M00R01
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 14 Actual	FY 15 Working	FY 16 Allowance	FY 15-16 Change	% Change Prior Year
General Fund	$91	$0	$0	$0	
Adjusted General Fund	**$91**	**$0**	**$0**	**$0**	
Special Fund	179,545	203,344	198,721	-4,623	-2.3%
Deficiencies and Reductions	0	0	-351	-351	
Adjusted Special Fund	**$179,545**	**$203,344**	**$198,370**	**-$4,974**	**-2.4%**
Federal Fund	1,575	3,132	228	-2,904	-92.7%
Adjusted Federal Fund	**$1,575**	**$3,132**	**$228**	**-$2,904**	**-92.7%**
Reimbursable Fund	346	0	173	173	
Adjusted Reimbursable Fund	**$346**	**$0**	**$173**	**$173**	
Adjusted Grand Total	**$181,557**	**$206,476**	**$198,770**	**-$7,706**	**-3.7%**

Note: The fiscal 2015 working appropriation reflects deficiencies and the Board of Public Works reductions to the extent that they can be identified by program. The fiscal 2016 allowance reflects back of the bill and contingent reductions to the extent that they can be identified by program.

- The fiscal 2016 allowance for the Health Regulatory Commissions decreases by $7.7 million, or -3.7%, net of contingent and across-the-board reductions. This is mainly due to funding added through budget amendments in fiscal 2015 not being carried over into fiscal 2016.

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

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Personnel Data

	FY 14 Actual	FY 15 Working	FY 16 Allowance	FY 15-16 Change
Regular Positions	99.70	103.70	103.70	0.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**99.70**	**103.70**	**103.70**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.63	4.46%
Positions and Percentage Vacant as of 12/31/14	9.80	9.45%

- There are no new positions in the allowance for the Health Regulatory Commissions.

- Turnover expectancy is decreased to 4.46% in the allowance, which requires the agency to maintain 5.0 vacant positions throughout the year. As of December 31, 2014, there were 9.8 vacant positions, or 9.45%.

Analysis in Brief

Major Trends

Use of Electronic Data Exchange Continues to Grow: Use of the State-designated Health Information Exchange (HIE) is increasing. The HIE is intended to make electronic health records and health information available in a secure environment to providers and patients.

Health Enterprise Zones: All five Health Enterprise Zones have seen a reduction in both hospital admissions as well as readmission rates.

Issues

Implementation of Maryland's Medicare All-payer Waiver: On January 1, 2014, Maryland entered into a new all-payer contract with the federal government which established new goals that the State must meet in order to maintain its Medicare all-payer waiver. These goals included placing all Maryland hospitals under global budgets in order to cap cost growth, as well as improvements in certain health outcomes, which include lowering hospital readmission rates and potentially preventable hospital acquired conditions. **The Health Services Cost Review Commission should comment on how it plans to reduce readmissions within the waiver test, what plans it may have for the remaining coordination support funds, and what if any new outreach programs it has planned for Phase II.**

Recommended Actions

1. Concur with Governor's allowance.

M00R01
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). 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 services 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.

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:

