the prevention of Healthcare-associated Infections (HAIs) were undertaken in fiscal 2011. Although there is a small amount of money in fiscal 2012 to fund the cost of the audit requirement for the infectious disease cooperative agreement with the Infectious Disease and Environmental Health Administration, the budget decreases overall for expenses related to HAI prevention by \$0.2 million.

M00R – DHMH – Health Regulatory Commissions

The Small Business Health Insurance Partnership is level-funded at \$2 million for fiscal 2012.

HSCRC

Operating expenses for HSCRC are basically level-funded in the fiscal 2012 allowance. There is an increase of \$0.2 million for contractual costs associated with the analysis and research of rate setting methodologies, measuring patient acuity in acute care hospitals, and other hospital related data collection critical for establishing fair and accurate hospital rates.

MCHRC

Operating expenses for MCHRC increase by roughly \$150,000 in the fiscal 2012 allowance. MCHRC has been tasked with assisting in the development of State and local strategic plans to achieve improved public health outcomes and encouraging the active participation of Safety Net providers in health reform. The development of a statewide public health needs assessment and strategic plan was a recommendation of the Health Care Reform Coordinating Council. The fiscal 2012 allowance includes \$0.5 million for this initiative.

Also, MCHRC partnered with MHCC to implement Patient Centered Medical Homes (PCMH) in fiscal 2011 and 2012. MCHRC was tasked with assisting federally qualified health centers and other primary care practices to become PCMHs and identifying ways that its resources can leverage additional assets to support participation in Maryland's program. The CHRC voted to budget \$300,000 in fiscal 2011 for the program's pilot activities related to practice transformation and \$150,000 for fiscal 2012, a decrease of \$0.2 million. Finally, the allowance includes \$2.0 million for grants to health resource centers, a decrease of \$0.2 million from fiscal 2011.

Transfers and Changes Per Budget Reconciliation and Financing Act of 2011

House Bill 72, the Budget Reconciliation and Financing Act (BRFA) of 2011, authorizes the transfer of \$1,000,000 from the special fund balance of MHCC in fiscal 2011. The bill also makes permanent the transfer of interest earned on certain special fund balances 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.

In addition to the fund transfers, House Bill 72 also specifies funding of \$3.0 million for fiscal 2012 and 2013 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 House Bill 72, payments from nonprofit health service plans would go to fulfill the subsidy requirements for the Senior Prescription Drug Assistance Program. The balance of the funds after the subsidy would support the Kidney Disease Program and MCHRC.

Issues

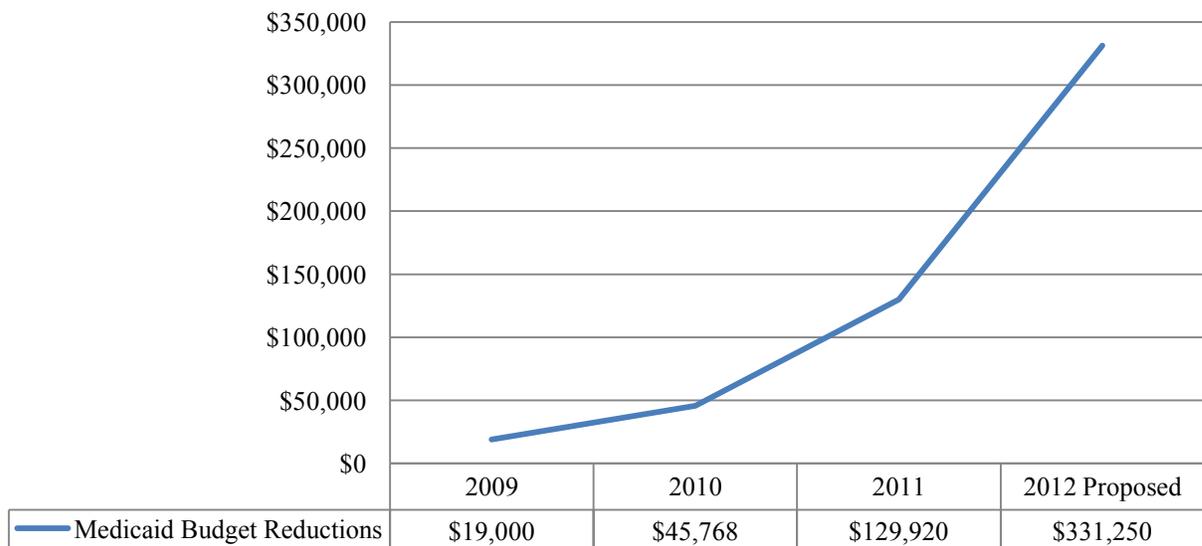
1. Financing the State’s Budget Deficit through Hospital Assessments

Amid recurring budget deficits, 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 2011, the Medicaid budget was reduced by \$130 million to be backfilled with special funds collected through a hospital assessment. HSCRC is the regulatory body tasked with implementing the charges to the hospitals and voted to assign 30% as hospital remittance and 70% as additional hospital rates passed on to the payor/patient. The fiscal 2012 budget includes an even higher amount of unidentified reductions to Medicaid, roughly \$331.3 million. HSCRC is again authorized to devise a method of achieving savings to the Medicaid program through the hospital rate setting system. It has yet to decide how the \$331.3 million cut will be assigned to the hospitals.

