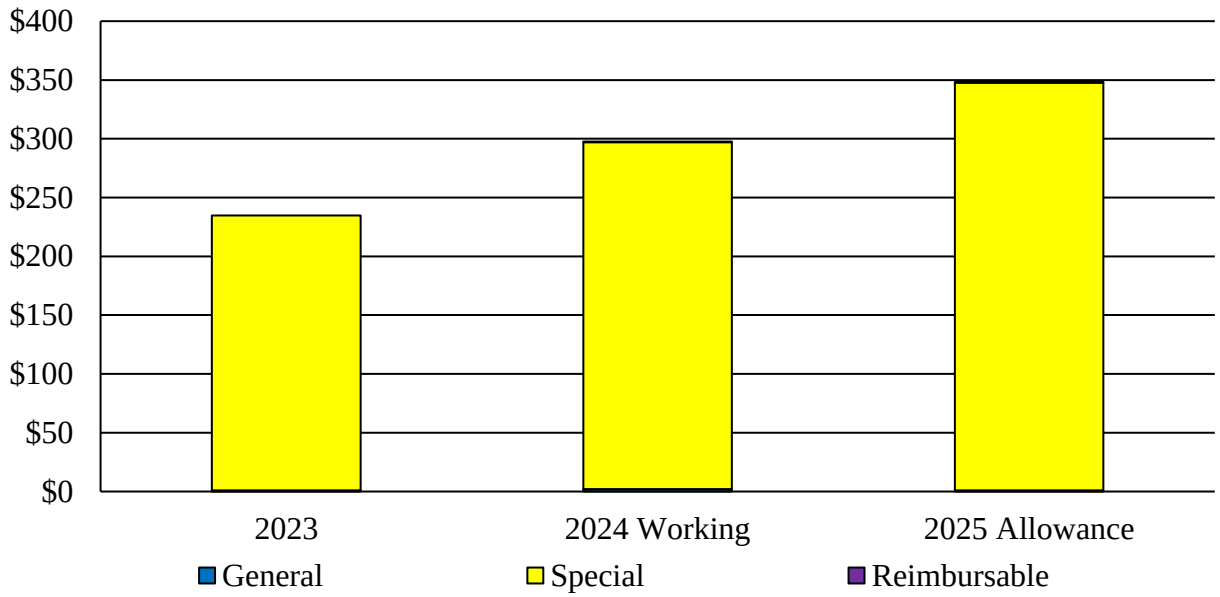
M00R01
Health Regulatory Commissions
Maryland Department of Health

Program Description

Three independent agencies within the Maryland Department of Health (MDH) comprise the Health Regulatory Commissions: (1) the Maryland Health Care Commission (MHCC); (2) the Health Services Cost Review Commission (HSCRC); and (3) the Maryland Community Health Resources Commission (MCHRC). These commissions regulate health care delivery, monitor price and affordability of service delivery, set hospital rates for regulated services, and expand access to care for Marylanders, respectively. Each commission has its own separate goals and initiatives. The Health Regulatory Commissions analysis also includes funding for the Prescription Drug Affordability Board (PDAB), which is an independent unit that was established in Chapter 692 of 2019 to protect Maryland residents and the State's health care system from the high costs of prescription drug products.

Operating Budget Summary

Fiscal 2025 Budget Increases $50.7 Million, or 17.1%, to $348.3 Million
($ in Millions)



Note: The fiscal 2024 working appropriation includes deficiencies. The fiscal 2024 impacts of statewide salary adjustments appear in the Statewide Account in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2025 impacts of the fiscal 2024 statewide salary adjustments appear in this agency's budget. The fiscal 2025 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget.

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- Various special funds support the Health Regulatory Commissions budget. The Uncompensated Care Fund (UCF) accounts for $135 million, or 39%, of the total fiscal 2025 allowance. In addition, the fiscal 2025 allowance includes $110 million in special funds from the Blueprint for Maryland's Future Fund for the Consortium on Coordinated Community Supports. Remaining special funds mainly consist of user fees assessed on health care payors, hospitals, nursing homes, and health care practitioners, among other special fund sources. General fund appropriations total $1.0 million in fiscal 2023 and 2025 and $2.0 million in fiscal 2024. Reimbursable fund appropriations total $560,000 in fiscal 2024 and 2025.

- The largest drivers of the increase of $50.7 million in the fiscal 2025 allowance compared to the fiscal 2024 working appropriation after accounting for a proposed deficiency appropriation are increases of $25.2 million for the Consortium on Coordinated Community Supports and $23.0 million in UCF expenditures. This spending growth is partially offset by the end of a one-time proposed deficiency that would add $5 million to the fiscal 2024 operating grant to the R Adams Cowley Shock Trauma Center (Shock Trauma).

Fiscal 2024

Implementation of Legislative Priorities

PDAB Operating Costs

MHCC staffed and funded PDAB from fiscal 2020 to 2022 while the board established a dedicated funding source of annual fees on prescription drug product manufacturers, pharmacy benefit managers, carriers, and wholesale prescription drug product distributors. Chapters 4 and 28 of 2021 required PDAB to repay any funds received from MHCC over a three-year period beginning June 1, 2021. Section 19 of the fiscal 2024 Budget Bill (Chapter 101 of 2023) added $1.0 million in general funds for operating costs supporting PDAB, and of this funding, $614,216 was used in October 2023 to reimburse MHCC for initial PDAB operating expenses. The October 2023 payment to MHCC completed the required reimbursement.

As of February 2, 2024, PDAB expected to spend remaining general funds totaling $385,784 on salaries in fiscal 2024. The board indicated that the availability of general funds to supplant PDAB special fund need allows the board to invest in long-term projects, such as transitioning to a website hosted by the Department of Information Technology, building databases, and procuring services related to the board's cost review function. Additionally, PDAB reported that the general funds contribute to an anticipated positive PDAB fund balance at the end of fiscal 2024, without requiring a fee increase. At the end of fiscal 2023, the PDAB special fund had a closing balance of $671,142.