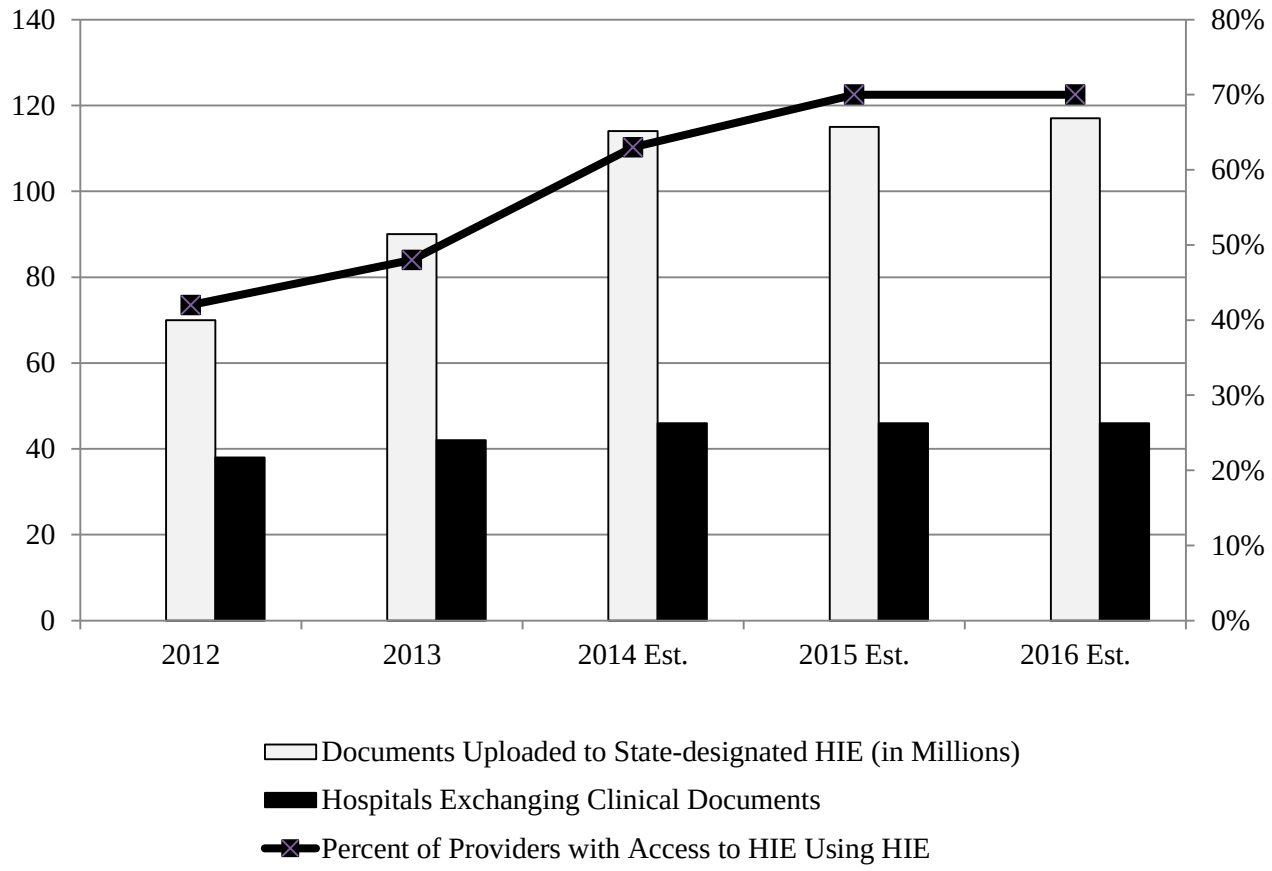
- identifying and seeking federal and State funding for the expansion of CHRCs;
- developing outreach programs to educate and inform individuals of the availability of CHRCs;
- assisting uninsured individuals under 200% of the federal poverty level (FPL) to access health care services through CHRCs; and
- overseeing the implementation of the Health Enterprise Zones (HEZ) established in Chapter 3 of 2012.

Performance Analysis: Managing for Results

1. Use of Electronic Data Exchange Continues to Grow

One of the goals of MHCC is to reduce the rate of growth in health care spending in Maryland. One strategy to lower costs is eliminating unnecessary administrative expenses through the adoption of an electronic data exchange. A new Managing for Results measure around this strategy was adopted in the fiscal 2014 budget which measures the utilization of the State Health Information Exchange (HIE). Maryland's designated HIE is the Chesapeake Regional Information System for our Patients (CRISP), which is charged with making electronic health records and health information available in a secure environment to providers and patients. **Exhibit 1** shows the number of documents uploaded to the HIE, the number of hospitals exchanging clinical documents, and the percentage of those providers who have access to the HIE who utilize it. As displayed in the exhibit, the use of the HIE continues to grow as a higher proportion of providers with access to the HIE use the system.