Medicaid Reduction to Hospital Payments in Previous Years

Previous budgets have used special funds from hospital assessments to replace general fund reductions to the Medicaid program. **Exhibit 5** shows reductions to the budget beginning in fiscal 2009 through 2012.

Exhibit 5
Medicaid Budget Reductions Assigned to Hospitals
Fiscal 2009-2012
(\$ in Thousands)



Source: Department of Budget and Management

Fiscal 2011 Actions

As mentioned above, the 2011 budget bill included a reduction to the Medicaid program to be implemented by HSCRC through the re-imposition of Medicaid Day Limits (MDLs) or through the hospital rate setting system. 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 reductions through the hospital rate setting system. **Exhibit 6** shows the reductions made to the Medicaid budget for which HSCRC approved 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 the past, HSCRC has had a policy to split assessments equally between the payors and hospitals. However, for the fiscal 2011 Medicaid reductions, the Commission voted to divert from that policy and instead adopted a one-time policy that assigned 70% of the total to payors through increased hospital rates and 30% of the total to hospitals through a remittance. The alternative mechanism aimed to 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 rates in 2011.

Exhibit 6 Financing Mechanisms to Account for Fiscal 2011 Medicaid Reductions

	<u>Total Reduction</u>	<u>Hospital Portion (Remittance)</u>	<u>Payor Portion (Assessment)</u>	<u>Total Paid to Medicaid by Hospitals</u>
Fiscal 2011 Reduction	\$123,000,000	\$36,900,000	\$86,100,000	\$123,000,000
Feedback Effect on Rates				
Payor Portion of fiscal 2011 Reduction	86,100,000			
Medicaid Fee for Service Percent	7.8%			
Subtotal Feedback Effect	\$6,919,614	\$2,075,884	\$4,843,730	\$6,919,614
Total Financing by Hospitals and Payors for Budget Reductions		\$38,975,884	\$90,943,730	\$129,919,614

Source: Health Services Cost Review Commission

Exhibit 6 includes the cost associated with a feedback effect on Medicaid. Because rates increase as a result of the assessment, 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

\$6.9 million as indicated in Exhibit 6. The cost of the feedback is also split 70/30 between payors and hospitals.

Fiscal 2012 Actions

Besides the increased amount of the reduction in fiscal 2012, there are other significant changes to assessments assigned to hospitals. The BRFA of 2011 makes permanent changes to the way that the cost of graduate medical education is included in hospital rates, the methodology for calculating averted uncompensated care savings due to Medicaid expansion associated with Chapter 7 of 2007, and adds a subsidy for the general operations of the Medicaid program to the hospital rate system.

First, the BRFA directs the HSCRC to change the way the cost of graduate medical education is included in hospital rates in a way that is equitably distributed across all hospitals. Currently, only the teaching hospitals have a component in their rates to support graduate medical education at those hospitals. Language in the BRFA directs HSCRC to pool those costs across all hospitals. The funds collected for graduate medical education would still be directed to the teaching hospitals to support graduate medical education at those institutions. Savings to the Medicaid program resulting from this change is estimated to be \$17.5 million general funds and \$17.5 million federal funds.

Next, the methodology for calculating the savings associated with the reduction in uncompensated care resulting from Medicaid expansion is changed to not exceed the greater of the total savings realized in averted uncompensated care from the healthcare coverage expansion or 1.5% of hospital net patient revenue. In theory, the cost to the health care industry for the assessment is offset by savings associated with averted uncompensated care and was previously calculated through a reconciliation process by the hospitals and DHMH. The language in the BRFA changes this methodology and allows HSCRC to potentially collect more than is actually saved by healthcare coverage expansion.

Finally, language in the BRFA adds an annual subsidy to support the general operations of the Medicaid program equal to 2.5% of hospital net patient revenue that is to be shared among hospitals and payors in a manner that HSCRC determines most equitable. In fiscal 2012, this equals \$331.3 million as referenced in the first section of this Issue. This assessment has the greatest potential to negatively affect the health care industry by passing along a subsidy for the Medicaid program to the hospitals and payors.