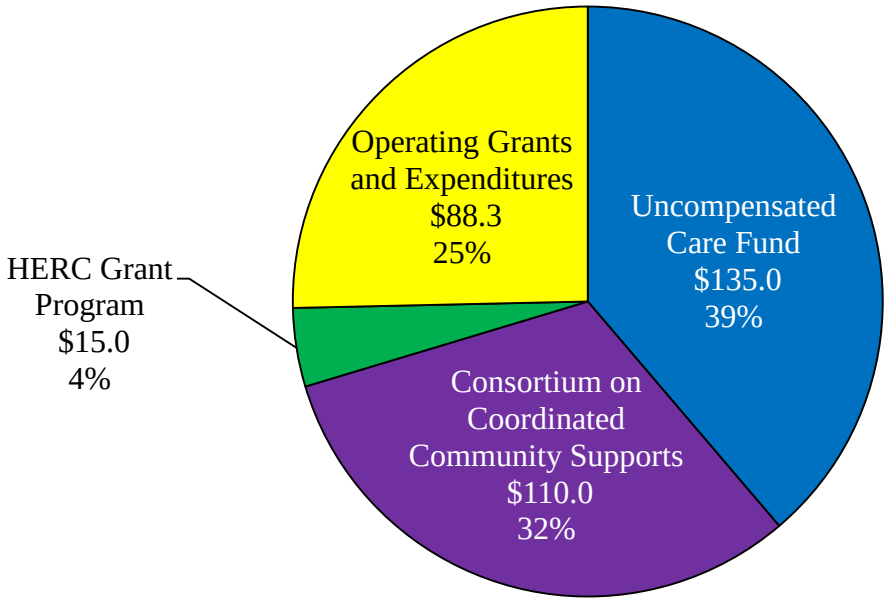
Proposed Deficiency

The fiscal 2025 budget includes a proposed deficiency of $5 million in special funds from the Maryland Emergency Medical System Operations Fund (MEMSOF) for MHCC to distribute a one-time enhancement to the operating grant for Shock Trauma. Section 19 of the fiscal 2024 Budget Bill added general funds within the Maryland Institute for Emergency Medical Services Systems (MIEMSS) to be paid into MEMSOF to cover shortfalls in the fund, which included language to ensure that Shock Trauma received grant awards of $8.7 million in fiscal 2024 and $3.7 million in fiscal 2025. MHCC's fiscal 2024 working appropriation, adjusted to add the proposed deficiency, and fiscal 2025 allowance meets these specified grant awards.

Fiscal 2025 Overview of Agency Spending

The fiscal 2025 allowance for the Health Regulatory Commissions totals $348.3 million, almost entirely in special funds. As shown in **Exhibit 1**, the largest component of the budget is the UCF at $135 million, accounting for 39% of total expenditures. HSCRC distributes the UCF to acute general hospitals that provide a disproportionate amount of uncompensated care through charity care or financial assistance and bad debt for regulated services that are not anticipated to be paid for out-of-pocket by the patient. The next largest share of the budget is the Consortium on Coordinated Community Supports within MCHRC, with $110 million in special funds from the Blueprint for Maryland's Future Fund, or 32%, of the fiscal 2025 allowance. MCHRC also administers the Health Equity Resource Communities (HERC) grant program, which comprises 4% of the budget.

Exhibit 1
Overview of Agency Spending
Fiscal 2025 Allowance
($ in Millions)



Total Expenditures: $348.3 Million

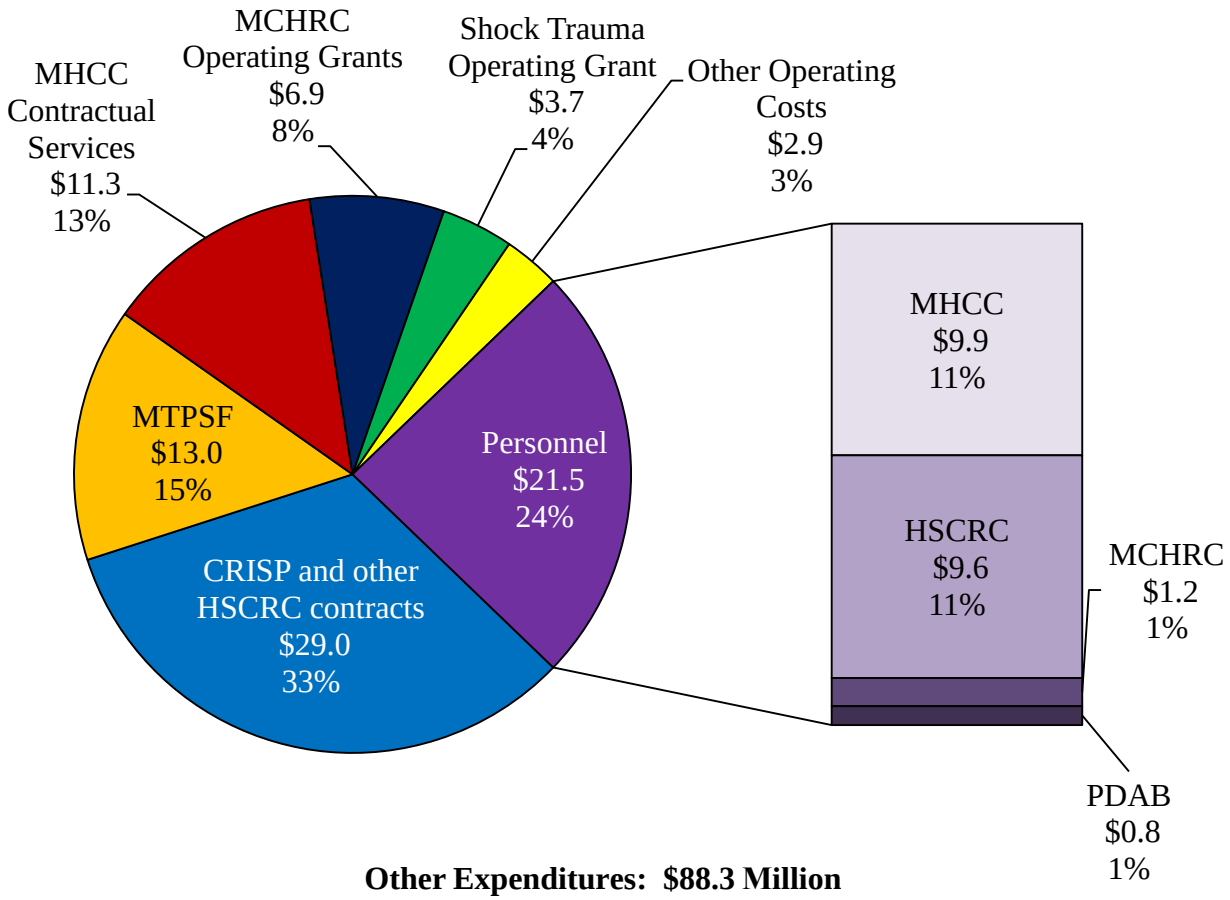
HERC: Health Equity Resource Communities

