

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

***Operating Budget Data***

(\$ in Thousands)

	<u>FY 11</u> <u>Actual</u>	<u>FY 12</u> <u>Working</u>	<u>FY 13</u> <u>Allowance</u>	<u>FY 12-13</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
Special Fund	\$144,236	\$162,658	\$162,120	-\$538	-0.3%
<b>Adjusted Special Fund</b>	<b>\$144,236</b>	<b>\$162,658</b>	<b>\$162,120</b>	<b>-\$538</b>	<b>-0.3%</b>
Federal Fund	2,644	3,314	2,800	-514	-15.5%
<b>Adjusted Federal Fund</b>	<b>\$2,644</b>	<b>\$3,314</b>	<b>\$2,800</b>	<b>-\$514</b>	<b>-15.5%</b>
Reimbursable Fund	374	285	100	-185	-64.9%
<b>Adjusted Reimbursable Fund</b>	<b>\$374</b>	<b>\$285</b>	<b>\$100</b>	<b>-\$185</b>	<b>-64.9%</b>
<b>Adjusted Grand Total</b>	<b>\$147,254</b>	<b>\$166,256</b>	<b>\$165,020</b>	<b>-\$1,236</b>	<b>-0.7%</b>

- The most significant increase in the Health Regulatory Commissions budget is \$4 million in the budget of the Maryland Community Health Resources Commission to implement Health Enterprise Zones.
- The overall decline in the Health Regulatory Commissions budget is driven by a \$5 million drop in funding for the Uncompensated Care Fund.

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

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***Personnel Data***

	<b><u>FY 11 Actual</u></b>	<b><u>FY 12 Working</u></b>	<b><u>FY 13 Allowance</u></b>	<b><u>FY 12-13 Change</u></b>
Regular Positions	95.60	98.70	99.70	1.00
Contractual FTEs	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
<b>Total Personnel</b>	<b>95.60</b>	<b>98.70</b>	<b>99.70</b>	<b>1.00</b>

***Vacancy Data: Regular Positions***

Turnover and Necessary Vacancies, Excluding New Positions	4.05	4.10%
Positions and Percentage Vacant as of 12/31/11	13.00	13.17%

- One new regular position is included in the fiscal 2013 budget. That position, in the Maryland Health Care Commission, is intended to support the commission’s efforts to implement patient centered medical homes.

## *Analysis in Brief*

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### Major Trends

**Small Group Market:** The recession has negatively impacted the ability of small employers to offer health insurance. Further, the Comprehensive Standard Health Benefit Plan became less affordable in fiscal 2011.

**Medicare Waiver:** Data reveals some increased pressure on the Medicare waiver cushion. The most recent estimate from the Health Services Cost Review Commission (HSCRC) projects a significant and alarming deterioration in that cushion.

### Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Delete 1 new position based on available vacancies.	\$ 42,464	1.0
2. Add language restricting funds for the development of Health Enterprise Zones.		
<b>Total Reductions</b>	<b>\$ 42,464</b>	<b>1.0</b>

### Updates

**Inclusion of Capital Replacement Costs in Hospital Rates:** The 2011 *Joint Chairmen's Report* included narrative requesting HSCRC to study the issue of capital replacement costs and how to include these costs in the hospital rates set by the commission. The commission submitted the report in December 2011 and is summarized in this update.

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**Health Regulatory Commissions**  
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## ***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. The agencies variously regulate the health care delivery system, monitor the price and affordability of services offered in the industry, and improve access to care for Marylanders. The three commissions are the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), and the Maryland Community Health Resources Commission (MCHRC).

MHCC, 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.

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MCHRC was established in 2005 to strengthen the safety net for uninsured and underinsured Marylanders. The safety net consists of community health resource centers (CHRC), which range from federally qualified health centers to smaller community-based clinics. MCHRC's responsibilities include:

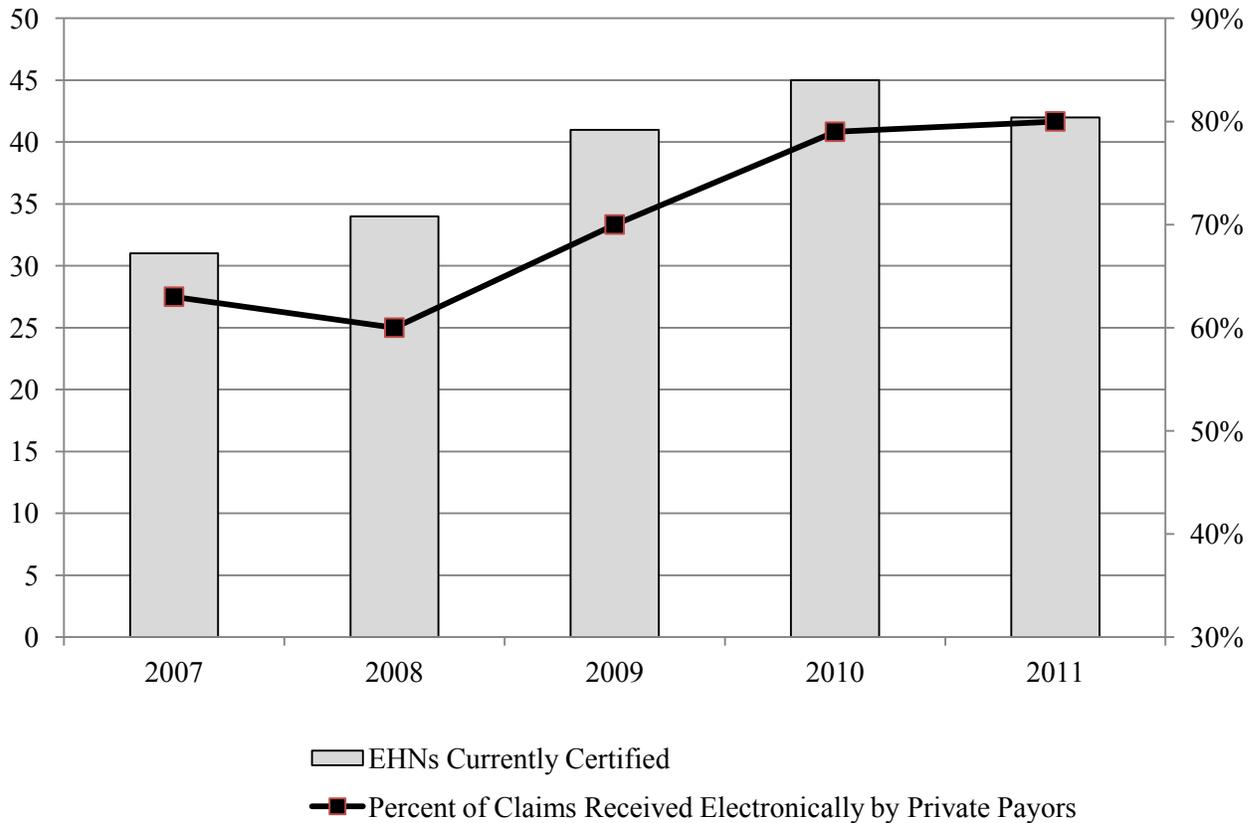
- identifying and seeking federal and State funding for the expansion of CHRCs;
- developing outreach programs to educate and inform individuals of the availability of CHRCs; and
- assisting uninsured individuals under 200% of the federal poverty level to access health care services through CHRCs.

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

One of the goals of MHCC 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 (IT); 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 shown in the exhibit, the number of EHNs in the State, which had been steadily increasing since fiscal 2007, actually fell in fiscal 2011. However, according to MHCC, EHNs are certified on a two-year cycle, and the drop reflects early certification of EHNs which can artificially influence the number of certified EHNs in any one year. In any event, the percent of claims paid electronically by private payors increase slightly to 80% in fiscal 2011.

**Exhibit 1**  
**Utilization of Electronic Health Networks in Maryland**  
**Fiscal 2007-2011**



EHN: electronic health networks

Source: Department of Health and Mental Hygiene

**Exhibit 2** presents data on the small group market. Specifically, the exhibit shows that the percentage of small employers in Maryland offering coverage has fallen to 35% in fiscal 2011. This directly relates to the recent recession. Under current law, the average premium of the Comprehensive Standard Health Benefit Plan must amount to no more than 10% of Maryland annual average wage – the so-called affordability cap. The reported Managing for Results (MFR) data noted that the average plan cost 88% of the affordability cap in fiscal 2011. However, updated data from MHCC is that the average plan cost 95% of the affordability cap. This jump reflects the additional costs associated with conforming Maryland’s insurance products to federal mandates required under the Patient Protection and Affordable Care Act.

**Exhibit 2**  
**Small Group Market – Various Data**  
**Fiscal 2007-2011**

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
% Small Employers Offering Coverage	40%	41%	39.6%	38%	35%
Average Cost of Plan as Percent of Affordability Cap	92%	93%	85%	88%	95%

Note: Data reported in the Managing for Results for the affordability gap in fiscal 2011 is 88%. The data shown here is updated data from the Maryland Health Care Commission.

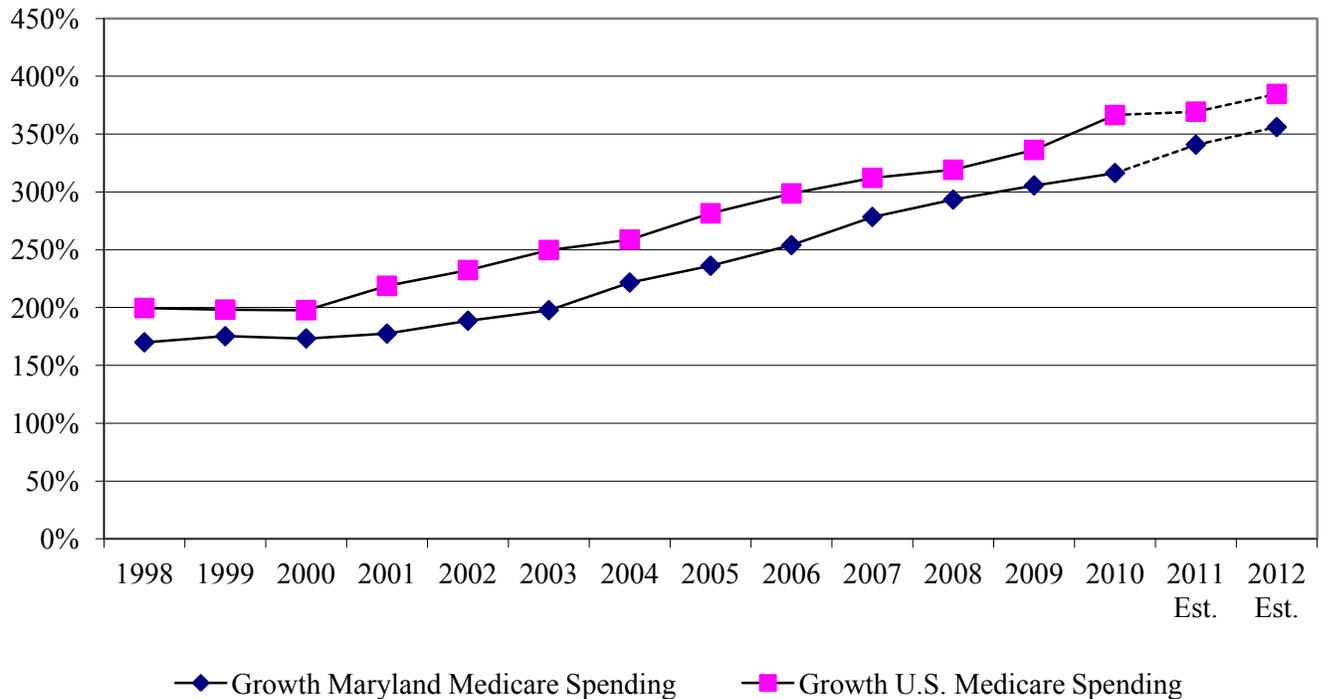
Source: Department of Health and Mental Hygiene