The assessment for both averted uncompensated care and the subsidy to support the Medicaid program are to be paid by all acute care and specialty hospitals, including publicly operated hospitals. Previously, only acute care hospitals were included in the assessment for averted uncompensated care. Also, the assessments authorized through the BRFA will be on both regulated and unregulated revenue. The HSCRC does not have the regulatory authority to assess a payment on unregulated revenue, so the practical effect will be that a higher percentage would be applied to regulated revenue for the assessments.

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.

Neither the budget bill nor the BRFA specify how the assessment to support the Medicaid program will be implemented in fiscal 2012. Some portion will be assigned to payors through higher hospital rates and some will be assigned to the hospitals out of their bottom line. If the HSCRC follows the methodology determined in fiscal 2011 that payors are responsible for 70% of the assessment, the rate charged at hospitals in Maryland would increase by \$231.9 million. Although the exact split is unknown at this time, the implication of this assessment puts upward pressure on hospital costs.

First, the reliance on an assessment on payors and patients at hospitals to finance Medicaid reductions is equivalent to a tax with the effect of increasing the cost of hospital services and reducing hospital operating margins. All payors are impacted, including private insurers which will have to account for the increased cost of hospital care. 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 Medicaid program.

Second, the change to the methodology used to calculate averted uncompensated care has the potential to pass along more costs than savings associated with Medicaid healthcare coverage expansion. To the extent that the savings realized are less than 1.5% of net patient revenues, payors in the system will be charged an additional amount in hospital rates to make up the difference.

If rates are constantly increased to achieve savings for the Medicaid program or for other State purposes, Medicare payments will also increase thereby eroding the waiver cushion. Maryland's Medicare waiver is in jeopardy if continued assessments are passed through to the hospital payment system. A full discussion of the implications of the BRFA language on Maryland's Medicare Waiver follows.

2. Implications of the BRFA on Maryland's Medicare Waiver

As mentioned earlier, BRFA of 2011 includes language that would make the assessment to support the Medicaid program an annual assessment of 2.5% of net patient revenues to be shared between hospitals and payors. The inclusion of a permanent subsidy to Medicaid through the hospital rate system could be interpreted to violate the all payor aspect of the system since one payor in the system (Medicaid) is subsidized by all others. Also, an increase of 2.5% to hospital rates threatens to violate the other provision needed to maintain the waiver – that 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. The Medicare waiver represents an additional \$1 billion in revenue to

Maryland hospitals than Medicare would otherwise pay for hospital visits. Loss of the waiver would result in the loss of those revenues. It is important to remember that the split between payors and hospitals is still unknown; thus, the extent of the damage to the waiver from this assessment is also unknown.

Background

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 September 2009, the Maryland Medicare charge per case has increased by 307% since the waiver was awarded in 1980. Nationally, the Medicare charge per case has increased by 350% since 1980. **Exhibit 7** 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.

Exhibit 7
Medicare Cost Growth
Maryland vs. National Average

	<u>1980</u>	<u>2009</u>	<u>% Change</u>
Maryland	\$2,972	\$12,095	307%
National Average	2,293	10,309	350%

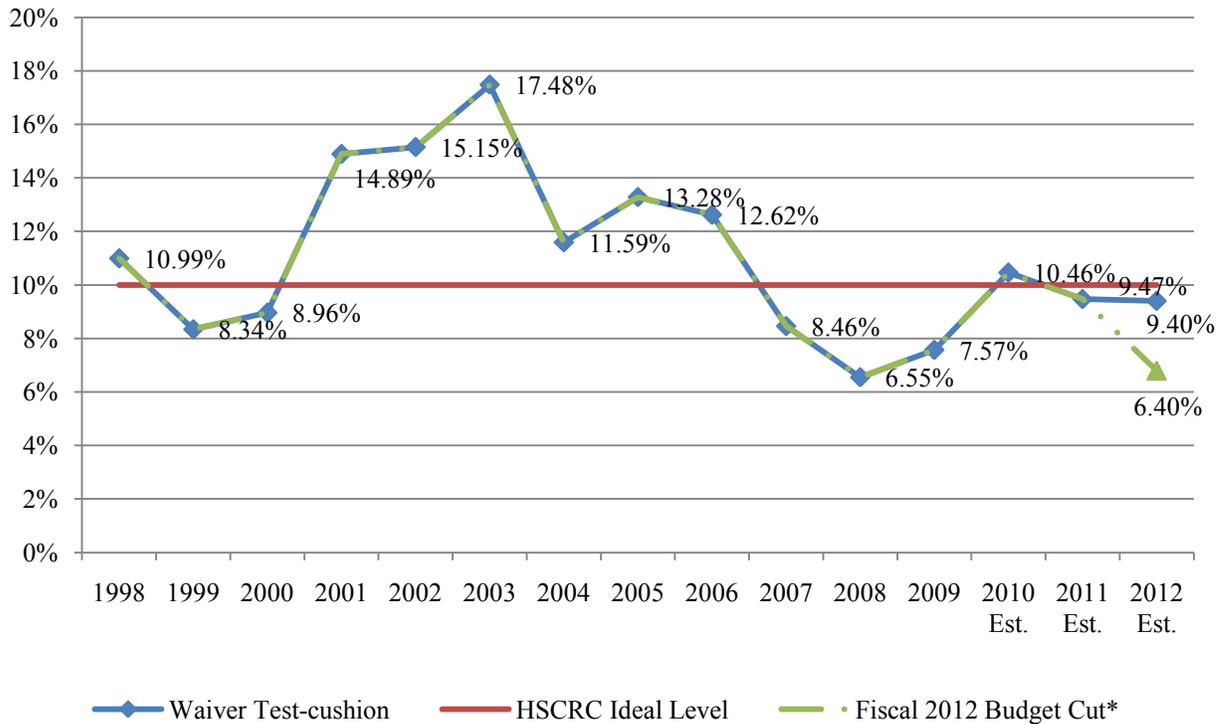
Source: Health Services Cost Review Commission

