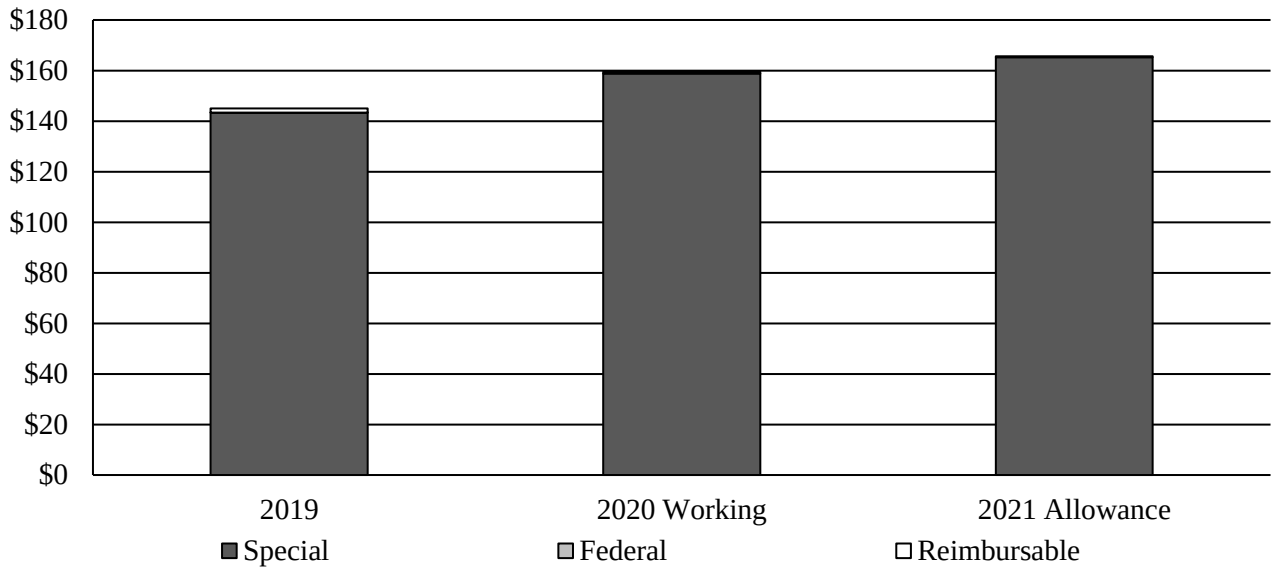
M00R01
Health Regulatory Commissions
Maryland Department of Health

Executive Summary

The Health Regulatory Commissions are three independent agencies that separately regulate health care delivery, monitor price and affordability of service delivery, and expand access to care for Marylanders.

Operating Budget Summary

Fiscal 2021 Budget Increases $6.2 Million or 3.9% to $165.7 Million
($ in Millions)



Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

- Budget growth from fiscal 2019 to 2020 is attributed to actual expenditures for the Uncompensated Care Fund closing well under the appropriation.

- The increase from fiscal 2020 to 2021 concerns funding for the Chesapeake Regional Information System for our Patients (CRISP). However, this increase is overstated as funds for similar expenditures in fiscal 2020 from hospital assessments are not yet reflected in the fiscal 2020 budget.

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Key Observations

- ***Total Cost of Care (TCOC):*** Maryland's TCOC model is underway and building on achievements made during the all-payer model. However, reimbursements through the Maryland Primary Care Program may present challenges for meeting savings goals in the out-years.

- ***Hospital Rates Generate Support for Expired Funding:*** After the statutory authority to expend Maryland Health Insurance Program Funds expired in fiscal 2019, the Health Services Cost Review Commission (HSCRC) approved assessments to continue operating support for CRISP, Implementation and Advanced Planning, and the Integrated Care Networks, all now budgeted in HSCRC.

Operating Budget Recommended Actions

1. Adopt narrative requesting that the Health Services Cost Review Commission evaluate cost savings from the Maryland Primary Care Program.

2. Adopt narrative requesting the Health Services Cost Review Commission to outline its policy on appropriate levels of hospital profits and policy tools available to constrain hospital profits.

3. Restrict $1,000,000 in Community Health Resource Commission special fund expenditures for the support of Local Health Improvement Coalitions.

M00R01
Health Regulatory Commissions
Maryland Department of Health

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are three independent agencies within the Maryland Department of Health (MDH): the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), and the Maryland Community Health Resource Commission (MCHRC). These commissions regulate health care delivery, monitor price and affordability of service delivery, and expand access to care for Marylanders, respectively. Each commission has its own separate goals and initiatives.

- MHCC develops quality and performance measures for health maintenance organizations, hospitals, and ambulatory care facilities; directs and administers State health planning functions; and conducts Certificate of Need evaluations for regulated entities. MHCC also issues grants to trauma centers through the Maryland Trauma Physicians Fund and operating grants to the Shock Trauma Center.

- HSCRC was established in 1971 to contain hospital costs, maintain fairness in hospital payments, and provide financial access for hospital care. HSCRC assures all purchasers of hospital health care services that the costs of the services are reasonable with rates set to be in relationship to the aggregate costs of the services provided. HSCRC is also focused on the implementation of the total cost of care (TCOC) contract with the Center for Medicare and Medicaid Innovation (CMMI).

- MCHRC was established in 2005 to strengthen the safety net for uninsured and underinsured Marylanders. This safety net is made up of community health resources, ranging from federally qualified health centers to local health departments, community-based clinics, and providers. The Health Regulatory Commissions awards and monitors grants to these entities as well as developing, supporting, and monitoring strategies to strengthen viability and improve efficiency.

Performance Analysis: Managing for Results

1. Continued Utilization of the State-designated Health Information Exchange

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 to eliminate unnecessary administrative expenses through the increased utilization of the State Health Information Exchange (HIE). HIE for Maryland is the Chesapeake Regional Information System for our Patients (CRISP), which aims to make electronic health records

and other health information available in a secure environment to providers and patients. Another feature of CRISP is the Encounter Notification System (ENS) that delivers real-time alerts to providers whenever one of their patients visits an emergency room or is admitted and discharged from a hospital. ENS can also provide a summary of care and give readmission alerts. The first four years of data are shown in **Exhibit 1**, which shows continued growth in the number of users, uses, and alerts of the ENS system.

Exhibit 1
Encounter Notification System
Fiscal 2016-2019

	2016	2017	2018	2019
Provider Queries	1,257,956	1,346,684	2,326,100	3,889,981
Unique Users	25,862	53,189	87,815	100,707
Encounter Notification System Alerts to Physicians	18,019,775	18,488,775	30,801,132	37,179,145

Source: Governor's Fiscal 2021 Budget Books

Further, MHCC has set a goal for over 85% of private payer claims to be electronic. Data for fiscal 2019 indicates that 96.5% of these claims are handled electronically.

2. Health and Health Outcome Measures

Last year, the Health Regulatory Commissions added outcome measures that relate to hospital performance in preventing various different hospital-acquired conditions. These conditions are often related to avoidable hospital expenditures. The goal is to have hospitals at or above the national average for these conditions, which are listed in **Exhibit 2**.