Exhibit 1
Utilization of State-designated HIE
Calendar 2012-2016 Est.



HIE: Health Information Exchange

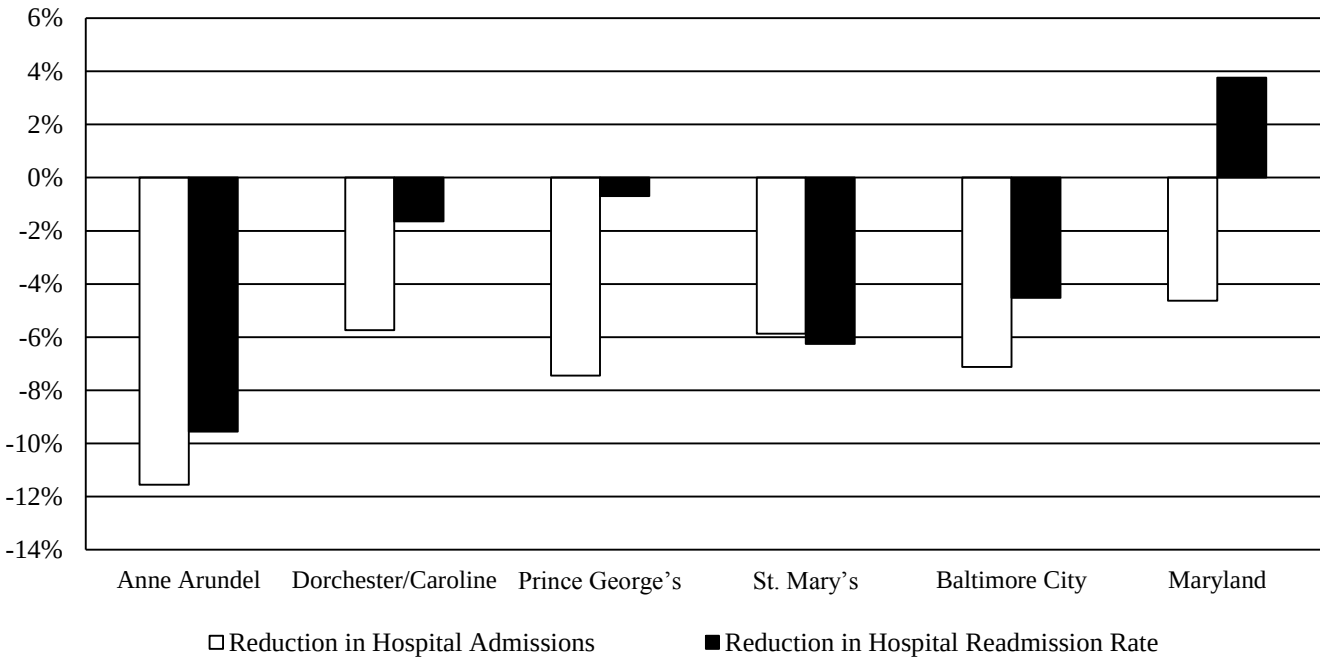
Source: Department of Health and Mental Hygiene

2. Health Enterprise Zones

Health Enterprise Zones (HEZ) were established in Chapter 3 of 2012 with the goals to (1) reduce health disparities; (2) improve health outcomes; and (3) reduce health costs and hospital admissions and readmissions in specific areas of the State. Currently, there are five HEZs in the State, which each focus on a specific part of the following jurisdictions: Anne Arundel County, Dorchester and Caroline counties, Prince George's County, St. Mary's County, and Baltimore City.