M00R – DHMH – Health Regulatory Commissions

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 8**, over the past decade, the waiver cushion has fluctuated below and above the 10.0% minimum level. Information on the national average has an 18-month lag, so the most current actual data is from fiscal 2009 when there was a cushion of 7.57%. HSCRC estimates that the cushion will improve to 10.46% in fiscal 2010 before falling to 9.47% in fiscal 2011 and even farther to 9.4% in fiscal 2012. However, if a fiscal 2012 assessment is implemented and increases hospital rates for the subsidy to the Medicaid program (approximately \$331.3 million, or 2.5%, of net patient revenues) and for any amount above the actual level of averted uncompensated care up to 1.5% of net patient revenues (approximately \$38.0 million), the waiver cushion could be reduced by 3%. The waiver impact would be reduced depending on how much is assigned to the payors through increased hospital rates.

**Exhibit 8
Medicare Waiver Cushion
Fiscal 1998-2012**



HSCRC: Health Services Cost Review Commission

*The severity of the erosion to the waiver depends on the amount of the fiscal 2012 reduction assigned to payors through increased hospital rates.

Source: Department of Health and Mental Hygiene

The agency should comment on any initial plans to implement the reduction and its implications for the Medicare waiver.

3. Healthcare-associated Infections

Background

HAIs are infections that patients acquire during the course of receiving medical treatment for other conditions. HAIs are the most common complication affecting hospitalized patients, with

between 5 and 10% of patients acquiring one or more infections during their hospitalization. According to the Centers for Disease Control and Prevention (CDC), HAIs account for an estimated 1.7 million infections and 99,000 associated deaths in annually. A 2006 Pennsylvania report showed that patients with an HAI were hospitalized for 20.6 days, compared to 4.5 days for patients without infections. Further, insurers paid almost 5.5 times the amount of money for their stay compared to patients without an HAI.¹

Four categories of infections account for approximately three quarters of HAIs in the acute care hospital setting. These include (1) surgical site infections; (2) central line-associated bloodstream infections (CLABSIs); (3) ventilator-associated pneumonia; and (4) catheter-associated urinary tract infections.

In Maryland, hospitals are required to report CLABSIs and data on Health Care Worker Seasonal Influenza Vaccination Rates to the MHCC. This data is then compiled and published in the Maryland Hospital Performance Evaluation Guide.