Note: The fiscal 2025 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

Source: Department of Budget and Management

Exhibit 2 shows the remaining $88.3 million in operating expenditures and grants (accounting for 25% of the total fiscal 2025 allowance) excluding the UCF, Consortium, and HERC grants. Of this funding, $23.6 million, or 26.7%, supports grants for health care programs and initiatives including MCHRC operating grants and trauma services through the Maryland Trauma Physician Services Fund (MTPSF) and an operating grant for Shock Trauma. The State's designated health information exchange, Chesapeake Regional Information System for our Patients (CRISP) and other HSCRC contracts account for $29 million, or 33%, of operating costs. Personnel expenses comprise $21.5 million, or 24%, of operating costs, primarily supporting MHCC and HSCRC.

Exhibit 2
Operating Expenditures and Grants
Fiscal 2025 Allowance
($ in Millions)



Other Expenditures: $88.3 Million

CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resources Commission
MHCC: Maryland Health Care Commission
MTPSF: Maryland Trauma Physician Services Fund
PDAB: Prescription Drug Affordability Board
Shock Trauma: R Adams Cowley Shock Trauma Center.

Note: The fiscal 2025 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

Source: Department of Budget and Management

Proposed Budget Change

As shown in **Exhibit 3**, the fiscal 2025 allowance increases by $50.7 million compared to the fiscal 2024 working appropriation, after accounting for a proposed deficiency adding a one-time $5 million enhancement to the operating grant for the Shock Trauma Center. Increases of $25.2 million for the Consortium on Coordinated Community Supports, $23.0 million in UCF expenditures, and $8 million for the CRISP health information exchange drive the overall growth in spending.

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

How Much It Grows:	General Fund	Special Fund	Reimb. Fund	Total
Fiscal 2023 Actual	$1,000	$233,719	$0	$234,719
Fiscal 2024 Working Appropriation	2,000	294,984	560	297,544
Fiscal 2025 Allowance	1,000	346,730	560	348,290
Fiscal 2024-2025 Amount Change	-$1,000	$51,747	$0	$50,747
Fiscal 2024-2025 Percent Change	-50.0%	17.5%		17.1%

Where It Goes:	Change
Personnel Expenses	
Salary increases and associated fringe benefits including fiscal 2024 COLA and increments	$763
Reclassification	166
Salary and fringe benefits for 1.0 new HSCRC position	126
Additional administrative assistance for MCHRC due to recent program expansions	68
Turnover adjustments (increase from 4.33% to 4.40%)	-13
Other fringe benefit adjustments	-3
Health Services Cost Review Commission	
Uncompensated Care Fund	23,000
CRISP support due to an expected reduction in federal funding and expansion of data reporting and capabilities	8,000
New contract for full-rate reviews of individual hospitals	1,000
Consultant services to implement a newly designed annual filing form for hospitals using a web-based application	750
Information technology costs for software packages, enhanced remote access, and hospital data storage	721
End of a multi-vendor contract for data analysis and other services supporting rate setting, partially offset by new contracts with individual vendors	-3,285

Where It Goes:	**Change**
Maryland Health Care Commission	
Maryland Trauma Physician Services Fund	400
Audit services for CRISP privacy and security	280
Contract for database development	-592
Fiscal 2024 enhancement from the MEMSOF for the R Adams Cowley Shock Trauma Center operating grant	-5,000
Other Changes	
Consortium on Coordinated Community Supports (special funds from the Blueprint for Maryland's Future Fund)	25,155
Maryland Department of Health indirect costs	278
End of PDAB special fund repayment to the Maryland Health Care Commission	-300
One-time fiscal 2024 general fund appropriation for PDAB operating costs	-1,000
Other expenses	231
Total	**$50,747**

COLA: cost-of-living adjustments
CRISP: Chesapeake Regional Information System for Our Patients
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resources Commission
MEMSOF: Maryland Emergency Medical System Operations Fund
PDAB: Prescription Drug Affordability Board

Note: Numbers may not sum to total due to rounding. The fiscal 2024 working appropriation includes deficiencies. The fiscal 2024 impacts of statewide salary adjustments appear in the Statewide Account in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2025 impacts of the fiscal 2024 statewide salary adjustments appear in this agency's budget. The fiscal 2025 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget.