Exhibit 2 provides data on the reduction in hospital admissions and readmission rates in the five HEZs as compared to the State. Between calendar 2012 and 2013, each of the HEZs had a larger decline in the amount of hospital admissions per 1,000 than the statewide average, with the largest decline occurring in Anne Arundel County at 11.3%. All of the HEZs also saw larger declines in the hospital readmission rate within that zone as compared to the statewide readmission rate, again with the largest decline occurring in Anne Arundel County at 9.6%.

Exhibit 2
Health Enterprise Zones
Proportional Reduction in Hospital Admissions and Readmission Rates
Calendar 2012-2013



Source: Maryland Community Health Resources Commission

Fiscal 2015 Actions

Cost Containment

On January 7, 2015, the Governor proposed, and the Board of Public Works adopted, $205.3 million in reductions to the fiscal 2015 appropriation. Within these reductions, $3.0 million in general funds were removed and substituted with special funds from MCHRC for behavioral health services to the uninsured. These funds came out of the fund balance of the MCHRC.

Proposed Budget

As seen in **Exhibit 3**, the total appropriation for the Health Regulatory Commissions decreases by $7.7 million below the working appropriation net of all contingent and across-the-board reductions.

Exhibit 3
Proposed Budget
DHMH – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2014 Actual	$179,545	$1,575	$346	$181,557
Fiscal 2015 Working Appropriation	203,344	3,132	0	206,476
Fiscal 2016 Allowance	198,370	228	173	198,770
Fiscal 2015-2016 Amt. Change	-$4,974	-$2,904	$173	-$7,706
Fiscal 2015-2016 Percent Change	-2.4%	-92.7%		-3.7%

Where It Goes:

Personnel Expenses	
Increments and other compensation (prior to cost containment)	$507
Employee and retiree health insurance	301
Retirement contributions	208
Miscellaneous and additional salary adjustments	50
Social Security contributions	40
Workers' compensation adjustments	37
Turnover adjustments	22
Other fringe benefit adjustments	1
Section 21: abolition of employee increments	-138
Section 20: 2% pay reduction	-213
Maryland Health Care Commission	
Medical Care Database	227
Audit contractor	85
Small Employer Health Benefit Subsidy	-1,600
Expiring budget amendments (see text for details)	-7,404
Health Services Cost Review Commission	
Outside consulting contracts	205
Data processing	-186

Where It Goes:	
Maryland Community Health Resources Commission	
Operating grants	158
Health Enterprise Zone grants	-102
Other	96
Total	**-$7,706**

Note: Numbers may not sum to total due to rounding. The fiscal 2015 working appropriation reflects deficiencies and the Board of Public Works reductions to the extent that they can be identified by program. The fiscal 2016 allowance reflects back of the bill and contingent reductions to the extent that they can be identified by program.

Cost Containment

In fiscal 2016, the Administration has implemented several across-the-board reductions. This includes the elimination of employee increments and a 2% pay reduction, effective July 1, 2015. This agency's share of these reductions is $138,121 and $212,813, respectively.

Personnel

Personnel costs for the commissions increase by $1,165,855 before the cost containment actions. The largest increases are for increments and other salary adjustments (prior to cost containment), totaling $507,164. Other large increases include payments for employee and retiree health insurance, totaling $301,164, as well as retirement contributions, totaling $208,297. There is also an increase of $49,886 in additional salary adjustments and reclassification appropriations.

Other Changes

Most of the other large changes are contained in the MHCC budget. The largest increase is $227,000 for the Medical Care Database. However, these increases are more than offset by large decreases: $1.6 million due to the end of the Small Employer Health Benefit Subsidy given the availability of the Small Business Health Options Program in the Maryland Health Benefits Exchange; and $7.4 million in costs associated with various grants and other programs that were added midyear through budget amendments but are either not currently reflected in the allowance or are no longer expected to continue. This $7.4 million consists of $4.5 million in special funds to cover the cost of a contract with CRISP to perform work related to the HIE for the hospitals in the State, as well as $2.9 million in federal funds which are part of a grant for MHCC to cover the cost for the Health Insurance Premium Review and are related to the Affordable Care Act.