Exhibit 2
Hospital-acquired Conditions
Fiscal 2019

Goal	Measure	2019 Actual Result
75%	Percent of hospitals performing at or above the national average on preventing surgical site infections for hip procedures	100%
75%	Percent of hospitals performing at or above the national average on preventing surgical site infections for knee procedures	100%
75%	Percent of hospitals performing at or above the national average on preventing surgical site infections for CABG procedures	100%
75%	Percent of acute general hospitals at or above the national average on preventing CLABSIs in ICUs	92.30%
75%	Percent of acute general hospitals performing at or above the national average on preventing C. diff infections	97.80%
75%	Percent of acute general hospitals performing at or above the national average on preventing CAUTIs	97.30%

CABG: coronary artery bypass graft
CAUTI: catheter-associated Urinary Tract Infections
C. diff: clostridium difficile infections
CLABSI: central line-associated bloodstream infections
ICU: intensive care unit

Source: Governor's Fiscal 2021 Budget Books

It is also worth highlighting that, under both the all-payer model (APM) and TCOC model, hospitals had goals to achieve a reduction in hospital-acquired conditions. This is being monitored by HSCRC and incentivized through the Maryland Hospital Acquired Conditions program

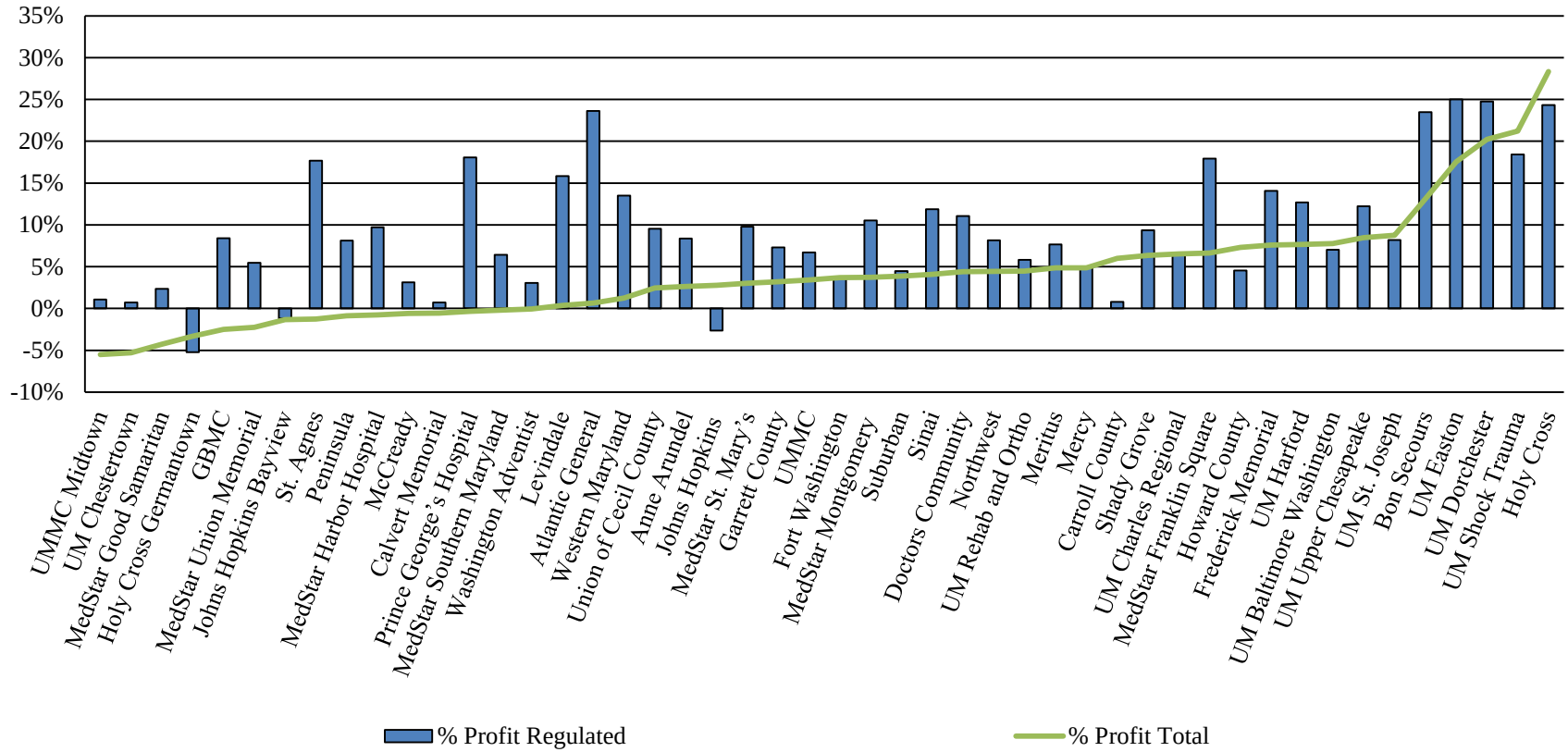
3. Hospital Revenues

Under HSCRC's all-payer rate setting authority and global budget system most, Maryland hospitals are still able to generate profits for both regulated and unregulated services. **Exhibit 3** shows operating profits for regulated service types and total profits in fiscal 2020 from July through November.

Exhibit 3

Hospital Profit – Percent of Expenditures

Fiscal 2020 July through November



GBMC: Greater Baltimore Medical Center
UM: University of Maryland
UMMC: University of Maryland Medical Center