Consortium on Coordinated Community Supports

Chapter 36 of 2021 (the Blueprint for Maryland's Future – Implementation) established the Maryland Consortium on Coordinated Community Supports within MCHRC to:

- develop coordinated community supports partnerships to meet student behavioral health needs and other related challenges in a holistic, nonstigmatized, and coordinated manner;
- provide expertise in developing best practices in the delivery of behavioral health services, supports, and wraparound services; and
- provide technical assistance to local school systems to support positive classroom environments and close achievement gaps.

Allowable Uses of Consortium Grants

The consortium is also tasked with implementing a grant program for coordinated community supports partnerships and developing a model for expanding available behavioral health services and supports to all students through the maximization of public funding through Medicaid (including billing for administrative costs), among other financing efforts. Chapter 36 required the Governor to appropriate increasing minimum funding levels for the consortium's grant program, and Chapter 713 of 2022 further increased mandated grant funding by $10 million each year. As a result, the mandated levels total $85 million and $110 million in fiscal 2024 and 2025, respectively. The fiscal 2024 working appropriation and fiscal 2025 allowance meet these funding requirements with special fund support from the Blueprint for Maryland's Future Fund. In accordance with Chapter 713, the Governor must appropriate at least $130 million for these grants annually beginning in fiscal 2026. Allowable uses of the consortium funding include:

- providing reimbursement to support the work of the consortium, under a memorandum of understanding, to the National Center for School Mental Health and other technical assistance providers;

- providing grants to coordinated community supports partnerships to deliver services and supports to meet students' holistic behavioral health needs; and

- paying associated administrative costs.

The Budget Reconciliation and Financing Act (BRFA) of 2024 contains a provision to expand the authorized uses of Blueprint funds for the consortium to include providing school-based behavioral health services and reimbursing the MDH Medical Care Programs Administration (MCPA) for school-based behavioral health services provided on a fee-for-service (FFS) basis through a Medicaid waiver. Medicaid reimbursement for school-based services is currently limited to services required by a student's Individual Educational Plan (IEP) and services provided by community-based providers that directly bill Medicaid. MDH indicated that it plans to amend regulations and seek federal approval for a State Plan Amendment to the Medicaid program that would allow for reimbursement for services delivered by school psychologists and social workers for students with or without IEPs. MDH indicates that it expects to implement this reimbursement beginning in the first quarter of calendar 2025.

By spending Blueprint special funds within the consortium to reimburse MDH for general funds spent on eligible Medicaid-covered services, this State spending would receive matching federal fund rates of 50% under Medicaid and 65% under the Maryland Children's Health Program (MCHP). MDH estimates that $27.4 million in total funds ($12.7 million in general funds and $14.7 million in federal funds) will be spent in fiscal 2025 to provide school-based services to just under 530,000 students enrolled in Medicaid or MCHP and to support MDH technical assistance. The BRFA provision would allow the consortium to reimburse MDH for the $12.7 million of general fund expenditures and support school-based behavioral health services directly with Blueprint for Maryland's future funding. At that level, approximately $97.3 million

in Blueprint funds allocated for the consortium in fiscal 2025 would still be available for other authorized uses.

First Round of Consortium Grants

In August 2022, the consortium began meeting and, in August 2023, issued its first request for proposals (RFP) focused on grants to service providers statewide to expand access to high quality behavioral health or wraparound services. The RFP described the grants as being able to support each tier of the multi-tiered system of supports: (1) universal promotion or prevention; (2) early intervention; and (3) treatment. Under the RFP, the consortium made $120 million in funding available for 18-month grant terms beginning January 2024. This amount includes prior year special funds that were allocated to MCHRC and accrued to fiscal 2024. As shown in **Exhibit 4**, the consortium received a total request of $380.9 million across 258 eligible proposals. Of these, $136.4 million in requests for 123 projects in all 24 jurisdictions were recommended to advance for grant consideration by an application review committee. MCHRC anticipated awarding services grants in late January 2024 but had not yet published the awards as of February 3, 2024.

Exhibit 4
Proposals for Community Supports Service Grants by Jurisdiction
Fiscal 2024
($ in Thousands)

	Proposals Received	Funds Requested	Rec. Proposals	Rec. Funds	% Projects Rec.	% Funds Rec.
Allegany County	1	$831.8	1	$831.8	100%	100%
Anne Arundel County	17	28,399.9	8	13,392.6	47%	47%
Baltimore City	18	26,961.2	11	13,615.0	61%	50%
Baltimore County	12	18,959.1	7	9,492.4	58%	50%
Calvert County	16	42,437.3	7	3,427.2	44%	8%
Caroline County	2	766.2	2	766.2	100%	100%
Carroll County	5	6,928.4	2	1,853.5	40%	27%
Cecil County	10	5,606.5	5	2,634.5	50%	47%
Charles County	5	5,310.2	4	4,833.3	80%	91%
Dorchester County	9	8,623.8	4	1,417.5	44%	16%
Frederick County	21	13,360.9	12	8,685.6	57%	65%
Garrett County	2	1,334.7	1	796.2	50%	60%
Harford County	15	10,134.0	7	5,401.0	47%	53%
Howard County	10	12,181.4	5	5,661.0	50%	46%
Kent County	4	2,229.8	2	1,033.8	50%	46%
Montgomery County	10	19,978.2	8	13,256.6	80%	66%
Prince George's County	55	131,115.4	19	35,646.3	35%	27%

	Proposals Received	Funds Requested	Rec. Proposals	Rec. Funds	% Projects Rec.	% Funds Rec.
Queen Anne's County	7	$10,798.2	4	$1,495.9	57%	14%
Somerset County	6	3,104.6	1	587.0	17%	19%
St. Mary's County	4	4,952.6	2	3,233.1	50%	65%
Talbot County	3	6,989.0	1	871.4	33%	12%
Washington County	13	12,021.0	6	4,663.2	46%	39%
Wicomico County	4	2,166.8	2	1,343.3	50%	62%
Worcester County	9	5,687.0	2	1,510.4	22%	27%
Total	**258**	**$380,877.9**	**123**	**$136,448.7**	**48%**	**36%**

Source: Maryland Community Health Resources Commission

In October 2023, the consortium released a second RFP for grants to hub pilot programs that would coordinate service providers, act as a fiduciary by managing MCHRC grants and awarding grants to service providers as subgrantees and collect and report data. The RFP listed local behavioral health authorities and local management boards as the only two types of organizations eligible to apply for this funding and outlined allowable uses as mainly operating expenses. MCHRC anticipated providing $300,000 to $500,000 per hub grant, which would also have a term that expires June 30, 2025, in line with the services grants. MCHRC anticipated awarding the hub grants in February or March 2024.