Issues

1. Implementation of Maryland's Medicare All-payer Waiver

Maryland is the only state with an all-payer, rate-regulated hospital financing system. The authority of HSCRC to standardize rates for all payers, including Medicare and Medicaid, was established in 1980 by federal legislation. Prior to January 1, 2014, to maintain the waiver, the cumulative rate of growth in Medicare inpatient per admission costs at Maryland hospitals from 1981 to the present had to remain no greater than the cumulative rate of growth in Medicare inpatient per admission costs at hospitals nationally over the same time period.

As has been discussed in prior budget analyses, according to HSCRC, the drive for efficiency in health care has shifted from seeking to reduce resource use within an individual hospital stay to managing episodes of care across multiple settings and placing additional focus on prevention and population health. HSCRC has adopted rate-setting methodologies to encourage improved provision of services across settings by reducing preventable readmissions and providing capped revenue for hospital services to encourage provision of care at lower levels of acuity. Unfortunately, these methodologies, while promoting best practices, worked at cross-purposes in terms of the waiver test and its focus on Medicare per admission costs.

Thus, since 2012, HSCRC worked with payers, DHMH, and hospitals to modernize the waiver to align the incentives in the State's hospital financing system with improved quality, improved population health, and lower growth in the cost of care. Based on these discussions, HSCRC prepared a model design proposal for the federal Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation.

The Maryland All-payer Model Contract

After a process that included a draft proposal, stakeholder input, and changes to the original draft proposal, Maryland and the federal government agreed to a new five-year demonstration model, which began on January 1, 2014. The model includes the following major components:

- **All-payer Total Hospital Cost Growth Ceiling:** Maryland will limit inpatient and outpatient hospital cost growth for all payers to a trend based on the State's average 10-year compound annual gross State product per capita between 2003 and 2012 (3.58% for the first 3 years of the demonstration). After year 3, the State may adjust the overall cap based on updated data. The model agreement also allows the State to seek adjustments to the target based on per capita increases considered unrelated to the model, for example, a disease outbreak or the construction of a new hospital facility in Prince George's County. Adjustment is at the sole discretion of CMS.

- **Medicare Total Hospital Cost Growth Ceiling:** Maryland has agreed to limit Medicare per beneficiary total hospital cost growth (inpatient and outpatient), setting a per beneficiary

spending target sufficient to produce $330.0 million in cumulative Medicare savings over 5 years. Savings will be calculated by establishing a baseline of the actual Medicare per beneficiary total hospital expenditures for Maryland Medicare fee-for-service (FFS) beneficiaries in 2013, trending forward by the national average growth rate in Medicare per beneficiary expenditures in each year of the model, and comparing Maryland's annual Medicare per beneficiary total hospital expenditures to that baseline. The $330.0 million in cumulative savings represents a spending rate that is at the national trend in year 1 and approximately 0.5% below the national trend in years 2 through 5.

Again, adjustments to the Medicare savings calculation are permitted to be made under various circumstances, at the discretion of CMS.

- **Population-based Revenue:** Hospital reimbursement has shifted from a per-case system to a population-based system: defined as directly population-based, *i.e.*, hospital reimbursement tied to the projected services of a specified population of residents, or a fixed global budget for hospitals for services unconnected to the assignment of a specific population. There are various payment models currently used by HSCRC that meet this definition, and others could be developed and utilized. Examples of current payment models which meet this description include Total Patient Revenue payments, which began in 10 predominantly rural hospitals in fiscal 2011 and which guarantee fixed inpatient and outpatient revenue levels regardless of volume.

  Initially, HSCRC had agreed under the contract to have 80% of all hospital-based revenue into population-based models by year 5 of the contract. However, all hospitals agreed to global budgets which began on July 1, 2014, and these global budgets already include approximately 95% of all hospital revenue.