Source: Health Services Cost Review Commission

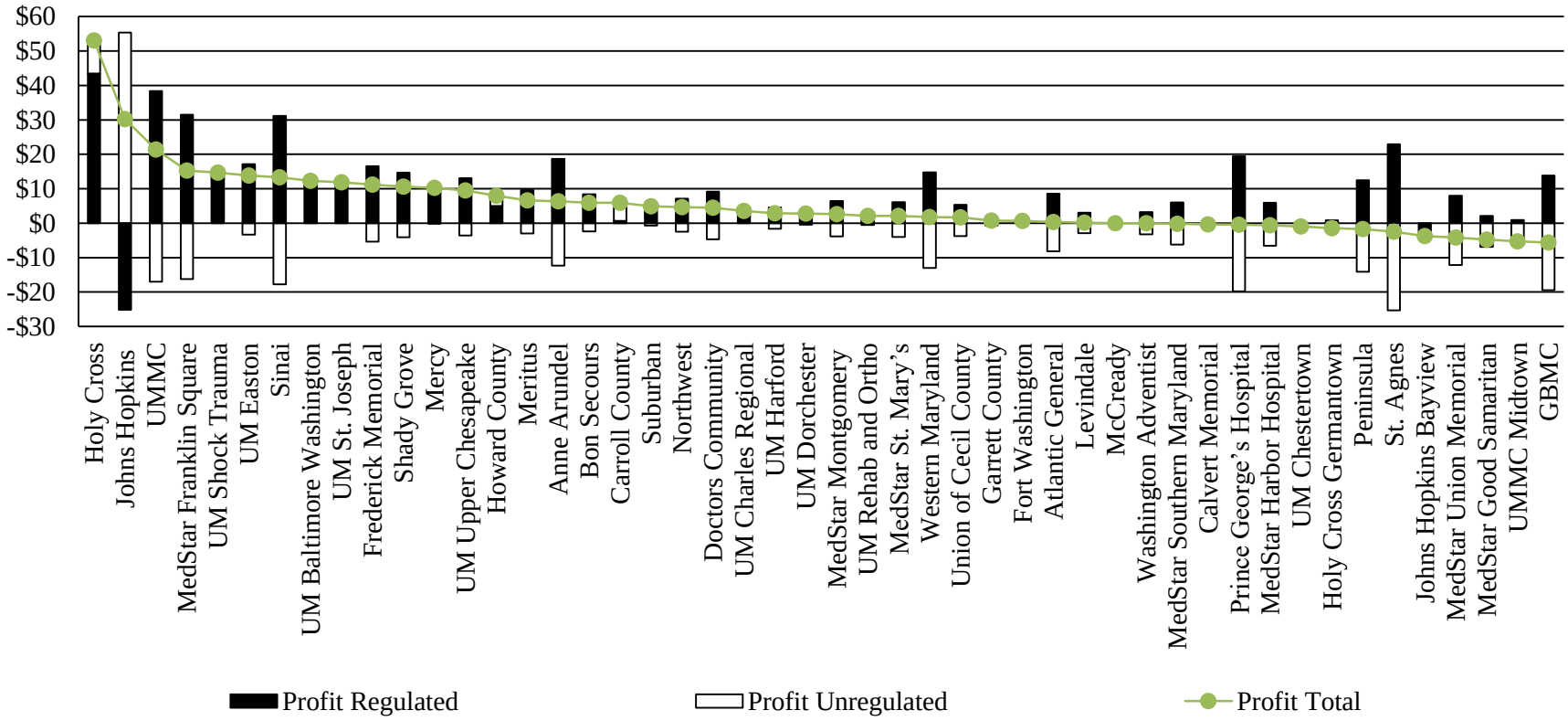
Over this period, 45 of the 48 hospitals were able to generate a profit on regulated revenues, 5 over 20% on regulated rates: Bon Secours (23.5% regulated profits); Atlantic General (23.6%); Holy Cross (24.3%); University of Maryland (UM) Dorchester (24.8%); and UM Easton (25%).

However, fewer hospitals generate a profit in their unregulated operations – only 8 over the period shown above. Even with most of the hospitals running a deficit in their unregulated operations, 33 hospitals made an overall profit, 3 with total profits over 20%: Holy Cross (28.3% total profit); UM Shock Trauma (21.2%); and UM Dorchester (20.2%).

These rates of hospital profits are consistent with fiscal 2019, where over the full year, 32 hospitals were able to generate a net profit, and 41 hospitals generated profits on the regulated rates.

The collective total profit of the hospitals over this period exceeds $263 million – nearly $440 million in profit from regulated services, offset by a collective deficit of $177 million in unregulated operations. **Exhibit 4** highlights which hospitals were able to make a profit on either regulated or unregulated services and the amount of profit for each. **The Department of Legislative Services (DLS) recommends adopting committee narrative asking HSCRC to detail its policies on what is considered an appropriate level of profit and tools and strategies available to constrain excessive hospital profits under the regulated rate structure. HSCRC should also comment on why it sets rates to offset unregulated hospital losses and the degree to which the regulated system should be responsible for mitigating losses on unregulated activities.**

Exhibit 4
Hospital Profit – Total Dollars
Fiscal 2020 July through November
($ in Millions)



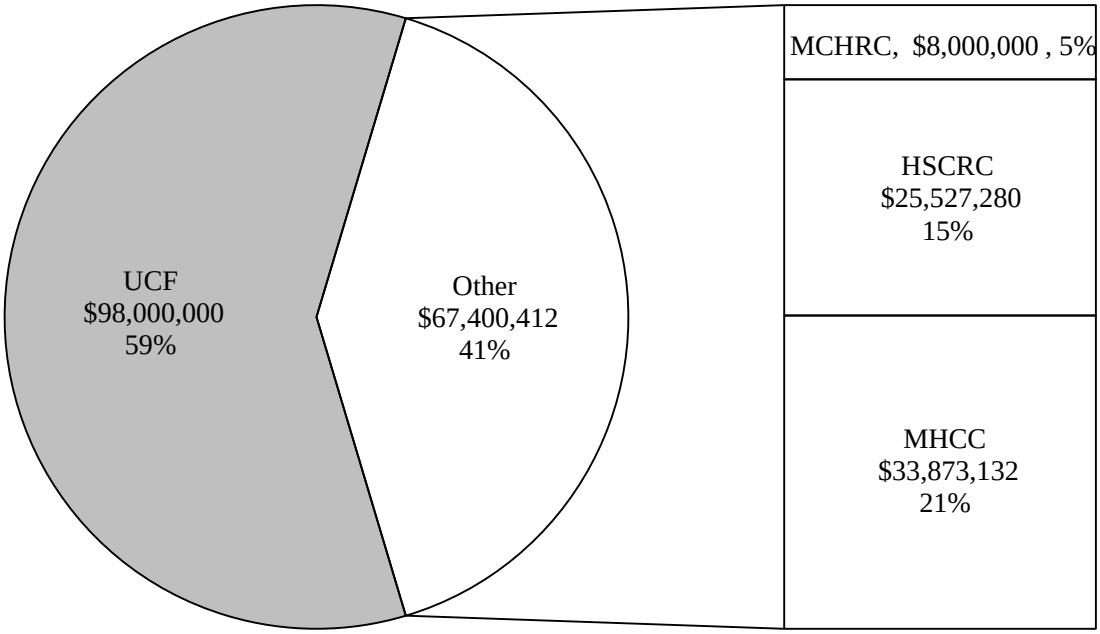
GBMC: Greater Baltimore Medical Center
UM: University of Maryland
UMMC: University of Maryland Medical Center

Source: Health Services Cost Review Commission

Fiscal 2021 Overview of Agency Spending

The fiscal 2021 allowance totals over $165 million, almost entirely in special funds. As shown in **Exhibit 5**, the single largest component of the budget is the Uncompensated Care Fund (UCF), $98 million, or 59% of the total funds. The UCF is managed by HSCRC but paid out to the acute general hospitals for providing uncompensated care. This special fund derives revenues from the acute general hospitals that treat a disproportionately lower share of uncompensated care with payments made to those hospitals that have a higher share of uncompensated care.