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HSCRC sets 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 3** 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 2010, the cumulative growth of Maryland Medicare payments has been 316.3%, compared to national growth of 366.4%. However, data presented in Exhibit 3, as estimated by HSCRC, suggests a significant narrowing of this gap in fiscal 2011 and 2012. This narrowing is attributed to a combination of things including Medicare cuts at the national level, the implementation of policies to limit the extent of one-day stays, payment reform initiatives, and the imposition of the hospital assessment to support the Medicaid program.

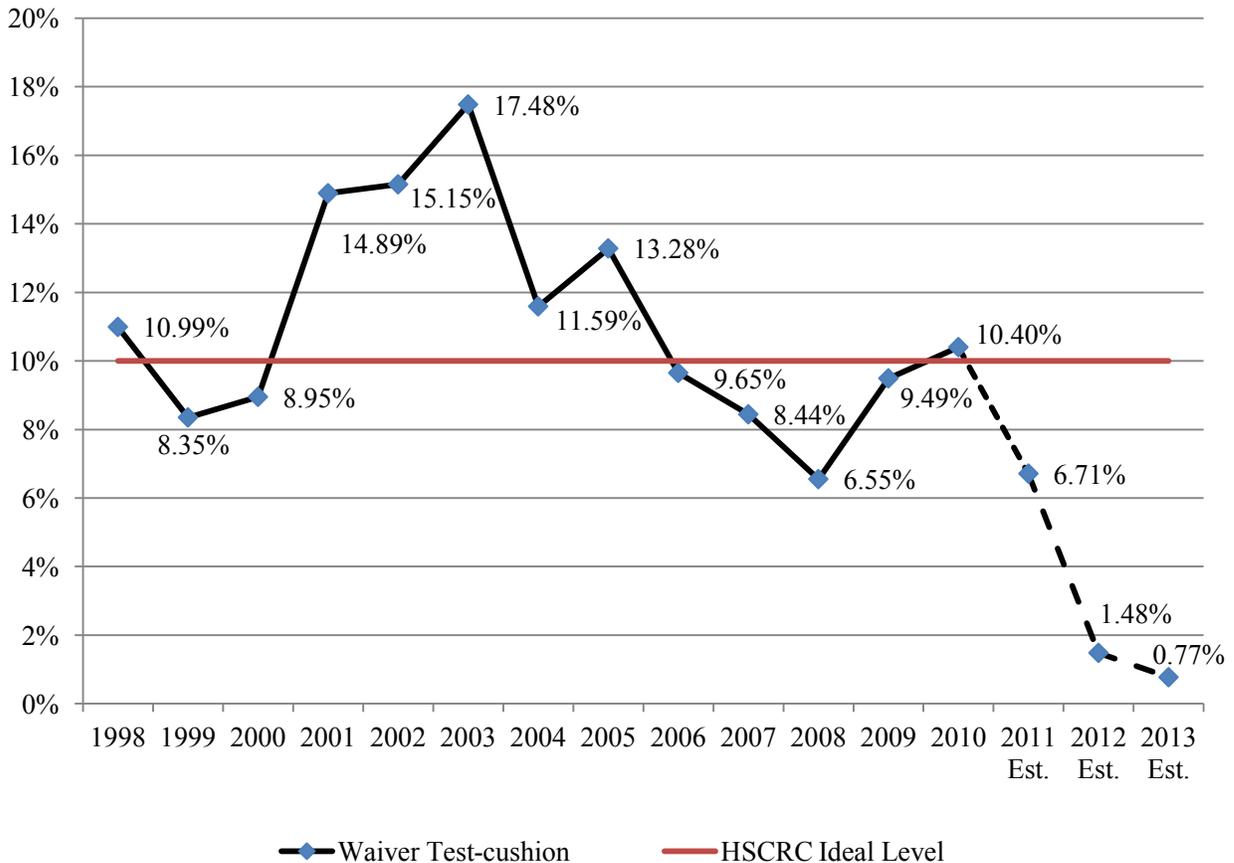
**Exhibit 3  
Medicare Growth: Maryland vs. National Average  
Fiscal 1998-2012**



Source: Department of Health and Mental Hygiene

This narrowing of the gap between cumulative Maryland and U.S. Medicare growth rates is also reflected in the primary measure used to monitor waiver performance, namely 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 10.0% is the lowest desirable level for the waiver margin; however, a margin between 12.0 to 15.0% is ideal. The larger the margin, the more flexibility HSCRC has to adjust rates while simultaneously weathering Medicare payment trends. As shown in **Exhibit 4**, 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 the end of fiscal 2010 when there was a cushion of 10.4%. For fiscal 2011 through 2013, the cushion is expected not only to slip back below 10.0% but to plummet close to 0%.