- **Reduction of Hospital Readmissions:** Maryland must reduce its Medicare readmission rate over five years. Specifically, the aggregate Medicare 30-day readmission rate by year 5 is equal to or less than the national readmission rate for Medicare FFS beneficiaries.

- **Reduction of Hospital Acquired Conditions:** Maryland will achieve an annual aggregate reduction of 6.89% across all potentially preventable conditions measures that comprise Maryland's Hospital Acquired Condition program. This represents a cumulative reduction of 30.0% over five years.

- **Medical Education Innovation:** Maryland must develop a five-year plan for medical and health professional schools to serve as a nationwide model for transformation initiatives.

- **Regulated Revenue at Risk:** Maryland must ensure that the aggregate percentage of regulated revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include readmissions, hospital acquired conditions, and value-based purchasing programs.

During the course of the waiver, a so-called triggering event could lead CMS to send the State a warning notice and potentially require a corrective action plan (see **Exhibit 4**). Unsurprisingly, as noted in the exhibit, while the new all-payer model seeks to generate savings for all payers, the focus of CMS's concerns is very much on trends related to Medicare.

Exhibit 4
Maryland All-payer Model Contract: Triggering Events

Triggering Event
The State has not produced aggregate savings in Medicare per beneficiary hospital expenditures for Maryland resident fee-for-service beneficiaries for two consecutive years.
The State has failed to meet the cumulative Medicare savings targets by more than $100 million.
The annual growth rate in Medicare per beneficiary total cost of care for Maryland residents is greater than 1.0 percentage point above the annual national Medicare per beneficiary total cost of care during a single year.
Beginning in year 2 of the model, the annual growth rate in Medicare per beneficiary total cost of care for Maryland residents (regardless of state of service) is greater than the annual national Medicare per beneficiary total cost of care growth rate for two consecutive years.
The percentage of hospital revenue attributable to nonresident Medicare beneficiaries is 1.5 percentage points above the percentage level of calendar 2013.
A determination by CMS that the quality of care to Medicare, Medicaid, and MCHP recipients has deteriorated.

CMS: Centers for Medicare and Medicaid Services
MCHP: Maryland Children's Health Program

Source: Maryland All-payer Model Agreement, February 2014

Implementation activities for the new contract began in late 2013, including the convening of an advisory council to provide broad input on guiding principles to consider in implementing new payment systems. During Phase I of the demonstration, four workgroups were convened on specific methodological issues and policy questions to provide advice on long-term policy changes. The four workgroups were each designed around the following topics:

- global budgets and payment models;
- performance measurement changes to reflect new all-payer model requirements;
- overview of physician engagement and alignment needs; and
- data and infrastructure strategy.

In early January 2015, three of the workgroups held a joint briefing with public comment on the cost of defensive medicine and how it could impact the new all-payer model. A report on this and other workgroup activities is expected in February 2015.

New Medicare Waiver Test and Metrics

Initial data and performance under the new waiver is shown in **Exhibit 5**. The most noticeable trait is that the reduction in hospital readmission rates is below the goal established. So far, while readmissions have been declining, they are not meeting the targets that HSCRC had set out to achieve. In particular, the Medicare FFS decline is down only 1.63%, while the all-payer rate is down 4.04%.

Exhibit 5
Medicare Waiver Metrics

	Goal	Year 1 (2014)*
Per Capita All-payer Revenue Growth	< or = 3.58%	1.17%
Maryland Per Beneficiary Medicare FFS Revenue Growth	Maryland < National	-1.55%
Medicare FFS Per Beneficiary Growth Comparison	Maryland < or = National Year 1	TBD
	Maryland < National over 5 Years	TBD
Cumulative Medicare Savings Year 1	$0m	TBD
Cumulative Medicare Savings over Five Years	$330m	TBD
Reduction in Hospital Readmissions	-6.76%	-4.04%
Reduction in Hospital Acquired Conditions	-6.89%	-27.12%

FFS: Fee-for-service
TBD: to be determined

* 2014 data only through November 2014.

