M00R01
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change	% Change Prior Year
Special Fund	$176,322	$233,814	$230,337	-$3,477	-1.5%
Deficiencies and Reductions	0	0	-30	-30	
Adjusted Special Fund	**$176,322**	**$233,814**	**$230,307**	**-$3,507**	**-1.5%**
Federal Fund	1,449	2,492	0	-2,492	-100.0%
Adjusted Federal Fund	**$1,449**	**$2,492**	**$0**	**-$2,492**	**-100.0%**
Reimbursable Fund	0	173	173	0	
Adjusted Reimbursable Fund	**$0**	**$173**	**$173**	**$0**	**0.0%**
Adjusted Grand Total	**$177,770**	**$236,479**	**$230,480**	**-$5,999**	**-2.5%**

- The fiscal 2017 allowance for the Health Regulatory Commissions decreases by $6 million, 2.5%, net of back of the bill reductions. This is mainly due to funding added through budget amendments in fiscal 2016 not being carried over into fiscal 2017.

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

For further information contact: Jordan D. More Phone: (410) 946-5530

Personnel Data

	FY 15 Actual	FY 16 Working	FY 17 Allowance	FY 16-17 Change
Regular Positions	102.70	103.70	103.70	0.00
Contractual FTEs	0.00	0.00	0.00	0.00
Total Personnel	**102.70**	**103.70**	**103.70**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.67	4.50%
Positions and Percentage Vacant as of 12/31/15	11.80	11.38%

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

- Turnover expectancy within the allowance is 4.50%, which requires the agency to maintain 5.0 vacant positions throughout the year. As of December 31, 2015, there were 11.8 vacant positions, or 11.38%.

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.

Maryland All-payer Model Contract Metrics Continue to Show Progress: The new Maryland All-payer Model Contract contains numerous tests that the State must meet to maintain the waiver agreement. In 2014, which was year one of the demonstration, the State either met or exceeded all of the goals. In 2015, the State appears to be on pace with these metrics.

Issues

Moving through Phase I and Looking to Phase II – Implementing the All-payer Model Contract: 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 most hospital revenues under global budgets in order to cap cost growth, as well as improvements in certain health outcomes. So far, the Health Services Cost Review Commission (HSCRC) has been focusing on expanding care coordination and seeking waivers to allow for gain sharing, or Pay for Outcomes (P4O) arrangements between hospitals and physicians. **HSCRC should comment on the status of the internal physician and P4O waivers, and what progress has been made on the movement toward Phase II of the All-payer Model Contract, including possibly more aggressive outreach to the nonhospital provider community.**

The Beginning of Integrated Care Networks: In order to improve care coordination, HSCRC, along with the Maryland Health Care Commission (MHCC), have begun to establish Integrated Care Networks (ICN). The main vehicle through which the commissions are establishing these networks is through the State-designated HIE, the Chesapeake Regional Information System for our Patients. **HSCRC should comment on the current status of the ICN projects, where the infrastructure build out is so far, and what steps they plan to take to get more small, nonhospital-based providers into the ICNs.**

Preliminary Sunset Evaluations for MHCC and HSCRC: During the 2015 interim, the Department of Legislative Services (DLS) conducted a preliminary sunset evaluation on both MHCC and HSCRC. Beyond the main recommendation, which is for DLS to conduct a review of the missions and responsibilities of all three health care regulatory commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned, DLS also noted some other policy recommendations for the current legislative session. **Both commissions should comment on their progress toward addressing the DLS recommendations, including the ability of each commission to function under the current user fee assessment caps.**

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. 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 has the charge of improving access to affordable health care, as well as reporting information relevant to availability, cost, and quality of health care statewide. 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:

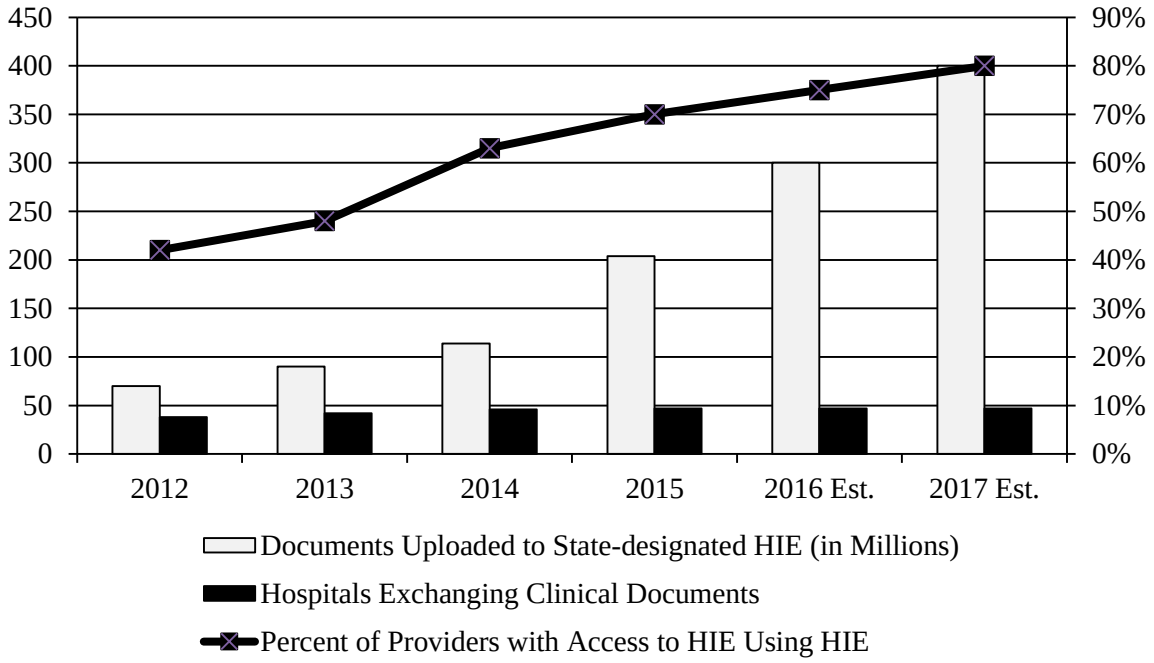
- identifying and seeking federal and State funding for the expansion of CHRCs;
- developing outreach programs to educate and inform individuals of the availability of CHRCs;
- assisting uninsured individuals under 200% of the federal poverty level to access health care services through CHRCs; and
- overseeing the implementation of the Health Enterprise Zones (HEZ) established in Chapter 3 of 2012, which ends at the completion of fiscal 2016.

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, specifically through 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 and utilize the HIE. 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. There was also an especially pronounced jump in the number of documents uploaded between fiscal 2014 and 2015, from 114 million to 204 million. That number is projected to double by fiscal 2017.

Exhibit 1
Utilization of State-designated HIE
Fiscal 2012-2017 Est.



HIE: Health Information Exchange

Source: Department of Health and Mental Hygiene

2. Maryland All-payer Model Contract Metrics Continue to Show Progress

The new All-payer Model Contract requires the State to meet certain metrics throughout the five-year waiver demonstration period in order for the State to maintain the waiver. **Exhibit 2** provides some detail on certain metrics that HSCRC monitors to ensure compliance with the tests that the Center for Medicare and Medicaid Innovation (CMMI) has required of Maryland. So far, the State has been meeting most of the metrics that are tested as part of the model contract. Some early signs of success include keeping per capita all-payer revenue growth below 3.58% in both calendar 2014 and 2015, although growth in calendar 2015 has increased from 1.47% to 2.62%. Further progress has also been exhibited with the savings that Maryland needs to achieve for Medicare fee-for-service (FFS) per beneficiary growth. In calendar 2014, Medicare FFS per beneficiary growth in Maryland shrank by 1.07%, as measured by the federal government, while growth in the nation increased by 1.06%. This resulted in a first year savings to Medicare of approximately $116 million, which is 35.0% of the savings that Maryland needs to achieve under this measure over the course of the five-year

demonstration. However, it is worth noting that the FFS per beneficiary Medicare growth, as measured by the State, increased in calendar 2015 by 1.64%. HSCRC will have to wait until CMMI examines its metrics to determine if the State has regressed in 2015.