**Exhibit 4  
Medicare Waiver Cushion  
Fiscal 1998-2013**



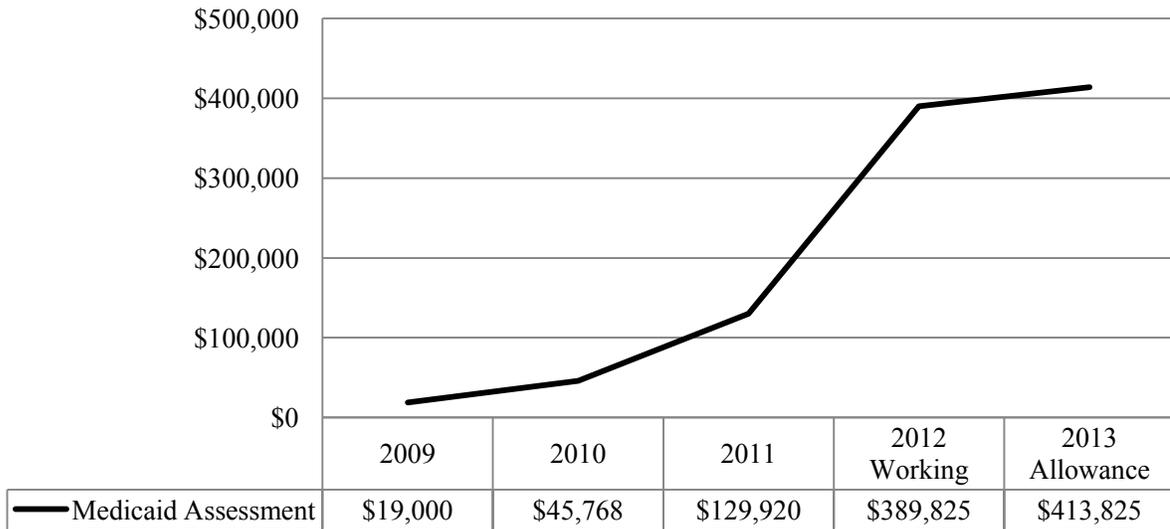
Note: Data shown are values/estimates for the end of each fiscal year.

HSCRC: Health Services Cost Review Commission

Source: Department of Health and Mental Hygiene

As understood from prior years, the budget can have some influence on the waiver cushion. To that end, the fiscal 2013 budget appears to do little to alleviate pressure on the waiver cushion. There is, as illustrated in **Exhibit 5**, a \$24 million, or 6.2% increase proposed in the Medicaid hospital assessment. While it is unknown how the HSCRC will allocate the additional \$24 million in the Medicaid assessment between the hospitals and payers, other significant cost containment actions proposed in the fiscal 2013 Medicaid budget involve additional cost-shifting from Medicaid to other payors including Medicare.

**Exhibit 5  
Medicaid Assessment Funding  
Fiscal 2009-2013  
(\$ in Thousands)**



Source: Department of Budget and Management

Ultimately, while not minimizing the fact that this cost-shifting approach is not helpful to the waiver cushion, in the long term, HSCRC’s efforts to “bend the cost curve” through other initiatives currently being implemented mean that the State will need to modify its Medicare waiver. These initiatives include:

- The implementation of a Global Payment Structure or Total Patient Revenue (TPR) system. In fiscal 2011, 10 hospitals were utilizing this payment methodology, and HSCRC is hoping that number will grow to 11 in fiscal 2013. Primarily implemented in rural hospitals, TPR involves hospitals receiving a global budget that covers all inpatient and outpatient services provided by the hospital. If the hospital can achieve increased efficiencies, contain costs, and reduce avoidable admissions and readmissions, it can retain the financial savings that it realizes. Conversely, if costs increase over the global budget amount, the hospital bears the financial risk.
- The implementation of a bundled payment admission-readmission system. HSCRC is currently negotiating with 31 hospitals to establish a 30-day window admission-readmission structure whereby hospitals will receive a single payment that covers both the initial admission and any subsequent related readmission within 30 days. Again, if hospitals can limit readmissions then they can generate savings.

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- Future initiatives include expanding the TPR model into more urban-suburban areas through so-called population-based rates.

While these initiatives are designed to reduce hospital expenditure and improve patient quality, if successful, they could also constrain or reduce growth in hospital utilization and discharges. Thus, success is likely to increase growth in Medicare payment per discharge at the same time as holding down expenditures.

HSCRC has begun exploring different measures for the waiver test and also investigating whether to broaden what is in the waiver test, for example, including both regulated costs (inpatient and outpatient as opposed to just inpatient) as well as unregulated costs (physician fees). **HSCRC should be prepared to update the committees on its discussions and any potential timeline to update the Medicare waiver to recognize the ongoing changes in payment structure.**

## **Proposed Budget**

As shown in **Exhibit 6**, the Governor's fiscal 2013 allowance for Health Regulatory Commissions declines by \$1.236 million (0.7%). Major changes are discussed below.