Source: Health Services Cost Review Commission

HSCRC has indicated that they are continuing to monitor this issue and are considering ways to address this, including using the $15 million from the Budget Reconciliation and Financing Act of 2015 to provide support for more care coordination and outreach into the community to help with readmissions. Of the $15 million, only approximately $2 million has been used to provide funding for 10 or more regional planning efforts to develop care coordination projects in the community. While most of the data is still limited given that the demonstration only recently finished its first year, close monitoring of performance relative to goals is important since failure on some or all of these measures could lead to the federal government rescinding the waiver, which brings in approximately $1.8 billion in higher revenues to the State.

Moving on to Phase II

Now that the majority of hospital revenue is under the global budget structure, HSCRC is moving on to Phase II of the demonstration. This phase will focus on clinical improvement and infrastructure issues, with a primary focus on coordinating and integrating care and improving community-based care to reduce hospitalizations.

HSCRC should comment on how it plans to reduce readmissions within the waiver test, what plans it may have for the remaining coordination support funds, and what if any new outreach programs it has planned for Phase II.

Recommended Actions

1. Concur with Governor's allowance.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2014					
Legislative Appropriation	$0	$174,946	$927	$0	$175,873
Deficiency Appropriation	0	5,525	0	0	5,525
Budget Amendments	91	867	1,604	437	2,999
Reversions and Cancellations	0	-1,793	-955	-91	-2,840
Actual Expenditures	**$91**	**$179,545**	**$1,575**	**$346**	**$181,557**
Fiscal 2015					
Legislative Appropriation	$0	$198,616	$0	$0	$198,616
Cost Containment	0	0	0	0	0
Budget Amendments	0	4,728	3,132	0	7,861
Working Appropriation	**$0**	**$203,344**	**$3,132**	**$0**	**$206,476**

Note: Numbers may not sum to total due to rounding. The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies.

Fiscal 2014

Actual expenditures for the Health Regulatory Commissions were $5,684,052 above the legislative appropriation. This increase was derived as follows.

Deficiency appropriations added $5,525,179 in special funds, including $600,000 for MHCC for grants payable from the Trauma Physician Services Fund and for the Small Employer Health Benefit Premium Subsidy Program, as well as $5,145,824 for HSCRC to cover increased uncompensated care payments. These were partially offset by a decrease of $220,645 in special funds related to lower payments for health insurance and retirement contributions.

Budget amendments added $2,999,170, including $91,000 in general funds, $867,073 in special funds, $1,603,670 in federal funds, and $437,427 in reimbursable funds. The general fund increase of $91,000 represents funding that was originally budgeted in the Office of the Secretary to develop an Advance Directive Registry. There were numerous special fund increases, including $182,795 relating to the fiscal 2014 cost-of-living adjustment (COLA) and increments approved in the 2013 session but not included in the original allowance, $8,767 related to the realignment of the Department of Information Technology and the State Retirement Agency administrative fees, $125,511 for various HEZ and safety net grant activities, and $550,000 in increased contract costs related to the implementation of the all-payer model. The federal fund increase of $1,603,670 was for new grant money to improve health information technology and transparency programs. Reimbursable fund increases included $387,427 to expand the All-payer Claims Database in conjunction with the Maryland Health Benefit Exchange, as well as $50,000 to cover the costs of a joint study on the health care workforce in Maryland with other State agencies.

Cancellations totaled $2,840,297, including $1,793,490 in special funds, $955,395 in federal funds, and $91,412 in reimbursable funds, mainly due to unspent funds from the uncompensated care fund as well as decreased expenditures for federal grant projects.