Exhibit 5
Overview of Agency Spending
Fiscal 2021 Allowance



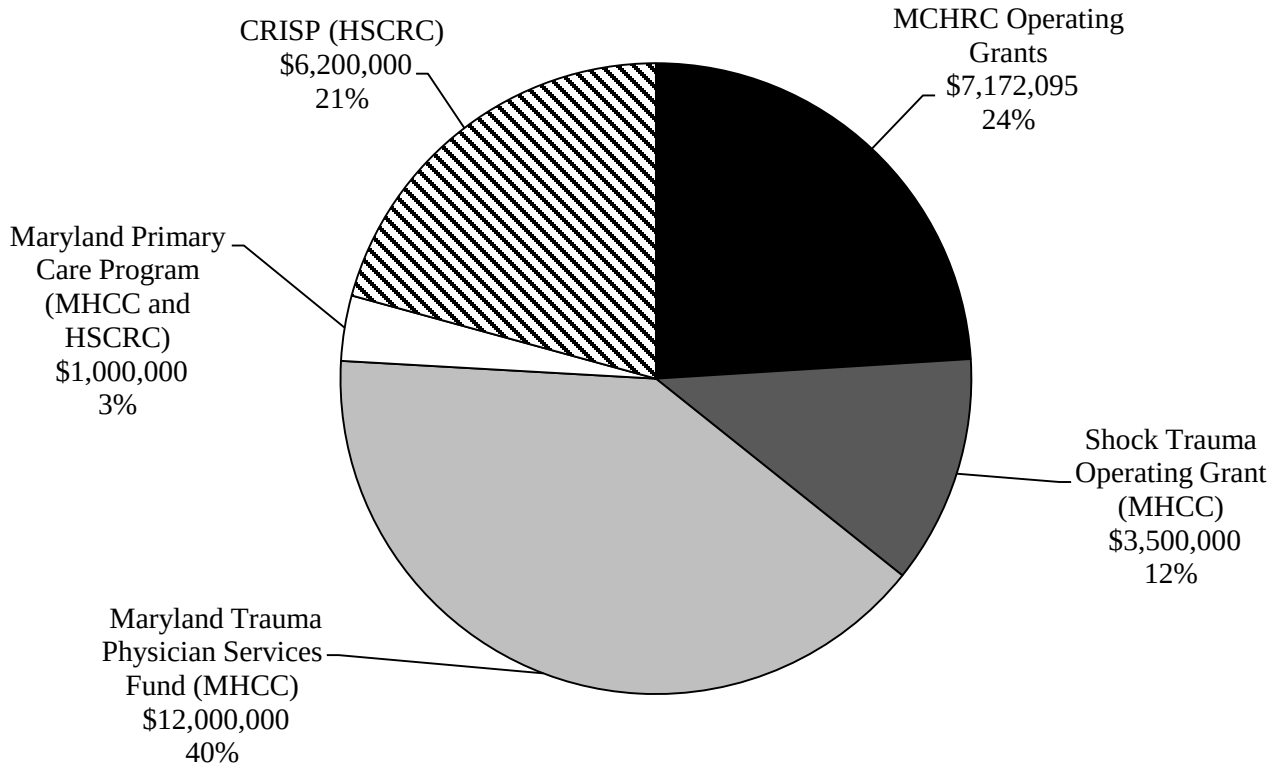
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resource Commission
MHCC: Maryland Health Care Commission
UCF: Uncompensated Care Fund

Source: Governor's Proposed Fiscal 2021 Budget

The Budget Reconciliation and Financing Act (BRFA) of 2020 as introduced includes a provision that pertains to MCHRC, discussed in greater detail later. However, if this action is adopted, it would result in an estimated decrease of MCHRC's budget by $4 million. The current budget bill does not reflect a contingent reduction for this proposed action.

Remaining expenditures are generally for the day-to-day operations of each of the three health regulatory commissions. However, other key areas of spending by commission are shown in **Exhibit 6**.

Exhibit 6
Other Funds
Fiscal 2021



CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resource Commission
MHCC: Maryland Health Care Commission

Source: Governor's proposed Fiscal 2021 Budget

CRISP operating expenditures were formerly paid out of the Integrated Care Network (ICN) fund managed jointly by MHCC and HSCRC. This funding was derived from money that remained unspent after the Maryland Health Insurance Program ended. The authority to expend that surplus funding expired in fiscal 2019. CRISP is now funded out of its own special fund that is generated from hospital assessments. These funds also support programs formerly supported with the ICN funds, including the State's 10% share of the Federal Implementation Advanced Planning Grant.

The Maryland Primary Care Program (MDPCP) Program Management Office (PMO) was also receiving funding from the ICN fund. In fiscal 2021, MHCC and HSCRC are contributing $500,000 each to support the MDPCP PMO. The MDPCP PMP is budgeted in the Public Health Administration. Both MHCC and HSCRC will provide support in fiscal 2020 as well.

Proposed Budget Change

The fiscal 2021 allowance increases by $6.1 million, as shown in **Exhibit 7**. This increase can almost entirely be accounted for by the CRISP special fund expenditures discussed previously. Other increases include costs associated with the operations of the new Prescription Drug Affordability Board (PDAB), which is budgeted in MHCC. Even with these increased expenditures, MHCC's budget decreases due to the lack of ICN spending. MCHRC also experiences a slight decrease in the amount of funding available for grants in fiscal 2021, although as noted previously, based on a provision in the BRFA of 2020, even this amount is overstated

Exhibit 7
Proposed Budget
Maryland Department of Health – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2019 Actual	$143,340	$55	$1,624	$145,019
Fiscal 2020 Working Appropriation	158,776	0	750	159,526
Fiscal 2021 Allowance	165,251	0	400	165,651
Fiscal 2020-2021 Amount Change	$6,475	$0	-$350	$6,125
Fiscal 2020-2021 Percent Change	4.1%		-46.7%	3.8%

Where It Goes:	Change
Personnel Expenses	
Regular earnings increases for existing positions, including $43,089 increases for positions transferred within the commissions	$472
New positions for PDAB (5.0 FTEs)	455
Retirement contributions for existing personnel	242
Decrease in turnover adjustment for existing positions	194
New MHCC program manager for the Center for Health Care Facilities Planning and Development	136
Fiscal 2021 general salary increase, 2% effective January 1, 2021	129
Salary adjustment for shared assistant Attorney General in HSCRC budget no longer budgeted in fiscal 2021.	103
January 1, 2020 1% general salary increase annualization	61

Where It Goes:	**Change**
Personnel expenses for new MCHRC CFO	58
Increase in Social Security contributions for existing personnel	45
Other personnel adjustments	-11
Reduction in budgeted amount for additional assistance in HSCRC budget based on three-year average	-70
Decrease in personnel expenses related to abolishment of two PINs	-228
Decrease in employee and retiree health insurance	-582
Health Services Cost Review Commission	
CRISP operating expenditures budgeted in HSCRC rather than in the MHCC budget	6,200
Support for the MDPCP PMO: $500,000 in both the MHCC and HSCRC	1,000
Budgeted expenditures for moving offices within Baltimore City, including build out of new space, cubicles, and other needs for new space	605
Rent expenditures	238
Compensation for HSCRC contractual staff	22
Decrease in other operating expenses	-5
Costs associated with the management of hospital data	-165
End of Medicaid Data Sharing Contract	-200
Maryland Health Care Commission	
Expenditures related to PDAB	182
Shock Trauma Operating Grant	100
Decrease in other MHCC operating expenditures	-2
Trauma Equipment Grant issued out of Maryland Trauma Physicians Services Fund biannually, last issued in fiscal 2020	-300
Reduction in MHCC funding for CRISP	-2,500
Maryland Community Health Resource Commission	
Increase workload of MCHRC contractual administrator to staff the Interagency Council on School Based Health Centers, as required by Chapter 199 of 2017	20
Funding for MCHRC commissioners to attend Maryland Municipal League conference	14
Other operating expenditures	2
Funding available for MCHRC grants	-89
Total	**$6,125**

CFO: chief financial officer
CRISP: Chesapeake Regional Information System for our Patients
FTE: full-time equivalent
MCHRC: Community Health Resource Commission
MDPCP: Maryland Primary Care Program
MHCC: Maryland Health Care Commission
PDAB: Prescription Drug Affordability Board
PMO: Program Management Office

Note: Numbers may not sum due to rounding. The fiscal 2020 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2021 allowance includes contingent reductions and general salary increases.