Exhibit 2
Maryland All-payer Model Contract Metrics
Calendar 2014-2015

	Goal	Year 1 (2014)	Year 2 (2015)
Per Capita All-payer Revenue Growth	**< or = 3.58%**	**1.47%**	**2.62%**
Maryland Per Beneficiary Medicare FFS Hospital Revenue Growth[1]		-1.12%	1.64%
Medicare FFS Hospital Per Beneficiary Growth Comparison[2]			
Maryland		-1.07%	TBD
National		1.06%	TBD
Cumulative Medicare Savings Over Five Years	**$330m**	**$116m**	**TBD**
Reduction in Hospital Readmissions	Year 1: -6.76%; Year 2: -9.30%	-3.66%	-7.19%
Cumulative Reduction in Hospital Acquired Conditions	**-30.0% Over 5 Years**	**-26.26%**	**-33.91%**

FFS: fee-for-service

[1] This data is specific to Maryland and is used for real time monitoring.
[2] This data is based on Center for Medicare and Medicaid Innovation reporting.

Note: Calendar 2015 is through November with two exceptions. Readmissions data is through October of each year compared to the same timeframe in 2013. Hospital Acquired Conditions is through September of each year.

Note: Bold denotes one of the waiver test metrics.

Source: Health Services Cost Review Commission

Beyond financial measures, the waiver tests also require hospitals in the State to bring the readmission rate below the national readmission rate, as well as to reduce the number of hospital-acquired conditions by 30.0% over the five-year demonstration. For readmissions, HSCRC sets a yearly goal for all hospitals to meet. In neither calendar 2014 nor 2015 did the hospitals achieve this goal, although the reduction in the readmission rate did improve from -3.66% to -7.19%. Further, the State did close the gap with the national readmission rate by 0.21 percentage points. For

hospital-acquired conditions, the State has already exceeded the cumulative goal of 30.0%, having reduced hospital acquired conditions by 33.91% through the end of 2015.

Proposed Budget

As seen in **Exhibit 3**, the total appropriation for the Health Regulatory Commissions decreases by $6 million below the working appropriation net of back of the bill reductions.

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

How Much It Grows:	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$176,322	$1,449	$0	$177,770
Fiscal 2016 Working Appropriation	233,814	2,492	173	236,479
Fiscal 2017 Allowance	230,307	0	173	230,480
Fiscal 2016-2017 Amount Change	-$3,507	-$2,492	$0	-$5,999
Fiscal 2016-2017 Percent Change	-1.5%	-100.0%		-2.5%

Where It Goes:

Personnel Expenses	
Retirement contributions	$154
Employee and retiree health insurance	101
Other fringe benefit adjustments	-9
Social Security contributions	-53
Workers' compensation premium assessment	-139
Regular earnings and other compensation	-618
Maryland Health Care Commission	
All-payer Claims Database contract increase	834
Expiring Network for Regional Health Care Improvements grant	-100

Where It Goes:

Trauma equipment grant	-300
Various data contracts	-422
Federal grants	-2,264
CRISP Grants	-10,750
Health Services Cost Review Commission	
Integrated Care Networks project	6,528
All-payer Model contracts	1,186
Other Changes	
Other operating expenses (all commissions)	-146
Total	**-$5,999**

DHMH: Department of Health and Mental Hygiene
CRISP: Chesapeake Regional Information System for our Patients

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

Personnel

Personnel costs for the commissions decrease by approximately $565,000 net of the back of the bill reduction for health insurance costs. The largest increases are for retirement contributions ($154,000) and health insurance contributions ($101,000). However, these are more than offset by a decrease of approximately $618,000 in regular earnings and other compensation. This is mainly due to the high number of vacancies within the various commissions, which is leading to lower budgeted salary levels for these vacant positions as positions are reset back to base salaries. However, it should be noted that in fiscal 2016, HSCRC had a budget amendment which increased salaries mid-year due to personnel being hired at larger than base salaries.