Public Reporting

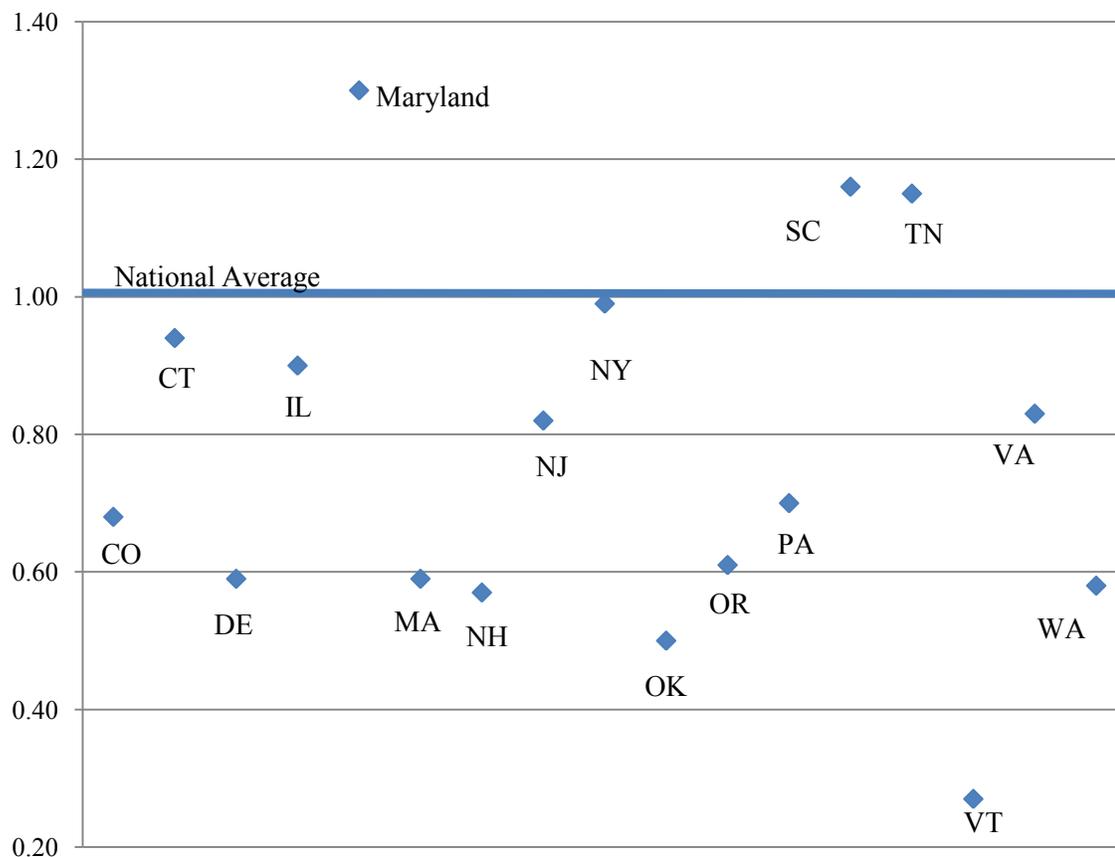
Public reporting of HAIs has grown significantly at the State level, amid the belief that promoting transparency will improve care, expand and improve infection prevention measures, reduce the morbidity and mortality associated with HAIs, and cut health care costs.

CLABSIs are one of the HAI types for which reporting is most frequently mandated by states. In fact, Maryland is 1 of 17 states that require hospitals to report CLABSIs. A recent CDC report produced by the National Healthcare Safety Network, entitled *First State-Specific Healthcare-Associated Infections Summary Data Report*, showed that Maryland has the highest rate of CLABSIs of all states that are required to report, as shown in **Exhibit 9**.

Exhibit 9 shows the Standardized Infection Ratio (SIR) for all 17 states. The SIR is used to measure the relative difference of CLABSI occurrences during the reporting period to a common referent period. Maryland has a SIR of 1.30 which indicates that there is an excess of observed CLABSIs compared to the predicted number nationally.

¹ *Lessons from the Pioneers: Reporting Healthcare-Associated Infections*, National Conference of State Legislatures

**Exhibit 9
Standardized Infection Ratio**



Source: Centers for Disease Control and Prevention

Maryland-specific Activities

In response to the significant impact that HAIs have had on both patients and the health care system, an HAI Advisory Committee was formed by MHCC in 2008 following a recommendation from MHCC’s Technical Advisory Committee on HAIs. The committee continues to meet on a regular basis to monitor initiatives in the State aimed at reducing HAIs.

Prevention Plan and Initial Activities

In January 2010, the committee developed an HAI prevention plan based on a template developed by the CDC, and focuses on four main targets: (1) develop or enhance HAI program infrastructure; (2) HAI surveillance, detection, reporting, and response; (3) prevention; and (4) evaluation, oversight, and communications. The plan focuses on acute care hospitals, but officials anticipate expanding the scope to include nursing homes, ambulatory surgical centers, and other health care providers. **Exhibit 10** below describes the major activities being undertaken.