Anticipated Funding Levels for CRISP and the MDPCP

The fiscal 2021 allowance includes separate budget lines for CRISP and the MDPCP and shows this funding as increasing for fiscal 2021. However, HSCRC and MHCC have also agreed to fund the MDPCP PMO in fiscal 2020 at the same levels outlined for fiscal 2021 with each commission contributing $500,000 from respective special funds to support reimbursable funds for the program. MHCC anticipates needing to process a budget amendment for fiscal 2020, while HSCRC does not. Further, the HSCRC commissioners at the May 2019 meeting approved a hospital assessment outside of their rate-setting structure to support CRISP projects in fiscal 2020 and 2021. HSCRC anticipates being able to provide $5.39 million from this assessment for this purpose in fiscal 2020 and does not anticipate needing a budget amendment for this funding, as actual UCF spending for fiscal 2020 will be lower than budgeted. When accounting for these anticipated changes, funding for CRISP actually grows by just $810,000 from fiscal 2020 to 2021, and funding for the MDPCP PMO is unchanged at $1 million in each year between the two commissions.

Related BRFA Actions

The BRFA of 2020 as introduced includes an action related to the Health Regulatory Commissions, specifically MCHRC. The proposal pertains to the CareFirst premium tax exemption, making the distribution of $8 million to MCHRC a cap rather than a floor and making the distribution of $14 million to the Senior Prescription Drug Assistance Program (SPDAP) a floor rather than a cap. In recent years, the CareFirst premium tax exemption payment has been declining and is projected to be $18.6 million for fiscal 2021. This BRFA action would effectively reduce the MCHRC budget from $8 million to $4 million for fiscal 2021.

MCHRC previously provided $1 million in support for Local Health Improvement Coalitions (LHIC), which considering the proposed BRFA action would be difficult for MCHRC to provide in fiscal 2021. To account for this decrease in available MCHRC funds, $1 million in general funds is provided to LHICs in the MDH Administration budget. In the MDH Administration budget analysis, DLS recommended deleting the general funds for LHICs and instead providing support for LHICs through MCHRC special funds. To accommodate this fund swap, based on an analysis of spending need in the SPDAP for fiscal 2021, DLS is making a corresponding BRFA recommended action in the Medicaid budget analysis to delay changing the allocation priority of the CareFirst premium tax exemption until fiscal 2022. **To ensure continued support for LHICs and to replace general funds deleted in the MDH Administration budget, DLS recommends restricting $1,000,000 special funds from the MCHRC budget for the funding of LHICs.**

Personnel Data

	FY 19 Actual	FY 20 Working	FY 21 Allowance	FY 20-21 Change
Regular Positions	110.90	103.90	108.90	5.00
Contractual FTEs	13.30	7.57	7.87	0.30
Total Personnel	**124.20**	**111.47**	**116.77**	**5.30**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	2.86	2.63%
Positions and Percentage Vacant as of 12/31/19	10.00	9.62%
Vacancies Above Turnover	7.14	6.99%

- The health regulatory commissions added a net of 5 positions for fiscal 2021. This was largely driven by PDAB, which is budgeted in MHCC. PDAB accounts for 5 positions: an executive; a general counsel; a pharmacist; and 2 administrative positions. Two more positions are added into the regulatory commissions: chief financial officer for MCHRC to monitor grant progress; and a program manager for MHCC in its Center for Health Care Facilities Planning and Development.

- These additions were offset by the department abolishing 2 positions in MHCC.

Issues

1. TCOC

In July 2018, Maryland and the federal CMMI agreed to the terms of a new TCOC model. The model, effective January 1, 2019, builds on the State's prior APM contract that was in effect calendar 2014 through 2018. TCOC is designed to (1) improve population health; (2) improve care outcomes for individuals; and (3) control growth in the TCOC for Medicare beneficiaries. To accomplish these goals, the model is designed to move beyond hospitals to address Medicare patients' care in the community. TCOC will continue for 10 years provided that the State meets the requirements of the agreement.

Under TCOC, Maryland commits to reaching a compounded annual Medicare savings target of $300 million through the end of calendar 2023 (program year 5) in Medicare Part A (*e.g.*, hospital services) and Part B (*e.g.*, doctor office visits, preventive services, and other nonhospital services) expenditures. The compounded annual savings targets, as outlined by the model contract, are shown in **Exhibit 8**. Based on the current savings requirements of the base model, APM and TCOC are estimated to result in cumulative savings to Medicare of $1,934 million by the end of calendar 2023. Prior to the end of calendar 2022 (program year 4), CMMI will assess the State's progress and determine if TCOC is on track to meet its savings goal. By the end of calendar 2023, CMMI and Maryland will establish the formula for the allowable Medicare cost growth rate for the remaining five years of TCOC.

Exhibit 8
TCOC Annual Medicare Savings Targets
Calendar 2018-2023
($ in Millions)

Year	PY	Annual Medicare TCOC Savings Targets	Annual Medicare TCOC Saving Increment	Cumulative Savings to Medicare
2018	Base	-	-	$869
2019	PY 1	$120	-	989
2020	PY 2	156	$36	1,145
2021	PY 3	222	66	1,367
2022	PY 4	267	45	1,634
2023	PY 5	300	33	1,934

PY: program year
TCOC: total cost of care

Source: Health Services Costs Review Commission

Closing and Evaluation of APM

As previously discussed, the TCOC model builds off the success of APM, which ended in calendar 2018. The end of APM provided the opportunity for the Centers for Medicare and Medicaid Services (CMS) to issue their final report and evaluation of APM. Ultimately, CMS found that Maryland was able to achieve cost savings in Medicare throughout APM without cost shifting to other payors. CMS found that reductions in hospital expenditures were driven by reduced expenditures for outpatient hospital services. Further, the report highlights that hospitals were able to operate within their global budgets without adverse effects on their financial status. The evaluation also finds that slower growth in emergency department (ED) expenditures also contributed to savings under APM. However, this reduction was attributed to decreases in payments per ED visits for the Medicare group rather than a decrease in ED utilization. Alternatively, and encouragingly, ED admission rates did fall for commercial payors and Medicaid beneficiaries. CMS suggested that these groups were more easily convinced of seeking care in alternative settings, likely because they are on balance healthier than Medicare beneficiaries. CMS also noted where Maryland has further room for improvement, including coordination with community providers following hospitalization and furthering strategies to reduce avoidable utilization.