MCHRC should clarify:

- **the timing of Consortium on Coordinated Community Supports service grants and hub grant distribution;**

- **whether the first round of service grants spends all Blueprint funding carried over from prior years and the fiscal 2024 appropriation, or if there will be remaining funds; and**

- **the timing and criteria for awarding consortium grants using $110 million allocated in the fiscal 2025 allowance, considering that the first RFP for service grants will be awarded for an 18-month term ending June 30, 2025.**

The Department of Legislative Services (DLS) recommends adopting committee narrative requesting a report on the timing and use of consortium grants in fiscal 2024 and 2025 year to date.

Change in Funding Source for MCHRC Operating Grants

In addition to the Consortium on Coordinated Community Supports grants and the HERC grant program, MCHRC provides grants to support the State's safety net providers who operate programs targeting various health priorities. The current funding priorities for these grants include diabetes prevention; maternal and child health; and behavioral health services, including overdose response activities. Operating grants along with MCHRC's administrative expenses had been supported with funding through the Carefirst premium tax credit exemption through fiscal 2022. These funds were shared between MCHRC and the Senior Prescription Drug Assistance Program (SPDAP) under MCPA, with MCHRC traditionally receiving $8 million. Over time, however, the ability of this fund source to support both programs waned. As a result, a provision in the BRFA of 2021 dedicated all Carefirst premium tax exemption funding to SPDAP beginning in fiscal 2023 and diverted $8 million of the health insurance provider assessment that primarily supports the Reinsurance Program in the Maryland Health Benefit Exchange to MCHRC in fiscal 2023 and 2024 only.

Chapter 644 of 2023 requires the Governor to allocate $8.0 million from the Cigarette Restitution Fund (CRF) to MCHRC each year from fiscal 2025 through 2029. The fiscal 2025 allowance provides CRF special funds totaling $6.9 million for operating grants and $1.1 million for administrative expenses. CRF uses are restricted in statute. For example, at least 30% of the annual appropriation must be used for Medicaid. Due to Medicaid being an entitlement program, any shortfalls in CRF availability resulting from the new use in MCHRC through fiscal 2029 would require general funds to backfill the costs that would have otherwise been paid for with CRF support. The fiscal 2025 allowance projects enough CRF revenue to cover the new MCHRC appropriation while still maintaining required the funding level for Medicaid, though the fiscal 2025 closing fund balance is projected at only $20,000.

Personnel Data

	FY 23 Actual	FY 24 Working	FY 25 Allowance	FY 24-25 Change
Regular Positions	116.90	117.90	118.90	1.00
Contractual FTEs	7.47	11.66	11.51	-0.15
Total Personnel	**124.37**	**129.56**	**130.41**	**0.85**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	5.19	4.40%
Positions and Percentage Vacant as of 12/31/23	13.00	11.03%
Vacancies Above Turnover	7.81	

- The fiscal 2025 allowance includes 1 new position under HSCRC to support the Hospital Performance Measurement Team within the Center for Quality and Population-based Methodologies by performing data quality assurance and analytics, among other duties.

- As of December 31, 2023, the Health Regulatory Commissions had 13 vacancies, including: 6 positions in MHCC; 4 positions in MCHRC; and 3 positions in HSCRC. Of the vacancies in MCHRC, 3 were new program manager positions provided in fiscal 2024.

Key Observations

1. State Funding for Trauma Centers in Maryland

Trauma centers are hospital facilities designated by MIEMSS that meet specified regulatory standards. Trauma care designations include Primary Adult Resource Center (PARC), Levels I through III centers, pediatric trauma centers, and specialty referral centers. Of these designations, PARC and Level I trauma centers must meet the highest standards. Although HSCRC covers many trauma center costs directly and indirectly in the global budget revenue (GBR) provided through its hospital rate-setting model, certain unregulated trauma costs are not covered. For example, physician rates and fee schedules fall outside of HSCRC's regulatory authority and are not included in GBR. HSCRC accounts for certain standby costs for trauma physicians, but the physicians must be on the hospital premise and may not be on-call, while MIEMSS' standards for trauma centers include having certain types of physicians on-call at all times.