MHCC

The largest changes are contained in the MHCC budget. Most of the large decreases are due to expiring programming, including $10.8 million to CRISP for work related to the HIE as well as the initial infrastructure build-out of the Integrated Care Networks (ICN), which are further discussed in Issue 2. There is also a decrease of $2.3 million in federal funds due to the expiration of a federal grant related to insurance rate premium review. One major increase, however, in the MHCC budget is approximately $834,000 for an increase in the contract for the All-payer Claims Database. This

contract is currently being rebid, and these costs are required to cover the costs of a new contractor taking over the project as well as increased reporting deliverables.

HSCRC

Several large increases are contained within the HSCRC budget. The largest increase, $6.5 million, is for increases in the ICN project, particularly for greater connectivity to community-based providers and for care management software. The costs for contracts concerning data and performance measurement for the All-payer Model Contract project also increase by $1.2 million.

Issues

1. Moving through Phase I and Looking to Phase II – Implementing the All-payer Model Contract

Effective January 1, 2014, Maryland entered into a contract with the federal government to replace the State's 36-year-old Medicare waiver with the new Maryland All-payer Model Contract. Whereas under the old waiver test, Maryland's success was based solely on the cumulative rate of growth in Medicare inpatient per admission costs, the new model contract contains completely different benchmarks and components that the State must meet throughout the 5-year demonstration model to continue to have a waiver and be able to set Medicare hospital rates.

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.

- **Medicare Hospital Savings:** Maryland has agreed to produce $330 million in cumulative Medicare hospital savings over 5 years by holding the growth in Maryland Medicare FFS hospital spending below the national Medicare growth rate.

- **Population-based Revenue:** Initially, HSCRC had agreed under the contract to have 80.0% of all hospital-based revenue into population-based models by year 5 of the contract, *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. However, all hospitals agreed to global budgets, which began on July 1, 2014, and these global budgets already include approximately 95.0% of all hospital revenue.

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

- **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 5 years.

- **Medical Education Innovation:** Maryland must develop a 5-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 model contract, a so-called triggering event could lead CMMI 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 the CMMI concerns is very much on trends related to Medicare. As noted in the performance analysis earlier in this document, HSCRC is currently meeting or exceeding all of the model contract goals.

Exhibit 4
Maryland's 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 two 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 the CMMI that the quality of care to Medicare, Medicaid, and MCHP recipients has deteriorated.

CMMI: Center for Medicare and Medicaid Innovation
MCHP: Maryland Children's Health Program

Source: Maryland All-payer Model Agreement, February 2014

Extending the Model

As previously stated, over 95% of hospital revenue is now included within the global budgets. However, for the model to be a long-term success, better care coordination both inside and outside of the hospital is going to be required. For example, hospital readmissions is the one measure where the State is not currently meeting or exceeding its own goals or expectations. This is arguably because hospitals within the State are not progressing on care coordination as quickly as would otherwise be desired. In order to better address this current deficit, HSCRC is seeking additional waivers from the federal government in order to begin implementing gain sharing programs between physicians in the State and hospitals.

In particular, there are three waivers which HSCRC and hospitals would like to have in order to implement accountable care organization style arrangements. The first waiver would be for physicians that work inside of the hospitals. These physicians are currently still reimbursed on an FFS-basis, and thus do not have the same incentives to reduce hospital utilization as the hospitals themselves have under the new waiver. The second waiver would be for providers who specialize in either primary or post-acute care, including nursing homes, hospice, and other services. This waiver would allow hospitals to set up a Pay for Outcomes (P4O) program where these providers share in the risk and reward structure that is part of the global budgets. The third waiver would allow hospitals and physicians to share data across settings to help hospitals and physicians conduct risk stratification to address high-needs patients.

If these waivers for physicians are granted, HSCRC would then like to move to an ICN structure where both certain physicians as well as the hospitals are all under a unified governance structure where they all share in savings and incentives that align with the goals and tests of the waiver. However, as discussed in the following issue, these ICNs could take a significant amount of time to set up.