Exhibit 9 shows the differences between the APM and TCOC goals and objectives. Maryland was able to meet all the goals and objectives under APM and preliminary data suggest Maryland is on track to meet these targets under TCOC for calendar 2019. The third quarter estimate for calendar 2019 savings for Medicare under TCOC is $316 million, although actual savings will not be available until certified by CMS mid-2020.

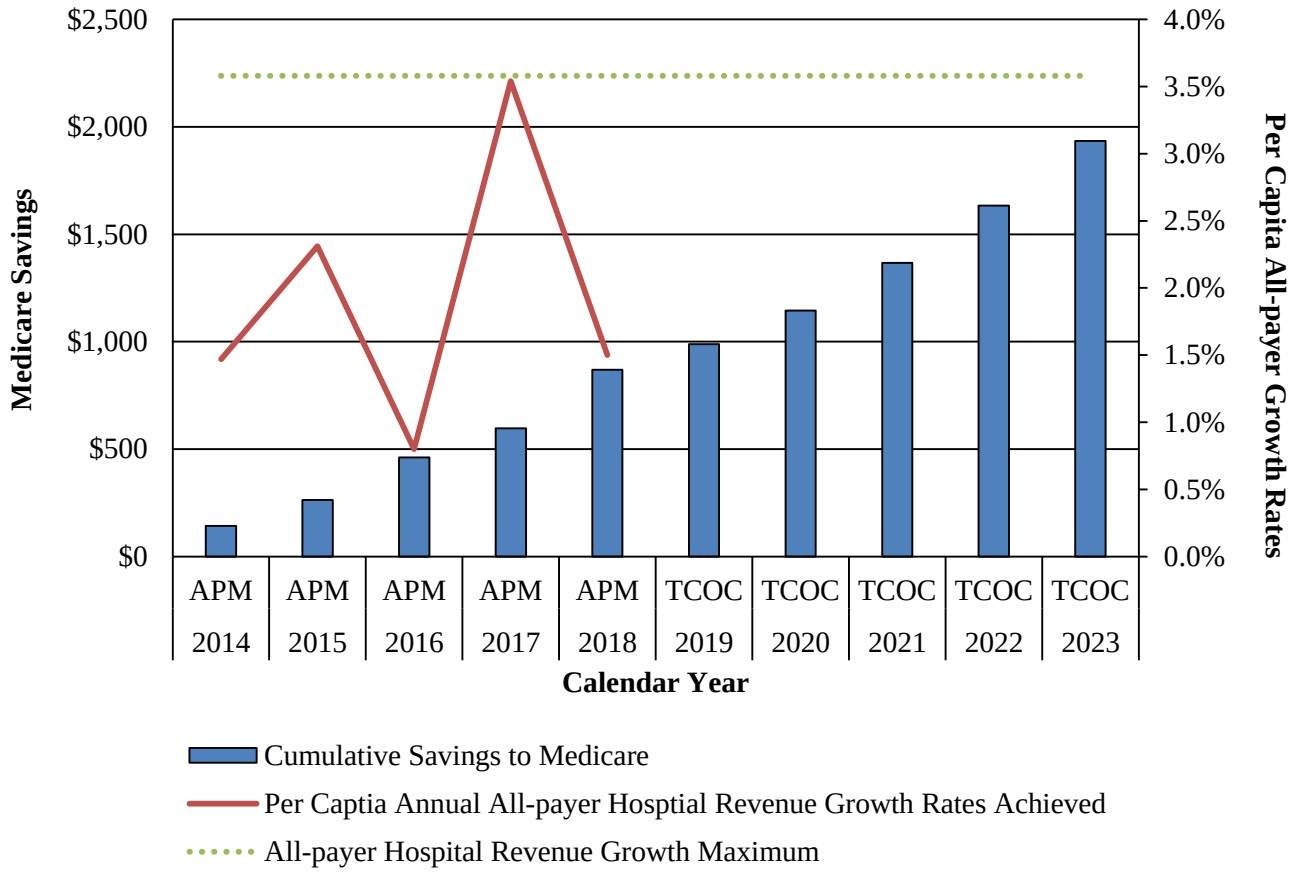
Exhibit 9
All-payer Model and Total Cost of Care Comparisons

All-payer Goals	All-payer Results	Total Cost of Care
Less than or equal to 3.58% compound annual growth per capita	Average of 1.92% over all-payer model	Less than or equal to 3.58% compound annual growth per capita
Reduce Medicare hospital costs by $330 million cumulatively over five years	$869 million cumulative savings for total cost of care. $1.4 billion in hospital savings, offset by increase in care provided outside of hospital settings	Reduce Medicare total cost of care by an annual rate of $300 million by 2023
Medicare readmission rate must be equal to or below the national readmission rate after five years	2018 national readmission rate: 15.45% ; 2018 Maryland readmission rate: 15.4%	Hospital revenue at risk with continuation of Readmission Reduction Incentive Program. The State must meet or exceed any reductions in the readmissions rate that occur in the national program
30% reduction in hospital-acquired conditions over five years	51.5% reduction in hospital-acquired conditions	Hospital revenue at risk with continuation of Maryland Hospital-acquired Conditions Program. The State must meet or exceed any reductions in the hospital-acquired conditions rate that occur in the national program
No population health metrics measured	n/a	Population health improvement programs for diabetes. Opioid-related program under development

Source: Health Services Costs Review Commission

Considering one of the foundational goals of both APM and TCOC is savings achieved to Medicare and the rate of hospital revenue growth, **Exhibit 10** combines the results from APM in both measures and adds savings targets under TCOC in Exhibit 8 to highlight cumulative savings to Medicare over the 10 years of the two models.

Exhibit 10
Actual and Anticipated Savings under TCOC and APM
Calendar 2014-2023
($ in Millions)



APM: All-payer Model Contract
TCOC: total cost of care

Note: APM growth and savings displays represent actuals achieved by Maryland under the model.

Source: Health Services Costs Review Commission

Medicare Performance Adjustments and Care Redesign Programs

In an effort to bring accountability for TCOC to hospitals, HSCRC will use a Medicare Performance Adjustment (MPA). MPA is a scaled positive or negative adjustment to each hospital's

Medicare payments relative to a per capita TCOC benchmark. For calendar 2018, the percentage of each hospital's Medicare revenue at risk under MPA was 0.5%. For calendar 2019, the revenue at risk is 1.0%. HSCRC will determine the share of revenue at risk for calendar 2020 and beyond. MPA adjustments are based on the all-cause readmissions rates and the hospital-acquired conditions quality programs. HSCRC reports that based on hospital performance in calendar 2018, 12 of 46 hospitals were able to attain the maximum 0.5% revenue at risk, while 6 hospitals lost all 0.5% under MPA.