Fiscal 2015

To date, the working appropriation for the commissions has increased by a total of $7,860,790, including $4,728,372 in special funds and $3,132,418 in federal funds. The largest special fund increase is $4,500,000 for MHCC to cover the cost of a contract with CRISP to perform work related to the HIE for the hospitals in the State. There is also a $123,199 increase in special funds for MCHRC to hire an administrator position, as well as fund a contract with Johns Hopkins to evaluate the HEZ program. The balance of the special funds, totaling $105,173, is for the 2015 COLA. All of the federal fund increase is tied to a grant for MHCC to cover the cost for the Health Insurance Premium Review and are related to the Affordable Care Act.

Object/Fund Difference Report
DHMH – Health Regulatory Commissions

Object/Fund	FY 14 Actual	FY 15 Working Appropriation	FY 16 Allowance	FY 15 - FY 16 Amount Change	Percent Change
Positions					
01 Regular	99.70	103.70	103.70	0.00	0%
Total Positions	**99.70**	**103.70**	**103.70**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$ 10,941,524	$ 12,206,082	$ 13,371,937	$ 1,165,855	9.6%
02 Technical and Spec. Fees	26,959	34,233	36,158	1,925	5.6%
03 Communication	75,660	87,090	94,365	7,275	8.4%
04 Travel	94,375	158,570	211,781	53,211	33.6%
08 Contractual Services	159,556,963	182,663,181	173,847,493	-8,815,688	-4.8%
09 Supplies and Materials	77,752	79,553	81,694	2,141	2.7%
10 Equipment – Replacement	29,659	21,600	50,495	28,895	133.8%
11 Equipment – Additional	54,926	354,800	168,800	-186,000	-52.4%
12 Grants, Subsidies, and Contributions	10,287,381	10,394,643	10,750,106	355,463	3.4%
13 Fixed Charges	411,910	476,632	508,425	31,793	6.7%
Total Objects	**$ 181,557,109**	**$ 206,476,384**	**$ 199,121,254**	**-$ 7,355,130**	**-3.6%**
Funds					
01 General Fund	$ 91,000	$ 0	$ 0	$ 0	0.0%
03 Special Fund	179,545,059	203,343,966	198,720,636	-4,623,330	-2.3%
05 Federal Fund	1,575,035	3,132,418	228,118	-2,904,300	-92.7%
09 Reimbursable Fund	346,015	0	172,500	172,500	N/A
Total Funds	**$ 181,557,109**	**$ 206,476,384**	**$ 199,121,254**	**-$ 7,355,130**	**-3.6%**

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. The fiscal 2016 allowance does not reflect contingent or across-the-board reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

Program/Unit	FY 14 Actual	FY 15 Wrk Approp	FY 16 Allowance	Change	FY 15 - FY 16 % Change
01 Maryland Health Care Commission	$ 32,469,662	$ 38,505,064	$ 30,384,530	-$ 8,120,534	-21.1%
02 Health Services Cost Review Commission	141,082,416	159,813,824	160,425,684	611,860	0.4%
03 Maryland Community Health Resources Commission	8,005,031	8,157,496	8,311,040	153,544	1.9%
Total Expenditures	**$ 181,557,109**	**$ 206,476,384**	**$ 199,121,254**	**-$ 7,355,130**	**-3.6%**
General Fund	$ 91,000	$ 0	$ 0	$ 0	0.0%
Special Fund	179,545,059	203,343,966	198,720,636	-4,623,330	-2.3%
Federal Fund	1,575,035	3,132,418	228,118	-2,904,300	-92.7%
Total Appropriations	**$ 181,211,094**	**$ 206,476,384**	**$ 198,948,754**	**-$ 7,527,630**	**-3.6%**
Reimbursable Fund	$ 346,015	$ 0	$ 172,500	$ 172,500	N/A
Total Funds	**$ 181,557,109**	**$ 206,476,384**	**$ 199,121,254**	**-$ 7,355,130**	**-3.6%**

Note: The fiscal 2015 working appropriation does not include January 2015 Board of Public Works reductions and deficiencies. The fiscal 2016 allowance does not reflect contingent or across-the-board reductions.