Exhibit 10 Healthcare-associated Infection Prevention Activities

Maryland Health Care Commission (MHCC)	State law requires MHCC to collect and report data on healthcare-associated infections (HAIs) through the Maryland Hospital Performance Evaluation Guide. This guide includes measures that compare hospital performance on processes of care that are designed to prevent infections for patients undergoing surgery. The law specifies that the system for reporting data must adhere to the current recommendations of the federal Centers for Disease Control and Prevention (CDC) and the CDC Healthcare Infection Control Practices Advisory Committee regarding the public reporting of HAIs.
Infectious Disease and Environmental Health Administration (IDEHA)	IDEHA conducts surveillance for and investigates outbreaks and unusual cases of communicable diseases in Maryland's population. Maryland is one of ten states that participate in the Emerging Infections Program, a population-based network of the CDC, U.S. Department of Agriculture, Food and Drug Administration, and state health departments to assess the public health impact of emerging infections and to evaluate methods for the prevention and control.
Maryland Health Quality and Cost Council	Formed in 2007, the council is tasked with developing strategic health policy reforms to improve the health of Maryland's citizens, maximize the quality of health care services, and contain health care costs. The council has prioritized conducting a statewide hand hygiene initiative and prevention of HAIs as part of its work plan.

Source: *Maryland Healthcare-Associated Infections Prevention Plan*, Maryland Health Care Commission

Also, the Office of Health Care Quality established a new initiative in fiscal 2010 to improve quality assurance of ambulatory surgical centers by implementing a survey process to promote better infection control practices, increase the extent to which infection control deficiencies are both identified and remedied, and prevent future serious infections. While reporting by ambulatory surgical centers is not required in the State of Maryland, it does help to identify sources of HAIs in the State.

The agency should update the committees on the collections of HAIs so far and whether or not Maryland hospitals have improved.

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Patient Centered Medical Homes Initiative

The General Assembly approved legislation in the 2010 session to create a PCMH pilot program which is designed to improve health outcomes and reduce the cost of health care by elevating the role of primary care in Maryland's health system. PCMHs involves a model of practice in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care to patients. The PCMH pilot program will provide primary care physicians and nurse practitioners with financial incentives and assistance to expand access to care, promote wellness and prevention, utilize multi-disciplinary teams to treat patients, and coordinate care to improve disease management and the overall health of patients.

MHCC is tasked with facilitating the program and identifying physician groups to participate. MHCC will identify approximately 200 doctors in 50 or 60 practices serving as many as 200,000 patients. Participating practices will focus on prevention and offer extended hours, same-day appointments, and electronic communications. Practices in the program will develop management plans for those with chronic illnesses and coordinate care with specialists and pharmacies. The coordinated care is expected to translate into savings by keeping patients healthy and out of the emergency room.

In 2010, MHCC entered into a contract to train, educate, and provide transformation assistance for primary care practices that enroll in the program. The funds are available for this amendment from MHCC fee collections.

Collaboration

MCHRC is also involved with this initiative by assisting FQHCs and other primary care practices to become PCMHs and by identifying ways that its resources can leverage additional assets to support the participation of those practices in Maryland's program.

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

Now in its third year of operation, the Health Insurance Partnership has provided a subsidy for 314 businesses to offer health insurance coverage to their employees, resulting in coverage for over 1,495 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.

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

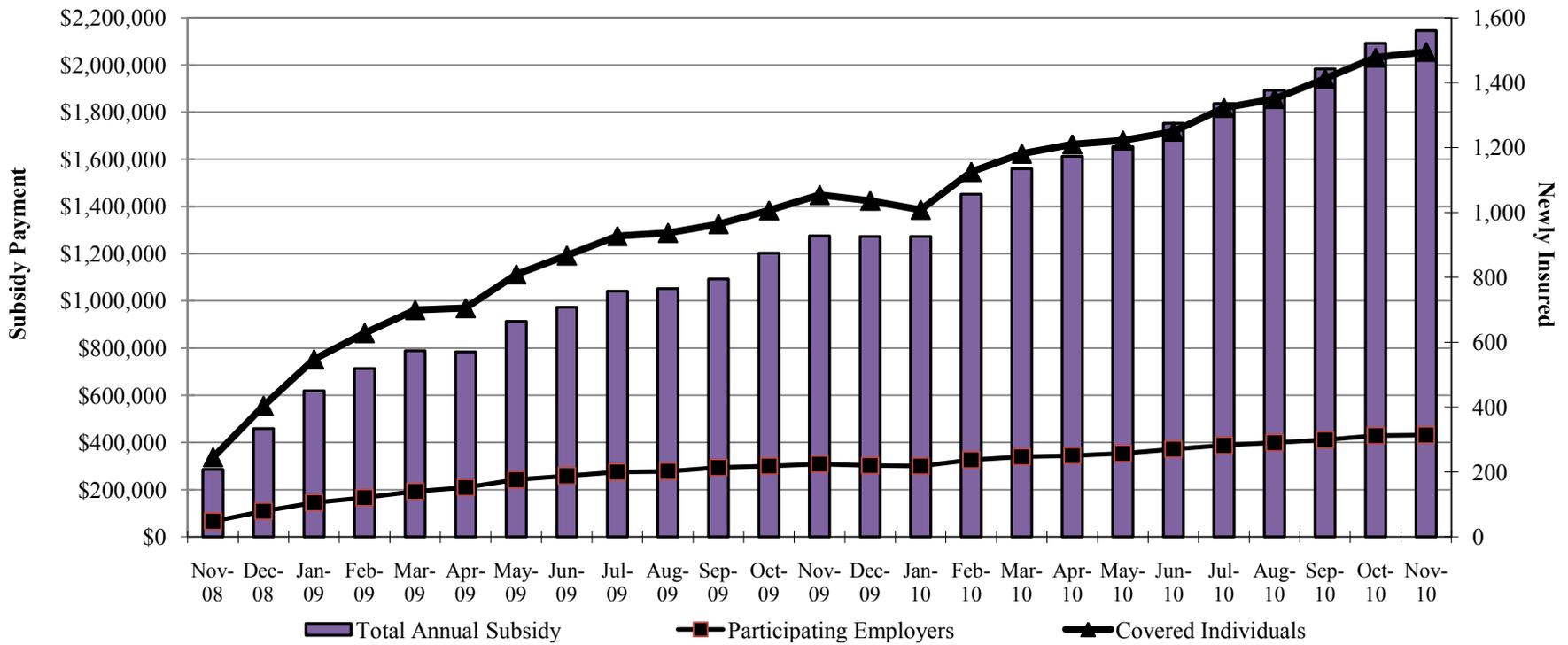
UMMS, a private nonprofit corporation, was created by legislation in 1984 to provide governance and management over the operation of the formerly State-run University of Maryland Hospital. The mission of the medical system is to provide tertiary care to the State and surrounding areas, to provide comprehensive 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 UMMS 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 11
Small Business Health Insurance Partnership
Cost and Enrollment
November 2008-Novemeber 2010