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**Exhibit 6**  
**Proposed Budget**  
**DHMH – Health Regulatory Commissions**  
**(\$ in Thousands)**

<b>How Much It Grows:</b>	<b>Special Fund</b>	<b>Federal Fund</b>	<b>Reimb. Fund</b>	<b>Total</b>
2012 Working Appropriation	\$162,658	\$3,314	\$285	\$166,256
2013 Allowance	<u>162,120</u>	<u>2,800</u>	<u>100</u>	<u>165,020</u>
Amount Change	-\$538	-\$514	-\$185	-\$1,236
Percent Change	-0.3%	-15.5%	-64.9%	-0.7%
Contingent Reductions	\$0	\$0	\$0	\$0
Adjusted Change	-\$538	-\$514	-\$185	-\$1,236
Adjusted Percent Change	-0.3%	-15.5%	-64.9%	-0.7%

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**Where It Goes:**

<b>Personnel Expenses</b>	<b>\$230</b>	
Turnover adjustment .....		\$165
Workers' compensation premium assessment .....		94
Employee and retiree health insurance.....		86
Retirement contributions.....		61
New position (patient centered medical homes) .....		55
Other fringe benefit adjustments .....		-30
Reclassifications.....		-50
Removal of one-time fiscal 2012 \$750 bonus.....		-67
Regular salaries .....		-84
<b>Maryland Health Care Commission</b>	<b>-\$311</b>	
Patient-centered medical homes evaluation .....		300
Small Employer Health Benefit Premium Subsidy .....		300
Medical care database contract .....		-97
Trauma Services Fund.....		-300
Health Insurance Exchange Cooperative Agreement.....		-514
<b>Health Services Cost Review Commission</b>	<b>-\$5,020</b>	
Computer software upgrades.....		66
Consulting fees.....		-86
Uncompensated Care Fund .....		-5,000
<b>Maryland Community Health Resource Commission</b>	<b>\$3,878</b>	
Health Enterprise Zones.....		4,000
Grant evaluation .....		-122
<b>Other</b> .....		-13
<b>Total</b>		<b>-\$1,236</b>

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

**Personnel**

Personnel expenditures across all three commissions increase by \$230,000, the largest component of the increase being a significant adjustment to lower the budgeted turnover rate. There is 1 new position, at a cost of \$55,000, in MHCC to assist in the ongoing implementation of patient-centered medical homes in Maryland. These and other personnel cost increases are partially offset by less funding for reclassifications (\$50,000), although it should be noted that there is still \$243,000 for reclassifications in both MHCC and HSCRC. There are also savings from the removal of the one-time fiscal 2012 \$750 bonus (\$67,000) and in regular salaries (\$84,000).

## **Maryland Health Care Commission Nonpersonnel Expenditures**

MHCC nonpersonnel expenditures decrease by \$311,000 in fiscal 2013 from fiscal 2012. Funding for consultants to evaluate the patient-centered medical home initiative increases by \$300,000. Patient-centered medical homes are designed to achieve better health outcomes, increase patient satisfaction, and lower per capita health care costs. These medical homes embody certain principles: maintenance of an ongoing patient-physician relationship; provision of care through a physician-directed team; ensuring that all patient needs are met regardless of the specific services offered by the practice; coordinating care both with other medical providers as well as nonmedical supports; improving quality through such things as the use of evidence-based care, health IT; and enhancing patient access to care. MHCC's initiative is designed to enroll 50 practices serving 200,000 patients. Payments for the three-practice pilot began in July 2011. Medicaid is also participating in this initiative.

There is a further \$300,000 increase for the Small Employer Health Benefit Premium Subsidy. Created in the 2007 special session and funded with the averted uncompensated care assessment, the subsidy assists small businesses in purchasing health insurance for their employees through the Health Insurance Partnership. As of December 2011, the partnership has enrolled 370 businesses, with 1,066 participating employees and 1,805 covered lives. While a far cry from the original utilization estimates for the program, there has been solid growth in enrollment over the past 12 months, up 20%. MHCC reported in December that in fiscal 2011 subsidy payments amounted to \$2.278 million. Based on current enrollment, it expects to spend just over \$2.5 million in subsidies in fiscal 2012, compared to a fiscal 2012 budget of \$2.0 million. The fiscal 2013 allowance is \$2.3 million. Presumably, the program will require additional funding, most likely at the expense of Medicaid.

Offsetting these increases are a variety of reductions including \$300,000 in the Maryland Trauma Physicians Services Fund program. Specifically, every other year the commission gives grants up to a value of 10% of the fund's surplus. In fiscal 2012, grant funding was budgeted at \$300,000. Fiscal 2013 is an off-year where no grants are awarded.

Additionally, there is a \$514,000 reduction in spending related to the State Health Information Exchange (HIE) Cooperative Agreement. The development of a statewide HIE is designed to create an interconnected, consumer driven, electronic health care system that enables stakeholders to securely share data, facilitate and integrate care, create efficiencies, and improve outcomes. Maryland's HIE is being implemented through the Chesapeake Regional Information System for our Patients (CRISP). CRISP is funded through a \$10 million award from HSCRC derived from the all-payor system, as well as federal grants which are budgeted in MHCC. Fiscal 2013 funding for the HIE reflects a changing focus with:

- no funding provided for the intrastate activities (a decline of almost \$2.8 million);
- an increase of almost \$1.5 million for interstate activities plus participation in the nationwide Health Information Network (preliminary work on this activity is included in the fiscal 2012 budget); and

- \$800,000 from a recently awarded Challenge Grant to integrate certain long-term care facilities into the HIE. Initial efforts are focused on six long-term care facilities that are part of the Erickson Retirement Communities, Lorien Health Systems, and Genesis Healthcare. Initially the intent is to exchange clinical summaries and medication histories between the nursing homes and acute care facilities through the HIE.