Maryland Trauma Physician Services Fund

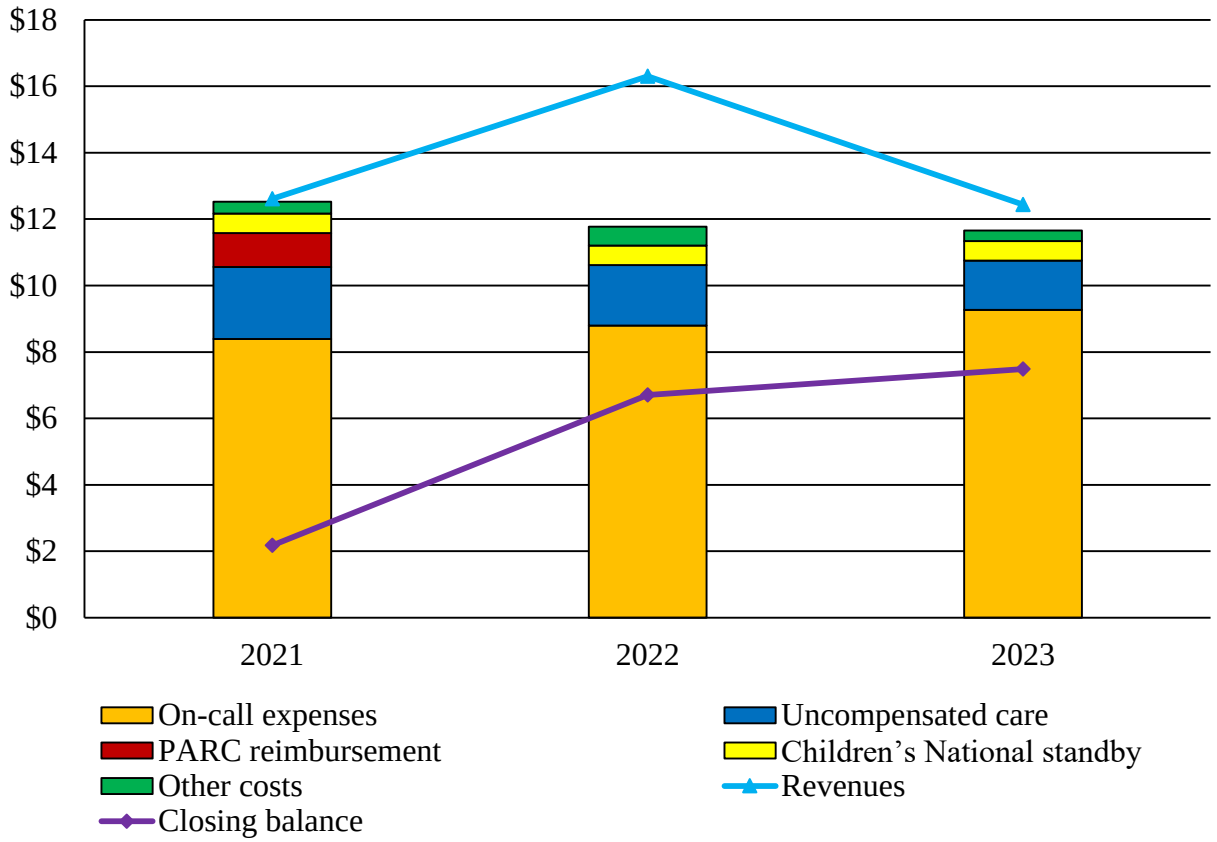
MHCC and HSCRC jointly administer the MTPSF to subsidize the following documented costs:

- uncompensated care incurred by a trauma physician in providing trauma care;
- undercompensated care incurred by a trauma physician in providing trauma care to Medicaid enrollees;
- costs incurred by a trauma center to maintain trauma physicians on-call as required by MIEMSS;
- costs incurred by the State PARC (Shock Trauma) to maintain specified surgeons and anesthesiologists on-call and on standby as required by MIEMSS; and
- costs incurred by MHCC and HSCRC to administer the fund and audit reimbursement requests.

The MTPSF is financed by a $5 surcharge on all Maryland vehicle registrations. Disbursements from the fund must be made in accordance with a methodology established jointly by MHCC and HSCRC to calculate costs incurred by trauma physicians and centers that are eligible to receive reimbursement. The established methodology must meet numerous requirements outlined in statute. Those requirements specifically outline the parameters to determine the amount of reimbursement made to trauma physicians and trauma centers for Levels I, II, and III trauma centers; a pediatric trauma center; and the Maryland Trauma Specialty Referral Centers. As shown in **Exhibit 5**, MTPSF revenues, including a $4.0 million general fund

appropriation in fiscal 2022, have outpaced recent expenditures. Primarily due to the general fund appropriation, the closing MTPSF balance grew from $2.2 million in fiscal 2021 to $7.5 million in fiscal 2023. At a January 23, 2024, House Appropriations Committee briefing, MHCC stated that the statute governing MTPSF allocations is specific and formula-based, and that legislation would be required to alter the fund uses and allocations.

Exhibit 5
Maryland Trauma Physician Services Fund Revenues and Expenditures
Fiscal 2021-2023
($ in Millions)



Children's National: Children's National Medical Center
PARC: Primary Adult Resource Center

Note: Fiscal 2022 revenues include $4.0 million in general funds provided for the Maryland Trauma Physicians Fund.

Source: Maryland Health Care Commission; Health Services Cost Review Commission

Section 19 of the fiscal 2024 Budget Bill added $9.5 million in general funds to the Dedicated Purpose Account (DPA) to provide additional assistance to trauma facilities in Maryland experiencing financial challenges. MHCC is responsible for determining the allocation criteria for this funding, which is not required to follow MTPSF disbursement methodology. At least 45 days before the transfer of DPA funds, MHCC must submit a report to the budget committees outlining this allocation criteria. As of February 3, 2024, this report had not been submitted. Section 19 also added an enhancement to the annual operating grant supported with MEMSOF funding that MHCC distributes to Shock Trauma. A proposed deficiency adds $5 million in MEMSOF support within MHCC to increase the Shock Trauma operating grant to $8.7 million in fiscal 2024.

Commission to Study Trauma Center Funding in Maryland Recommendations

Chapters 341 and 342 of 2023 established the Commission to Study Trauma Center Funding in Maryland to assess the adequacy of trauma center funding across the State for operating, capital, and workforce costs and identify opportunities to improve funding mechanisms. The chapters required MIEMSS and MHCC to staff the commission. The Commission to Study Trauma Center Funding was required to examine the following:

- current funding sources for State-designated trauma centers;
- MTPSF expenditures and revenues since the fund's establishment;
- changes to approved MTPSF uses over time;
- statutory and regulatory requirements for trauma centers at the time the MTPSF was established and changes since its establishment;
- changes in staffing, recruitment, compensation, or other factors that would impact the funding needed to operate a trauma center in the State;
- the amount needed to adequately fund trauma centers in the State;
- the funding mechanisms available to adequately fund trauma centers; and
- funding criteria that would impact the receipt of funds by existing or new trauma centers.