Beyond these waivers and gain sharing arrangements, HSCRC is also preparing to move into Phase II of the model contract, which requires a more total cost of care model. A proposal is due to CMMI from HSCRC at the end of calendar 2016 that would cover all health spending in the State from calendar 2019, which is the first year after the current five-year demonstration, and beyond. However, progressing to this new model could be difficult, especially given the difficulties that hospitals and HSCRC have already experienced with care coordination and outreach beyond the hospitals themselves. **HSCRC should comment on the status of the internal physician and P4O waivers, and what progress has been made on the movement toward Phase II of the All-payer Model Contract, including possibly more aggressive outreach to the nonhospital provider community.**

2. The Beginning of Integrated Care Networks

Beginning in fiscal 2016, both MHCC and HSCRC have engaged CRISP to begin the buildout of the software and other information technology infrastructure for an ICN. The purpose of an ICN is to create a system where multiple providers can coordinate care and integrate their efforts in order to better meet the needs of patients, as well as the goals and purposes of the all-payer waiver. Beginning in fiscal 2016, CRISP has developed a new Steering Committee, within its governing structure, to

provide targeted oversight of the effort and to direct the project as it moves forward. Early work has focused on seven workstreams:

- ***Ambulatory Connectivity:*** The project aims to achieve bi-directional connectivity with ambulatory practices, long-term care, and other health providers through multiple methods of connectivity.

- ***Data Router:*** The data router will receive and normalize health records, determine a patient-provider relationship, verify patient consent, and forward the records to where they should go in near real time.

- ***Clinical Portal Enhancements:*** The existing clinical query portal will be enhanced with new elements, including a care profile, a link to a provider directory, information on other known patient-provider relationships, and risk scores.

- ***Notifications and Alerting:*** New alerts will be built such that notification happens within the context of a providers existing workflow.

- ***Reporting and Analytics:*** Existing reporting capabilities will be expanded and made available to many more care managers.

- ***Basic Care Management Software:*** The current scope is for planning only.

- ***Practice Transformation:*** The current scope is for planning only.

CRISP has already made some early progress in the first six months of the project, including with ambulatory connectivity and care management software pilots. Ambulatory connectivity is picking up momentum, but deeper clinical integration is mostly occurring with larger hospital-owned practices. Smaller practices continue to be challenging. The care management software pilots will be in operation by March 2016.

Funding Sources

Funding for this project has been derived from two main sources. The first is through hospital rates as authorized by the Budget Reconciliation and Financing Act (BRFA) of 2014. The Act authorized HSCRC to include within hospital rates up to $15 million for care coordination activities. To date, this funding has gone to the various activities displayed in **Exhibit 5**. Much of the funding ended up in the MHCC budget, as MHCC is the principle State agency that contracts with CRISP. As seen in Exhibit 5, the primary funding priority for these dollars has been to build-out ICN infrastructure, particularly for the better management of Medicare patients. This focus makes sense in the context of the targets in the new All-payer Model Contract.

Second, the BRFA of 2015 authorized HSCRC in fiscal 2016 through 2019 to utilize a portion of the remaining fund balance from the Maryland Health Insurance Plan to support ICNs designed to reduce health care expenditures and improve outcomes for specified Medicare and dual-eligible (Medicaid and Medicare) patients, consistent with the goals of Maryland's All-payer Model Contract. There is more than $18 million included in the current working appropriation and $25 million in the fiscal 2017 allowance for this purpose. **HSCRC should comment on the current status of the ICN projects, where the infrastructure build-out is so far, and what steps they plan to take to get more small, nonhospital-based providers into the ICNs.**

Exhibit 5
2014 BRFA Coordination Funds Uses

Regional Partnerships	
Grants	$2,500,000
Technical assistance	1,000,000
CRISP	
CRS	1,539,000
ICN Initial	229,850
ICN Infrastructure	8,201,000
Total	**$13,469,850**

BRFA: Budget Reconciliation and Financing Act
CRISP: Chesapeake Regional Information System for our Patients
CRS: CRISP Reporting Service
ICN: Integrated Care Network

Source: Health Services Cost Review Commission

3. Preliminary Sunset Evaluations for MHCC and HSCRC

During the 2015 interim, both MHCC and HSCRC underwent preliminary sunset evaluations by the Department of Legislative Services (DLS). The main DLS recommendation was the same for both commissions, which was that the Legislative Policy Committee (LPC) waive both commissions from full evaluation at this time while requiring DLS to conduct a review, by December 1, 2016, of the missions and responsibilities of all three health care regulatory commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned. This recommendation was approved by LPC on December 15, 2015.