### **Health Services Cost Review Commission Nonpersonnel Expenditures**

The major change for HSCRC is lower funding (\$5 million) into the Uncompensated Care Fund. This fund is used to more fully share the costs of uncompensated care between hospitals, with hospitals that have lower than average uncompensated care paying into the fund to reduce uncompensated care for those hospitals with higher than average uncompensated care. The proposed reduction merely realigns projected spending more closely to the most recent actual.

### **Maryland Community Health Resources Commission Nonpersonnel Expenditures**

Funding for MCHRC sees an almost \$3.9 million increase in fiscal 2013. The major addition is \$4 million to implement recommendations of the Health Disparities Workgroup under the Maryland Health Quality and Cost Council. Specifically, that workgroup recommended the creation of Health Enterprise Zones (HEZ) modeled after the Harlem Children's Zone and Promise Neighborhood programs to reduce health and health care disparities, improve outcomes, and stem the rise in health care costs. In HEZ, community-based organizations apply for funds specifically to improve health in a zone. A zone can be designated using various criteria including high rates of chronic disease, health disparities, and a lack of access to primary care.

Additional parts of the HEZ model include access to the Loan Assistance Repayment Program to support existing and new primary care clinicians in an HEZ designated to receive community based funding as well as income, property and/or hiring tax credits, assistance for health IT, and other practice expenses. Ultimately, the goal of the HEZ is to work with existing providers, insurers, the public health system, nonmedical community agencies, and other stakeholders to create an integrated health care system with improved health care access.

Other recommendations of the workgroup include the Maryland Health Innovation Prize that is a financial reward for an individual, organization, or coalition with new or proven interventions and programs that have reduced health and health care disparities. MCHRC expects the prize to be privately funded. The workgroup also called for the collection of performance incentive data by race and ethnicity. Performance tracking, currently undertaken by HSCRC for hospital care and MHCC for primary care (patient-centered medical homes), does not track incentives by race or ethnicity and, therefore, there are no incentives or penalties based on race-specific or ethnic-specific performance. Adding this level of tracking, according to the workgroup, will identify areas of racial and ethnic disparities in health care quality metrics, determine whether the current race- and ethnic-neutral incentive formats improve minority health care and reduce health care disparities, and determine whether different incentive formats are required. An uncodified section of Senate Bill 234 and

House Bill 439, which formally establish the HEZ among other things, requires MHCC and HSCRC to study this issue.

One final element of change in the MCHRC budget is the reduction of \$122,000 in funding for consultants to aid the commission in reviewing applications for its available grant funding. That leaves only \$18,000 for that function. Any increase in this funding presumably would have to come out of the grants made by the commission.

## **The Budget Reconciliation and Financing Act of 2012**

There are several provisions of the Budget Reconciliation and Financing Act of 2012 that are related to the regulatory commissions:

- One provision allows for the alteration of the distribution of disproportionate share payments that generates \$9.1 million in general fund savings to Medicaid, or hospital remittances of the same amount to be used to support Medicaid, actions that produce a like amount of savings to the Medicaid program (a total fund savings of \$18.2 million), or a combination of both.

Disproportionate share hospital (DSH) is a federal program in Medicaid. Each state has a federal DSH allocation (which requires a state match) which is used to send supplemental funds to those hospitals that serve a high volume of uninsured and Medicaid patients. In Maryland, DSH is absorbed in the all-payor system. Half of the overall uncompensated care is paid through a statewide pooling mechanism (the Uncompensated Care Fund) with half built into the rates of the specific hospital that incurred the uncompensated care.

While the pooling mechanism works to equalize the impact of uncompensated care by moving funds from hospitals with a low level of uncompensated care to hospitals with a high level of uncompensated care, about half of the cost of uncompensated care is still funded through the rates of the hospitals with high levels of uncompensated care. Thus, the rate at a hospital that has higher levels of uncompensated care (typically in poorer parts of the state) will be higher than the rate of a hospital that has lower levels of uncompensated care (typically those in more affluent areas).

If the funding of uncompensated care was changed so that a greater percentage was funded via the pooling mechanism and a smaller percentage in the rates of the specific hospitals that incurred compensated care, rates at hospitals in more affluent areas (with lower Medicaid utilization) would rise while rates at hospitals in poorer areas (with greater Medicaid utilization) would fall. This would generate savings to the Medicaid program while shifting costs to those payers that tend to utilize hospitals in affluent areas to a greater degree (the privately insured and Medicare beneficiaries).

- Making \$6.6 million of fiscal 2013 special fund support for the Kidney Disease Program in Medicaid contingent on authorizing the use of revenue from a nonprofit health service plan. Absent this contingency the funding could otherwise have been used by the Senior

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Prescription Drug Assistance Program (which is anyway fully funded in the fiscal 2013 budget) or by MCHRC.

- Making \$6.2 million of fiscal 2013 special fund support for community mental health services contingent on authorizing the use of revenue from a nonprofit health service plan and adding these services to the permissible use of Carefirst revenue on a permanent basis. Absent this contingency, the funding again could otherwise have been used by MCHRC.