In early recognition that payment and performance measures were not efficiently aligned across hospitals, physicians, and other health care providers, the State obtained a care redesign amendment for APM in May 2017. TCOC now includes two different care redesign programs. The Hospital Care Improvement Program (HCIP), implemented by hospitals and physicians with privileges to practice at hospitals, seeks to improve efficiency and quality of care by encouraging effective care transitions, encouraging effective management of inpatient resources, and decreasing potentially avoidable utilization. Currently, 7 hospitals participate in HCIP. The Episode Care Improvement Program (ECIP) allows a hospital to link payments across providers for certain items and services furnished during an episode of care in order to align incentives, improve care management, eliminate unnecessary care, and reduce post-discharge emergency department visits and hospital readmissions. Currently, 22 hospitals participate in ECIP. Participating hospitals in HCIP and ECIP are listed in **Appendix 3**.

A third care redesign program, the Complex and Chronic Care Improvement Program (CCIP), aimed to strengthen primary care supports for complex and chronic patients, enhance care management, and facilitate overall practice transformation toward person-centered care. CCIP will end in December 2019 due to low participation and redundancy with the MDPCP.

Outcome and Population Measures

As highlighted in Exhibit 9, TCOC also includes a process to develop outcome-based credits aimed at improving general population health. Currently, the only outcome-based credit approved by CMMI is for programs that prevent and/or delay the onset of diabetes. Under this credit, if fewer Marylanders are diagnosed with diabetes in a given year, the State will be eligible to receive financial credits that will help achieve the savings goals under TCOC. HSCRC calculated the actuarial value of preventing one case of diabetes at $14,512 over a five-year period. Each year, the number of diabetes cases in Maryland will be compared to a control group aggregated from other states diabetes rates per 10,000 adults. The number of diabetes cases prevented in the over 45 population in Maryland will then be estimated and multiplied by $14,512 to calculate the total credit applied to Maryland's savings goal for TCOC in that year.

The other population based credit being considered by HSCRC pertains to the opioid crisis, although this has yet to be finalized. HSCRC reports that the third and final population health priority will be presented to CMS no later than December 2020.

MDPCP

An element of TCOC is the MDPCP, a voluntary program open to all qualifying Maryland primary care providers that makes available funding and support for the delivery of advanced primary care in Maryland. The MDPCP is intended to move Medicare fee-for-service (FFS) beneficiaries into advanced primary care and is an important part of meeting the commitments in TCOC by providing management of care and reducing unnecessary hospital and emergency department utilization. Provider practices must be approved by CMMI for participation in the MDPCP. Participating practices must undertake five functions to meet the standards for advanced primary care: (1) access to care and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver experience; and (5) planned care for health outcomes.

As of January 1, 2020, 476 practices were participating, representing all counties in Maryland. This is nearly 100 additional practices over the 370 participating in program year one. DLS estimates that there are 750 total eligible practices in the State. Providers are encouraged to enroll in the MDPCP through prospective additional per beneficiary per month payments (PBPM) for Medicare FFS. These payments and a performance bonus are based on a provider's progress through the MDPCP, either Track One or Track Two. On the first track, monthly care management fee payments range from $6 to $50 PBPM and $9 to $100 on Track Two. The MDPCP also includes a performance-based incentive of up to $2.50 and $4 PBPM.

These PBPM incentives are fully funded through Medicare. Practices may choose which track to apply for, but after the third year in the program, Track One practices must transition to Track Two. **Appendix 4** provides information on the requirements for each function by track.

While the additional FFS payments encourage providers to better align their practices with TCOC, the payments count against Maryland's goals under the TCOC agreement with CMS. Calendar 2019 saw $66 million in payments to primary care providers. In order for the MDPCP to contribute to the TCOC model, savings through advanced primary care will need to outpace these additional payments. **DLS recommends adopting narrative requesting the evaluation of the MDPCP. This evaluation should include comparisons of the MDPCP additional FFS payments and costs savings attributed to avoidable hospital or emergency department utilization by individuals receiving primary care services through the MDPCP.**

Operating Budget Recommended Actions

1. Adopt the following narrative:

   Health Services Cost Review Commission Evaluation of the Maryland Primary Care Program: Given the role of the Maryland Primary Care Program (MDPCP) in transforming care in the State under the total cost of care model, the budget committees request information on the effectiveness of the program. In particular, this evaluation should focus on cost-savings from the MDPCP reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives.

Information Request	Author	Due Date
Evaluation of the MDPCP	Health Services Cost Review Commission	October 1, 2020

2. Adopt the following narrative:

   Health Services Cost Review Commission Policy on and Management of Hospital Profits: Given the spending targets under the total cost of care model and Maryland's regulation of hospitals under global budgets, the committees are interested in how the Health Services Cost Review Commission (HSCRC) intends to manage hospitals that are generating excessive operating profits under regulated rates. HSCRC should submit a report detailing its policy on the appropriate level of hospital profits, detail tools available to regulate hospital profits, and outline future plans to employ these strategies to contain regulated profits.

Information Request	Author	Due Date
Policy tools available to HSCRC to constrain excessive hospital profits	HSCRC	October 1, 2020

3. Add the following language to the special fund appropriation:

   , provided that $1,000,000 of this appropriation made for the purpose of community health grants may not be expended for that purpose and instead may only be used to support Local Health Improvement Coalitions contingent on legislation delaying any change in revenue allocations to the Community Health Resource Commission. Funds not expended for this restricted purpose may not be transferred by budget amendment or otherwise to any other purpose and shall be canceled.

   Explanation: This budget language restricts $1,000,000 of special funds in the Community Health Resource Commission budget to be used to support Local Health Improvement Coalitions.

Appendix 1
2019 *Joint Chairmen's Report* Responses from Agency

The 2019 *Joint Chairmen's Report* (JCR) requested that the Health Regulatory Commissions prepare two reports. In addition to the reports discussed below, the Maryland Health Care Commission (MHCC) was tasked with assisting in a study of the services available at University of Maryland Shore Medical Center – Chestertown. At the time of this analysis, that report has yet to be submitted. Electronic copies of the full JCR responses can be found on the Department of Legislative Services Library website.

- ***Maryland Primary Care Program (MDPCP) Impact and Evaluation of Behavioral Health Services:*** The submitted Health Services Cost Review Commission (HSCRC) report detailed the components required for behavioral health integration (BHI) in the MDPCP. Further, the MDPCP held a webinar series on integrating behavioral health into primary care practices. The MDPCP reports that 223 the MDPCP practices are utilizing some model of BHI. The participating practices must complete quarterly reports and identify which model(s) of BHI they are utilizing. The report discusses two main models for BHI: (1) "Primary Care Behaviorist Model," which includes screening and a behavioral health specialist located at the practice site; and (2) "Care Management Model," which also screens patients but does not colocate a behavioral health specialist, rather has a care manager specializing in behavioral health. The MDPCP is discussed in Issue 1.

- ***Funding Plan for the MDPCP:*** HSCRC and MHCC submitted a letter to the budget committees noting that the expired Maryland Health Insurance Plan special funds proposed to fund the MDPCP were used to support Medicaid provider reimbursements as required by the Budget Reconciliation and Financing Act of 2019. The program management office for the MDPCP has a $3.2 million operating budget in HSCRC's budget, which MHCC and HSCRC both expressed commitment to find sustainable funding to support. At the time of the initial submission, that assessment of those funding options had not been completed, and the respective commissions planned to submit an addendum upon its completion. As discussed in the budget section of this analysis, support for fiscal 2020 and 2021 is included in various parts of the Maryland Department of Health's budget.