The Commission to Study Trauma Center Funding was required to submit findings and recommendations to the Governor and General Assembly by December 1, 2023, regarding these areas. As of February 2, 2024, findings and recommendations had not been submitted to the Governor and General Assembly. However, the commission presented its preliminary findings and recommendations at a House Appropriations Committee hearing on January 23, 2024.

Preliminary findings included that:

- most trauma centers reported that trauma readiness funding for maintenance of on-call physicians supported through the MTPSF and standby physicians supported through regulated hospital rates covered about 50% of readiness costs;
- readiness costs for secondary specialists were difficult to link to trauma readiness;
- uncompensated care substantially declined due to insurance coverage expansion attributed to the federal Patient Protection and Affordable Care Act initiatives; and
- trauma equipment grants through the MTPSF were inadequate as they were limited to 10% of the fund reserve.

Preliminary recommendations included:

- to increase on-call payments and standby payments;
- to increase on-call payments to the pediatric, hand, eye, and burn trauma centers consistent with increases for Level II and II trauma centers;
- to add flexibility for MHCC and HSCRC to modify MTPSF parameters;
- to enable non-physician providers to receive MTPSF payments;
- to include all standby costs for the four primary specialties in hospital rates;
- to have HSCRC audit hospitals' MIEMSS incremental trauma costs associated with trauma services;
- to conduct biannual audits to confirm that managed care organizations under Medicaid are reimbursing trauma providers at the Medicare rate;
- to increase the stipend paid to National Children Hospital Medical Center in Washington, D.C. to serve Maryland pediatric trauma patients, consistent with increased on-call payments;
- to improve data systems to enable linkages between the MIEMSS trauma registry, the HSCRC hospital data set, and the MHCC All-Payer Claims Database; and
- to evaluate use of trauma quality measures as a factor in awarding funds to trauma centers.

MHCC estimated that approximately $18 million would be needed to cover the shortfall of trauma readiness for the four principal trauma specialties, not including additional physician costs for the Shock Trauma center. There are additional costs to hospitals that could be addressed through other funding mechanisms, but HSCRC reports that this needs further analysis. MHCC's recommendations outlined several ways to bridge the funding for both standby physician costs and on-call physician services. Standby costs could be evaluated through HSCRC rates, while on-call costs could be funded via direct MTPSF payments.

The Health Regulatory Commissions should discuss any plans to implement the preliminary recommendations of the Commission to Study Trauma Center Funding in Maryland and discuss the timeframe for implementation. For preliminary recommendations that would require legislative action, such as changes to MTPSF allocations, MHCC and HSCRC should discuss whether any departmental bills will be introduced in the 2024 session. MHCC should also comment on any new revenue sources or changes to existing revenue sources for trauma centers that were considered by the Commission to Study Trauma Center Funding, such as changes to the Maryland vehicle registration surcharge.

2. Proposed Regulations Related to Restrictions of Protected Health Data

Language in the fiscal 2024 Budget Bill restricted special funds in MHCC, contingent on the enactment of Chapters 248 and 249 of 2023, until MHCC submits:

- regulations to the Joint Committee on Administrative, Executive, and Legislative Review for implementing restrictions of protected health data related to legally protected health care in health information exchanges and electronic health networks, as required under Chapters 248 and 249; and

- a letter to the budget committees confirming the submission of the regulations.

Chapters 248 and 249 generally prohibit, beginning December 1, 2023, the disclosure of mifepristone data or the diagnosis, procedure, medication, or related codes for abortion care and other sensitive health services by a health information exchange, electronic health network, or health care provider. The legislation expanded the purpose of MHCC to include the establishment of policies and standards to protect the confidentiality of patient and health care practitioner information related to legally protected health care. MHCC was required to adopt regulations for implementing connectivity to health information exchanges that restrict data of patients who have obtained legally protected health care.

In a letter submitted to the budget committees on January 9, 2024, MHCC reported that it approved emergency and proposed permanent regulations at its November 2023 meeting. The proposed regulations were published in the *Maryland Register* on January 12, 2024. MHCC noted that the regulations align with MDH's emergency regulations that require health information exchange and electronic health network entities operating in Maryland to restrict the disclosure of

legally protected health information. MHCC also reported that it would gather confirmations or plans from health information exchanges and electronic health networks for the entities to ensure that they will comply with the regulations by June 1, 2024. By April 1, 2024, MHCC expects to review these plans before assessing penalties for noncompliance or issuing waivers for the requirements. Through this work and outreach, MHCC found that some health information exchanges would need more time to update their systems to be able to block text-based legally protected health information.

DLS determined the letter to be in compliance with the language and recommends the release of $100,000 in special funds restricted in fiscal 2024 pending the submission of a letter regarding regulations for restrictions of protected health data required by Chapters 248 and 249. DLS will process a letter to this effect if no objections are raised by the subcommittees.

3. Total Cost of Care Model and Maryland Primary Care Program

In July 2018, Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) agreed to the terms of the Total Cost of Care (TCOC) model. The model, effective January 1, 2019, builds on the State's prior All-Payer Model (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 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 is set to continue through calendar 2026, provided that the State meets the requirements of the agreement. This will be followed by a two-year transition period, though HSCRC indicates that Maryland could transition to a new model earlier.

Under TCOC, Maryland commits to reaching an annual Medicare expenditure savings target of $300 million through the end of calendar 2023 (program year five) in Medicare Part A (*e.g.*, hospital services) and Part B (*e.g.*, doctor office visits, preventive services, and other nonhospital services). Based on the current savings requirements of the base model, APM and TCOC are estimated to result in cumulative savings to Medicare of $2.7 billion by the end of calendar 2023.