## ***Recommended Actions***

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	<b><u>Amount Reduction</u></b>	<b><u>Position Reduction</u></b>
1. Delete 1 new position (NEW001) based on available vacancies. The fiscal 2013 budget includes 1 new regular position in the Maryland Health Care Commission to support the implementation of the commission’s Patient Centered Medical Home initiative. However, as of January 1, 2012, the commission had 7 vacant regular positions. The commission should use 1 of those positions to support the initiative.	\$ 42,464 SF	1.0
2. Add the following language to the special fund appropriation:		

. provided that \$4,000,000 of this appropriation made for the purpose of funding Health Enterprise Zones is contingent on enactment of Senate Bill 234/House Bill 439 or other legislation authorizing the designation of Health Enterprise Zones. Further provided that the \$4,000,000 also may not be expended until the Maryland Community Health Resources Commission submits a report to the budget committees detailing how the funds will be spent. The report shall include, but not be limited to, specifics as to the criteria used in selecting Health Enterprise Zones, how funding is to be allocated, and what outcome measures and/or measurement system will be developed to monitor the progress in the Health Enterprise Zones. The budget committees shall have 45 days to review and comment on the report. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall be cancelled if the report is not submitted to the budget committees.

**Explanation:** The fiscal 2013 budget for the Maryland Community Health Resources Commission (MCHRC) includes \$4 million for the creation of Health Enterprise Zones (HEZ). HEZ are intended to reduce health and health care disparities, improve outcomes, and stem the rise in health care costs in those zones. The concept is modeled on the Harlem Children’s Zone and Promise Neighborhood programs. The language makes the appropriation contingent on legislation and withholds the funding until MCHRC provides additional detail on how the funding will be spent.

<b>Information Request</b>	<b>Author</b>	<b>Due Date</b>
Use of funding for the development of HEZ	MCHRC	45 days prior to the expenditure of funds
<b>Total Special Fund Reductions</b>		<b>\$ 42,464</b>
		<b>1.0</b>

## *Updates*

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### **1. Inclusion of Capital Replacement Costs in Hospital Rates**

The 2011 *Joint Chairmen's Report* included narrative requesting the HSCRC to study the issue of capital replacement costs and how to include these costs in the hospital rates set by the Commission. The Commission submitted the report in December 2011.

In the report, HSCRC noted that capital costs are included in hospital rates in five ways:

- Capital costs are built into the base rate. Specifically, when the commission moved to a charge-per-case system which established a per-case target that hospitals must meet for a particular rate year, a reasonable amount for capital costs was built into the base rate. That amount is included in the base rate and remains in that rate and is compounded by update factors.
- A component of the update factor is a forecast of expected “Market Basket” costs. This index of costs includes a capital component (including construction costs and equipment).
- Periodic policy adjustments to the update factor to allow for hospitals to take advantage of favorable financing markets for capital projects. According to HSCRC, \$4.4 billion of the \$5.9 billion in projects approved through the certificate of need process that occurred in hospital capital projects between fiscal 2001 and 2010 came in fiscal 2005 through 2007 when the commission included amounts in the annual update factor to take advantage of favorable financing.
- The update factor can also be adjusted on a hospital-by-hospital basis based on the commission’s Reasonableness of Charges methodology. Under this methodology, hospitals are compared to their peers to ensure that their charges are relatively reasonable and allows for adjustments for costs that are outside of the control of the hospital (including labor market, graduate medical education, case mix, disproportionate share, and capital costs). This adjustment can mitigate the potential negative impact that high capital costs could have on a hospital’s update factor.
- Finally, hospitals can attempt to obtain additional revenue to fund capital through a full or partial rate review. However, relatively few instances of this have occurred in the past decade.

The report also included comments from interested parties. Specifically:

- Hospitals argued that HSCRC policies are no longer viable sources to support capital replacement, expansion, and IT upgrades. For example, changes in the health marketplace, national constraint in Medicare payments (which add pressure to the Medicare waiver), efforts

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to reduce utilization of hospital services, as well as other factors limit the ability to fund capital costs through the current rate structure.

- Payer groups, on the other hand, argued that the current recognition of capital costs in the base update factor is adequate and that the rate structures of hospitals are adequate to generate reasonable profits and thus provide other ways to fund capital projects. Further, with utilization of inpatient services falling, the system should be looking to reduce capacity.

Ultimately, the commission argued that it includes a significant amount of capital costs in rates. This is a conclusion that was disputed in a separate letter sent from the Maryland Hospital Association to the budget chairs and chairs of the two health subcommittees of the budget committees. However, the commission also recognized in its report that the advent of new bundled payment structures may warrant the need to review its funding of capital projects in the near future, indicating that this discussion is far from over.