Appendix 2
Audit Findings

Audit Period for Last Audit:	July 1, 2014 – July 8, 2018
Issue Date:	Month Year
Number of Findings:	1
Number of Repeat Findings:	1
% of Repeat Findings:	100%
Rating: (if applicable)	

Finding 1: **The Maryland Health Care Commission (MHCC) did not have sufficient procedures and controls over the Maryland Trauma Physician Services Fund payments and related collections. In addition to finding mispayments for the Trauma Physicians Services Fund, the Office of Legislative Audits (OLA) found that MHCC did not have a process for retrieving overpayments. Further, OLA expressed concerns over the fund's recordkeeping consolidated within two staff positions.**

*Bold denotes item repeated in full or part from preceding audit report.

Appendix 3
Hospitals Participating in Care Redesign Program

Hospitals	Participation in: ECIP	HCIP
Anne Arundel Medical Center	X	
Atlantic General Hospital	X	
Carroll Hospital	X	
Doctors Community Hospital		X
Frederick Memorial Hospital	X	X
Greater Baltimore Medical Center	X	
Holy Cross Hospital	X	X
Holy Cross Hospital – Germantown		X
Howard County General Hospital	X	
Johns Hopkins Bayview Medical Center	X	
Johns Hopkins Hospital	X	
Medstar Franklin Square Medical Center	X	
Medstar Good Samaritan Hospital	X	
Medstar Harbor Hospital	X	
Medstar Montgomery Medical Center	X	
Medstar Southern Maryland Hospital Center	X	
Medstar St. Mary's Hospital	X	
Medstar Union Memorial Hospital	X	
Meritus Medical Center	X	
Meritus Medical Center		X
Northwest Hospital	X	
Peninsula Regional Medical Center	X	X
Sinai Hospital	X	
Suburban Hospital	X	
Western Maryland Health System	X	X

ECIP: Episode Care Improvement Program
HCIP: Hospital Care Improvement Program

Source: Health Services Cost Review Commission

Appendix 4
Maryland Primary Care Program Requirements

Function	Track 1 Requirements	Additional Track 2 Requirements
Access and Continuity	Empanel patients to care team	Ensure that patients have regular access through at least one alternative strategy (telemedicine, group visits, *etc.*)
	Provide access to care team or practitioner 24/7	
Care Management	Ensure that beneficiaries are risk stratified	Ensure that beneficiaries in long-term care management are engaged in personalized care planning processes
	Ensure that all beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, long term care management	Ensure that beneficiaries in long-term care have access to comprehensive medication management
	Ensure that beneficiaries receive timely follow-up after hospital or emergency department (ED) discharges (or other triggering events) and short-term care management	
Comprehensiveness and Coordination	Ensure coordinated referral management for beneficiaries seeking care from high-volume and/or high-cost specialists, EDs, and hospitals	Provide referrals to community resources for beneficiaries with identified health-related social needs
	Ensure that beneficiaries with behavioral health needs have access to integrated behavioral health care supplied by the practice	
Beneficiary and Caregiver Experience	Convene, at least annually, a Patient-Family/Caregiver Advisory Council and integrate recommendations into care and quality improvement activities	Engage beneficiaries and caregivers in a collaborative advance care planning process
Planned Care for Health Outcomes	Improve performance on key outcomes (*e.g.*, cost of care, beneficiary experience, utilization rates	

Source: Maryland Primary Care Program

Appendix 5
Object/Fund Difference Report
Maryland Department of Health – Health Regulatory Commissions

Object/Fund	FY 19 Actual	FY 20 Working Appropriation	FY 21 Allowance	FY 20 - FY 21 Amount Change	Percent Change
Positions					
01 Regular	110.90	103.90	108.90	5.00	4.8%
02 Contractual	13.30	7.57	7.87	0.30	4.0%
Total Positions	**124.20**	**111.47**	**116.77**	**5.30**	**4.8%**
Objects					
01 Salaries and Wages	$ 13,707,197	$ 15,281,478	$ 16,095,037	$ 813,559	5.3%
02 Technical and Special Fees	1,432,521	693,322	736,070	42,748	6.2%
03 Communication	87,236	87,141	85,815	-1,326	-1.5%
04 Travel	151,373	274,294	321,992	47,698	17.4%
08 Contractual Services	117,795,341	131,354,285	135,728,609	4,374,324	3.3%
09 Supplies and Materials	120,709	72,196	83,083	10,887	15.1%
10 Equipment – Replacement	190,581	0	75,000	75,000	N/A
11 Equipment – Additional	348,635	200,000	805,475	605,475	302.7%
12 Grants, Subsidies, and Contributions	10,735,615	10,961,589	10,672,095	-289,494	-2.6%
13 Fixed Charges	449,890	540,625	797,236	256,611	47.5%
Total Objects	**$ 145,019,098**	**$ 159,464,930**	**$ 165,400,412**	**$ 5,935,482**	**3.7%**
Funds					
03 Special Fund	$ 143,339,729	$ 158,714,930	$ 165,000,412	$ 6,285,482	4.0%
05 Federal Fund	54,890	0	0	0	0.0%
09 Reimbursable Fund	1,624,479	750,000	400,000	-350,000	-46.7%
Total Funds	**$ 145,019,098**	**$ 159,464,930**	**$ 165,400,412**	**$ 5,935,482**	**3.7%**

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.

Appendix 6
Fiscal Summary
Maryland Department of Health – Health Regulatory Commissions

Program/Unit	FY 19 Actual	FY 20 Wrk Approp	FY 21 Allowance	Change	FY 20 - FY 21 % Change
01 Maryland Health Care Commission	$ 42,157,110	$ 35,279,461	$ 33,873,132	-$ 1,406,329	-4.0%
02 Health Services Cost Review Commission	94,784,505	116,173,730	123,527,280	7,353,550	6.3%
03 Maryland Community Health Resources	8,077,483	8,011,739	8,000,000	-11,739	-0.1%
Total Expenditures	**$ 145,019,098**	**$ 159,464,930**	**$ 165,400,412**	**$ 5,935,482**	**3.7%**
Special Fund	$ 143,339,729	$ 158,714,930	$ 165,000,412	$ 6,285,482	4.0%
Federal Fund	54,890	0	0	0	0.0%
Total Appropriations	**$ 143,394,619**	**$ 158,714,930**	**$ 165,000,412**	**$ 6,285,482**	**4.0%**
Reimbursable Fund	$ 1,624,479	$ 750,000	$ 400,000	-$ 350,000	-46.7%
Total Funds	**$ 145,019,098**	**$ 159,464,930**	**$ 165,400,412**	**$ 5,935,482**	**3.7%**

Note: The fiscal 2020 appropriation does not include deficiencies, planned reversions, or general salary increases. The fiscal 2021 allowance does not include contingent reductions or general salary increases.