Report Summary

In the preliminary evaluations, DLS notes that both commissions continue to fulfill their statutory obligations, which have increased significantly since their most recent evaluations, meet their

respective performance metrics successfully, and provide important policy guidance to the State. However, the implementation of the new All-payer Model Contract, which was previously discussed, along with the changes brought forth by the federal Patient Protection and Affordable Care Act, are drastically changing the landscape of health policy in the State. Further, the change to a population-based approach within the waiver model now impacts not only hospitals but community providers as well. As such, MHCC, HSCRC, and MCHRC which currently each have varying policy and funding roles may now have overlapping responsibilities. The recommendation proposed by DLS, and approved by LPC, will seek to determine the extent to which the roles and responsibilities of the commissions overlap and possibly how these roles and responsibilities may be better aligned in moving forward.

Beyond this main recommendation, both preliminary sunset reviews also identified other policy considerations for the current legislative session. For HSCRC, DLS noted that should HSCRC, in conjunction with CMMI, attempt to expand the scope of the model contract, the current user fee cap of $12 million may need to be raised. DLS also noted that staffing concerns continue to be an issue within HSCRC and recommended that the commission continue to explore innovative ways to meet its staffing needs, including a reevaluation of its current salary schedule. For MHCC, DLS found that the current assessment fee cap of $12 million continues to be inadequate for funding all of the activities of the commission, and subsequently recommended that the cap be raised to $15 million. DLS also recommended that MHCC explore how the workload distribution calculation, which is used to determine what proportion of the user fee assessment each of the four users of MHCC contributes to the assessment, might consider future workload requirements as opposed to the current practice of only considering past workload. **Both commissions should comment on their progress toward addressing the DLS recommendations, including the ability of each commission to function under the current user fee assessment caps.**

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 2015					
Legislative Appropriation	$0	$198,616	$0	$0	$198,616
Deficiency Appropriation	0	0	0	0	0
Cost Containment	0	0	0	0	0
Budget Amendments	0	-10,687	3,132	0	-7,555
Reversions and Cancellations	0	-11,607	-1,684	0	-13,291
Actual Expenditures	**$0**	**$176,322**	**$1,449**	**$0**	**$177,770**
Fiscal 2016					
Legislative Appropriation	$0	$198,360	$228	$173	$198,760
Budget Amendments	0	35,454	2,264	0	37,718
Working Appropriation	**$0**	**$233,814**	**$2,492**	**$173**	**$236,479**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. Numbers may not sum to total due to rounding.

Fiscal 2015

Actual expenditures for the Health Regulatory Commissions were $20,845,270 below the legislative appropriation. Budget amendments removed $10,687,033 in special funds, primarily due to underutilization of the Uncompensated Care Fund ($14,786,156). Large increases in special funds through budget amendments included $4,500,000 to cover the cost of a contract with CRISP to perform work related to the HIE for hospitals in the State (of which subsequently $629,249 was transferred to Medicaid), $123,199 to hire an administrator position as well as fund a contract with Johns Hopkins to evaluate the HEZ program, and $105,173 for the 2015 cost-of-living adjustment. Special fund cancellations totaled $11,606,821, which were mainly related to higher than expected turnover and further underutilization of the Uncompensated Care Fund.

Federal fund expenditures increased by $1,448,584. This is due to a budget amendment that added $3,132,418 to cover the cost for the Health Insurance Premium Review grants, of which $1,683,834 was subsequently canceled.