Source: Department of Health and Mental Hygiene

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.

Exhibit 12
Operating Budget Subsidy for Shock Trauma Center
Fiscal 2007-2012
(\$ in Thousands)

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011 Working</u> <u>Appropriation</u>	<u>2012</u> <u>Allowance</u>
Operating Subsidy for Shock Trauma Center	\$3,200	\$3,264	\$3,361	\$3,200	\$3,200	\$3,200

Source: Department of Legislative Services

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 2011 capital budget submitted by the Governor deferred the final installment of \$3.5 million to fiscal 2012. However, that funding is again deferred a year due to sufficient funds from prior State appropriations. Also, UMMS is building a seven-story patient care building that will expand the Shock Trauma Center and connect it to the Weinberg Building. Future funding for Shock Trauma renovations will be coordinated with this project.

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 2010					
Legislative Appropriation	\$0	\$156,185	\$0	\$0	\$156,185
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	0	329	931	189	1,449
Cost Containment	0	-274	0	0	-274
Reversions and Cancellations	0	-6,157	-325	-71	-6,553
Actual Expenditures	\$0	\$150,083	\$606	\$117	\$150,807
Fiscal 2011					
Legislative Appropriation	\$0	\$161,071	\$0	\$330	\$161,400
Budget Amendments	0	227	2,644	1,550	4,420
Working Appropriation	\$0	\$161,298	\$2,644	\$1,879	\$165,821

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

Fiscal 2010

In fiscal 2010, the budget for the Health Regulatory Commissions closed at \$150.8 million, a decrease of \$5.4 million below the original legislative appropriation. Cancellations at the end of the fiscal year account for the majority of the change in the budget.

The special fund appropriation decreased by \$6.1 million over the course of fiscal 2010 as a result of cost containment, budget amendments, and cancellations. Cost containment actions taken by the Board of Public Works reduced personnel expenses by \$0.3 million as a result of statewide employee furloughs affecting all three commissions. Two other budget amendments changed the special fund appropriation during fiscal 2010. First, the HSCRC received \$0.4 million for contractual services and personnel expenses and MCHRC received \$0.1 million for community health resource center grants. The second amendment decreased the appropriation for MHCC by \$0.2 million due to contract savings for the Nursing Home Guide Redesign project.

At the end of the year, \$6.2 million in special fund appropriation was cancelled collectively across all three commissions.

- MHCC cancelled approximately \$1.4 million as a result of low enrollment in the small business subsidy (\$0.6 million), lower than expected revenues from the Maryland Trauma fund (\$0.4 million), and delayed contractual costs and operating savings within the commission (\$0.4 million);
- HSCRC cancelled approximately \$4.7 million due to lower than anticipated collections from the Uncompensated Care Fund; and
- MCHRC cancelled approximately \$0.1 million due to grant funding that was not processed by the end of the fiscal year.