## *Current and Prior Year Budgets*

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### 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 2011</b>					
Legislative Appropriation	\$0	\$161,071	\$0	\$330	\$161,400
Deficiency Appropriation	0	0	0	0	0
Budget Amendments		-781	2,644	1,550	3,412
Reversions and Cancellations	0	-16,054	0	-1,505	-17,559
<b>Actual Expenditures</b>	<b>\$0</b>	<b>\$144,236</b>	<b>\$2,644</b>	<b>\$374</b>	<b>\$147,253</b>
<b>Fiscal 2012</b>					
Legislative Appropriation	\$0	\$162,560	\$3,314	\$285	\$166,158
Budget Amendments	0	98	0	0	98
<b>Working Appropriation</b>	<b>\$0</b>	<b>\$162,658</b>	<b>\$3,314</b>	<b>\$285</b>	<b>\$166,256</b>

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

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## **Fiscal 2011**

The fiscal 2011 legislative appropriation for the Health Regulatory Commissions was reduced by just over \$14.1 million. This decrease was derived as follows:

- Budget amendments added just over \$3.4 million to the legislative appropriation. Specifically:
  - Special funds were reduced by \$781,000. This reduction was driven by lower than anticipated contractual expenditures at MHCC partially offset by an increase in funding associated with the development of patient-centered medical homes and activities associated with the development of a State Medicaid Health Information Technology system.
  - The reduction in special funds was more than offset by an increase in federal and reimbursable funds also related to the development of patient-centered medical homes (over \$2.6 million federal funds and \$300,000 reimbursable funds) and activities associated with the development of a State Medicaid Health Information Technology system (almost \$1.25 million in reimbursable funds).
- Reversions and cancellations reduced the legislative appropriation by almost \$17.6 million. Of this, just over \$16.0 million was in special funds and primarily related to lower than anticipated Uncompensated Care grants (\$13.7 million) and lower than anticipated spending in a variety of areas in MHCC (\$1.8 million).

## **Fiscal 2012**

To date, the fiscal 2012 legislative appropriation for the Health Regulatory Commissions has been increased by just over \$98,000, all in special funds. Of this amount, almost \$67,000 is to support the fiscal 2012 \$750 one-time bonus for State employees across the commissions, funding originally budgeted in the Department of Budget and Management, and \$31,500 in MCHRC from a Healthy People 2020 grant to be used to fund regional meetings for the State Health Improvement Process.

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

<u>Object/Fund</u>	<u>FY 11 Actual</u>	<u>FY 12 Working Appropriation</u>	<u>FY 13 Allowance</u>	<u>FY 12 - FY 13 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	95.60	98.70	99.70	1.00	1.0%
<b>Total Positions</b>	<b>95.60</b>	<b>98.70</b>	<b>99.70</b>	<b>1.00</b>	<b>1.0%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 9,115,930	\$ 10,180,344	\$ 10,410,598	\$ 230,254	2.3%
02 Technical and Spec. Fees	22,865	31,029	28,040	-2,989	-9.6%
03 Communication	70,604	99,827	88,813	-11,014	-11.0%
04 Travel	66,763	65,137	96,979	31,842	48.9%
08 Contractual Services	132,200,483	149,978,822	144,797,350	-5,181,472	-3.5%
09 Supplies and Materials	70,303	77,182	75,404	-1,778	-2.3%
10 Equipment – Replacement	51,946	78,000	41,000	-37,000	-47.4%
11 Equipment – Additional	10,802	20,312	47,303	26,991	132.9%
12 Grants, Subsidies, and Contributions	5,207,761	5,300,000	9,000,000	3,700,000	69.8%
13 Fixed Charges	436,076	425,707	434,523	8,816	2.1%
<b>Total Objects</b>	<b>\$ 147,253,533</b>	<b>\$ 166,256,360</b>	<b>\$ 165,020,010</b>	<b>-\$ 1,236,350</b>	<b>-0.7%</b>
<b>Funds</b>					
03 Special Fund	\$ 144,235,606	\$ 162,657,851	\$ 162,120,010	-\$ 537,841	-0.3%
05 Federal Fund	2,643,543	3,313,924	2,800,000	-513,924	-15.5%
09 Reimbursable Fund	374,384	284,585	100,000	-184,585	-64.9%
<b>Total Funds</b>	<b>\$ 147,253,533</b>	<b>\$ 166,256,360</b>	<b>\$ 165,020,010</b>	<b>-\$ 1,236,350</b>	<b>-0.7%</b>

Note: The fiscal 2012 appropriation does not include deficiencies.

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

<u>Program/Unit</u>	<u>FY 11 Actual</u>	<u>FY 12 Wrk Approp</u>	<u>FY 13 Allowance</u>	<u>Change</u>	<u>FY 12 - FY 13 % Change</u>
01 Maryland Health Care Commission	\$ 28,261,217	\$ 32,216,520	\$ 31,944,172	-\$ 272,348	-0.8%
02 Health Services Cost Review Commission	116,217,018	130,857,618	126,075,838	-4,781,780	-3.7%
03 Maryland Community Health Resources Commission	2,775,298	3,182,222	7,000,000	3,817,778	120.0%
<b>Total Expenditures</b>	<b>\$ 147,253,533</b>	<b>\$ 166,256,360</b>	<b>\$ 165,020,010</b>	<b>-\$ 1,236,350</b>	<b>-0.7%</b>
Special Fund	\$ 144,235,606	\$ 162,657,851	\$ 162,120,010	-\$ 537,841	-0.3%
Federal Fund	2,643,543	3,313,924	2,800,000	-513,924	-15.5%
<b>Total Appropriations</b>	<b>\$ 146,879,149</b>	<b>\$ 165,971,775</b>	<b>\$ 164,920,010</b>	<b>-\$ 1,051,765</b>	<b>-0.6%</b>
Reimbursable Fund	\$ 374,384	\$ 284,585	\$ 100,000	-\$ 184,585	-64.9%
<b>Total Funds</b>	<b>\$ 147,253,533</b>	<b>\$ 166,256,360</b>	<b>\$ 165,020,010</b>	<b>-\$ 1,236,350</b>	<b>-0.7%</b>

Note: The fiscal 2012 appropriation does not include deficiencies.