Fiscal 2016

To date, the working appropriation for the commissions had increased by a total of $37,718,311, including $35,454,477 in special funds and $2,263,834 in federal funds. The largest increase is $18,472,102 in special funds for the ICNs within HSCRC. Other special fund increases include:

- $14,750,000 for CRISP to be paid out of hospital rates per the BRFA of 2014;
- $1,718,206 for HSCRC to cover deficits in salaries and contractual services;
- $214,169 to restore a 2% pay reduction;
- $200,000 to increase the allotment for the University of Maryland Medical System Shock Trauma Center grant; and
- $100,000 for a grant from the Network for Regional Health Care Improvements.

The increase in federal funds is entirely due to a grant to MHCC to conduct Cycle IV of the Health Insurance Premium Rate Review under the federal Affordable Care Act.

Appendix 2

Audit Findings

Audit Period for Last Audit:	May 16, 2011 – June 30, 2014
Issue Date:	February 5, 2015
Number of Findings:	2
Number of Repeat Findings:	0
% of Repeat Findings:	0%
Rating: (if applicable)	n/a

Finding 1: One individual at MHCC had excessive control over the Maryland Trauma Physician Services Fund.

Finding 2: Grant agreements made by MCHRC were not always executed prior to disbursing funds and certain health care grants were not adequately monitored.

Object/Fund Difference Report
DHMH – Health Regulatory Commissions

Object/Fund	FY 15 Actual	FY 16 Working Appropriation	FY 17 Allowance	FY 16 - FY 17 Amount Change	Percent Change
Positions					
01 Regular	102.70	103.70	103.70	0.00	0%
Total Positions	**102.70**	**103.70**	**103.70**	**0.00**	**0%**
Objects					
01 Salaries and Wages	$ 11,854,382	$ 13,794,227	$ 13,258,907	-$ 535,320	-3.9%
02 Technical and Spec. Fees	22,558	36,158	37,633	1,475	4.1%
03 Communication	72,613	94,365	75,762	-18,603	-19.7%
04 Travel	89,772	211,781	237,177	25,396	12.0%
08 Contractual Services	154,684,547	194,810,323	205,563,601	10,753,278	5.5%
09 Supplies and Materials	64,661	81,894	79,670	-2,224	-2.7%
10 Equipment – Replacement	30,600	50,495	21,300	-29,195	-57.8%
11 Equipment – Additional	322,907	168,800	168,800	0	0%
12 Grants, Subsidies, and Contributions	10,142,122	26,722,208	10,560,345	-16,161,863	-60.5%
13 Fixed Charges	486,163	508,425	506,431	-1,994	-0.4%
Total Objects	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**
Funds					
03 Special Fund	$ 176,321,741	$ 233,814,224	$ 230,337,126	-$ 3,477,098	-1.5%
05 Federal Fund	1,448,584	2,491,952	0	-2,491,952	-100.0%
09 Reimbursable Fund	0	172,500	172,500	0	0%
Total Funds	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies or reversions. The fiscal 2017 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

Program/Unit	FY 15 Actual	FY 16 Wrk Approp	FY 17 Allowance	Change	FY 16 - FY 17 % Change
01 Maryland Health Care Commission	$ 32,624,993	$ 47,597,714	$ 34,319,369	-$ 13,278,345	-27.9%
02 Health Services Cost Review Commission	137,589,364	180,577,371	188,098,489	7,521,118	4.2%
03 Maryland Community Health Resources Commission	7,555,968	8,303,591	8,091,768	-211,823	-2.6%
Total Expenditures	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**
Special Fund	$ 176,321,741	$ 233,814,224	$ 230,337,126	-$ 3,477,098	-1.5%
Federal Fund	1,448,584	2,491,952	0	-2,491,952	-100.0%
Total Appropriations	**$ 177,770,325**	**$ 236,306,176**	**$ 230,337,126**	**-$ 5,969,050**	**-2.5%**
Reimbursable Fund	$ 0	$ 172,500	$ 172,500	$ 0	0%
Total Funds	**$ 177,770,325**	**$ 236,478,676**	**$ 230,509,626**	**-$ 5,969,050**	**-2.5%**

DHMH: Department of Health and Mental Hygiene

Note: The fiscal 2016 working appropriation does not include deficiencies. The fiscal 2017 allowance does not include contingent reductions.