Although not included in the original legislative appropriation, MHCC received budget amendments for federal funds and reimbursable funds. The federal funds were a result of a federal grant to promote HIT through the State's HIE. Although MHCC requested \$0.9 million through the budget amendment, \$0.3 million of that appropriation was cancelled at the end of the year because of lag time getting the HIE project underway.

MHCC also received a budget amendment for reimbursable funds in the amount of \$188,527 based on funds available from the Infectious Disease and Environmental Health Administration through an ARRA grant. These funds were used for the infectious diseases cooperative agreement that aims to improve surveillance and response for infectious diseases. MHCC played an active role in drafting the State HAI disease prevention plan and establishing the State's capacity to develop HAI prevention programs. At the end of the year, \$71,166 of that appropriation was cancelled but is expected to be reappropriated in fiscal 2011.

Fiscal 2011

The fiscal 2011 working appropriation is \$165.8 million, an increase of \$4.4 million over the original legislative appropriation due to budget amendments that have been processed over the fiscal year. First, a budget amendment for the PCMH initiative increased the budget by \$0.2 million in special funds, \$2.6 million federal funds, and \$0.3 million reimbursable funds. Also, a budget amendment was processed for the Medicaid HIT program in the amount of \$1.3 million, primarily reimbursable funds received from the Medicaid program for the project.

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

<u>Object/Fund</u>	<u>FY 10 Actual</u>	<u>FY 11 Working Appropriation</u>	<u>FY 12 Allowance</u>	<u>FY 11 - FY 12 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	96.60	96.60	99.70	3.10	3.2%
Total Positions	96.60	96.60	99.70	3.10	3.2%
Objects					
01 Salaries and Wages	\$ 9,085,740	\$ 9,712,177	\$ 10,214,265	\$ 502,088	5.2%
02 Technical and Spec. Fees	25,935	42,050	31,029	-11,021	-26.2%
03 Communication	96,636	115,545	99,827	-15,718	-13.6%
04 Travel	66,913	76,245	65,137	-11,108	-14.6%
08 Contractual Services	135,259,686	150,105,217	149,963,822	-141,395	-0.1%
09 Supplies and Materials	66,869	81,343	77,182	-4,161	-5.1%
10 Equipment – Replacement	26,649	12,000	78,000	66,000	550.0%
11 Equipment – Additional	2,431	25,000	20,312	-4,688	-18.8%
12 Grants, Subsidies, and Contributions	5,762,078	5,200,000	5,300,000	100,000	1.9%
13 Fixed Charges	413,679	451,171	425,707	-25,464	-5.6%
Total Objects	\$ 150,806,616	\$ 165,820,748	\$ 166,275,281	\$ 454,533	0.3%
Funds					
03 Special Fund	\$ 150,082,805	\$ 161,297,769	\$ 162,676,772	\$ 1,379,003	0.9%
05 Federal Fund	606,451	2,643,549	3,313,924	670,375	25.4%
09 Reimbursable Fund	117,360	1,879,430	284,585	-1,594,845	-84.9%
Total Funds	\$ 150,806,616	\$ 165,820,748	\$ 166,275,281	\$ 454,533	0.3%

Note: The fiscal 2011 appropriation does not include deficiencies. The fiscal 2012 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

<u>Program/Unit</u>	<u>FY 10 Actual</u>	<u>FY 11 Wrk Approp</u>	<u>FY 12 Allowance</u>	<u>Change</u>	<u>FY 11 - FY 12 % Change</u>
01 Maryland Health Care Commission	\$ 27,210,108	\$ 32,582,607	\$ 32,271,800	-\$ 310,807	-1.0%
02 Health Services Cost Review Commission	120,600,803	130,241,404	130,853,481	612,077	0.5%
03 Maryland Community Health Resources Commission	2,995,705	2,996,737	3,150,000	153,263	5.1%
Total Expenditures	\$ 150,806,616	\$ 165,820,748	\$ 166,275,281	\$ 454,533	0.3%
Special Fund	\$ 150,082,805	\$ 161,297,769	\$ 162,676,772	\$ 1,379,003	0.9%
Federal Fund	606,451	2,643,549	3,313,924	670,375	25.4%
Total Appropriations	\$ 150,689,256	\$ 163,941,318	\$ 165,990,696	\$ 2,049,378	1.3%
Reimbursable Fund	\$ 117,360	\$ 1,879,430	\$ 284,585	-\$ 1,594,845	-84.9%
Total Funds	\$ 150,806,616	\$ 165,820,748	\$ 166,275,281	\$ 454,533	0.3%

Note: The fiscal 2011 appropriation does not include deficiencies. The fiscal 2012 allowance does not include contingent reductions.