Most Targets Met in Calendar 2022

The State met or exceeded each of the goals evaluated by CMMI for TCOC in calendar 2019 and 2020. In calendar 2021 and 2022, Maryland did not meet the performance target related to readmissions. To meet that target, Maryland had to report a readmission rate for FFS Medicare beneficiaries below the national rate each year. Maryland's readmission rates were 0.23 percentage points and 0.16 percentage points higher than the national rates in calendar 2021 and 2022, respectively. HSCRC indicated that higher unadjusted readmission rates in Maryland are likely attributable to higher patient acuity relative to the United States. As a result, CMMI has agreed to consider a risk-adjusted readmissions measure.

In calendar 2022, Maryland also failed to meet a cost-related target referred to as the guardrail test, which measures per capita Medicare spending change. Under the guardrail test, Maryland's Medicare spending growth per beneficiary cannot exceed the national spending growth rate by more than 1% in any given calendar year or by any amount for two or more consecutive years. Calendar 2022 was the second consecutive year that Maryland's Medicare spending growth per beneficiary exceeded the national growth, reporting 0.9 percentage points above in calendar 2022 after reporting 0.6 percentage points above in calendar 2021. Based on data from January 2023 to September 2023, Maryland's Medicare TCOC growth is 2.84 percentage points below national growth in that time period and HSCRC expects Maryland to meet the calendar 2023 guardrail test. **Appendix 3** shows the State's performance on each of the goals in calendar 2020 through 2022.

Calendar 2023 Corrective Actions Taken to Meet Cost-related Targets

Maryland agreed to meet all targets in its TCOC contract with CMMI, so failing to meet annual Medicare cost savings targets would be concerning as it could lead to Maryland losing significant federal financial support, systemwide service delivery reforms, and quality improvement changes that are incorporated in the model. After reporting preliminary calendar 2022 data that would have failed the guardrail test and total Medicare savings targets in that year, HSCRC implemented multiple efforts to increase annual Medicare savings in calendar 2023 to attempt to bring Maryland back in compliance with the TCOC performance targets. These actions included:

- reducing all-payer hospital rates by $40 million, effective January 2023;

- discounting Medicare payments, which would reduce hospital revenues by $64 million. This action was approved by CMMI and implemented in March 2023. In December 2023, Maryland proposed to reverse $50 million of this reduction based on stronger than anticipated performance in calendar 2024, and CMMI approved this change;

- increasing the public payer differential by 1% to reduce Medicare and Medicaid rates and increase commercial payer rates by $50 million in fiscal 2023 and 2024 only. The existing public payer differential allows Medicare and Medicaid to pay 7.7% less than other payers in hospital rates due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. This action was approved by CMMI, and took effect in April 2023 with an end date in June 2024; and

- reducing the Medicaid deficit assessment imposed on hospitals by $50 million in fiscal 2024 only. This action was enacted through the BRFA of 2023. The Medicaid deficit assessment returns to the prior level in fiscal 2025.

In October 2023, HSCRC reported that CMMI had not asked the State to take additional corrective action due to its calendar 2023 efforts to reduce Medicare spending. These efforts are expected to allow Maryland to meet calendar 2023 cost-related targets and preliminary data from

January to May 2023 showed Maryland's annual TCOC Medicare growth rate falling below the national growth rate.

Maryland Primary Care Program

Another component of the TCOC model is the Maryland Primary Care Program (MDPCP), a voluntary program that offers incentives for primary care providers to deliver advanced primary care services with the goal of improving individual and population health outcomes prioritized under the model. The incentives are fully supported with federal funds and are provided through care management fees offering additional per Medicare beneficiary per month payment for care management and team-based care, performance-based incentive payments, and comprehensive primary care payments for certain eligible providers that transition to a more stable funding stream. Payments made through the MDPCP count toward TCOC Medicare spending. Beginning in calendar 2022, CMMI added Health Equity Advancement Resource and Transformation Payment as a new component to care management fees to address beneficiaries' social needs using existing fees.

As of January 2023, 538 primary care practices located across all 24 Maryland jurisdictions participated in the MDPCP, an increase of 30 providers compared to the start of calendar 2022. Among participating practices, the program attributes Medicare beneficiaries to practices that provide a plurality of the beneficiaries' health services. Practices assigned to a panel of beneficiaries are tasked with providing advanced primary care, which uses a model similar to a patient-centered medical home. At the start of calendar 2023, approximately 50% of eligible Medicare beneficiaries in Maryland (385,000) were attributed to a provider under the MDPCP.

Given the role of the MDPCP in TCOC, the budget committees have annually requested program evaluations, with particular focus on whether the cost of incentive payments have been offset by savings elsewhere in the State's health care system. In a response to committee narrative in the 2023 *Joint Chairmen's Report* (JCR), HSCRC found that incentive payments under the program caused a net increase in costs every year from calendar 2019 through 2022. As shown in **Exhibit 6**, despite the MDPCP consistently reporting some savings by reducing inpatient utilization, the increase in care management fees outpaced the dollar impact of any savings resulting from the program. **HSCRC should comment on potential changes to the MDPCP to make it cost effective. Considering the net increase in TCOC model costs, DLS recommends adopting committee narrative requesting a report evaluating the MDPCP from HSCRC, in consultation with the MDPCP Project Management Office within MDH.**

Exhibit 6
MDPCP Performance Results, Relative to Calendar 2018
Calendar 2019-2022

	2019	2020	2021	2022
Impact on Hospital Costs	-$14.1	-$72.1	-$110.4	-$114.1
MDPCP Fees	65.9	129.7	182.0	198.6
Net Impact on Costs	**$51.7**	**$57.6**	**$71.6**	**$84.5**
Impact on Inpatient Utilization	-0.67%	-1.17%	-2.88%	-2.66%

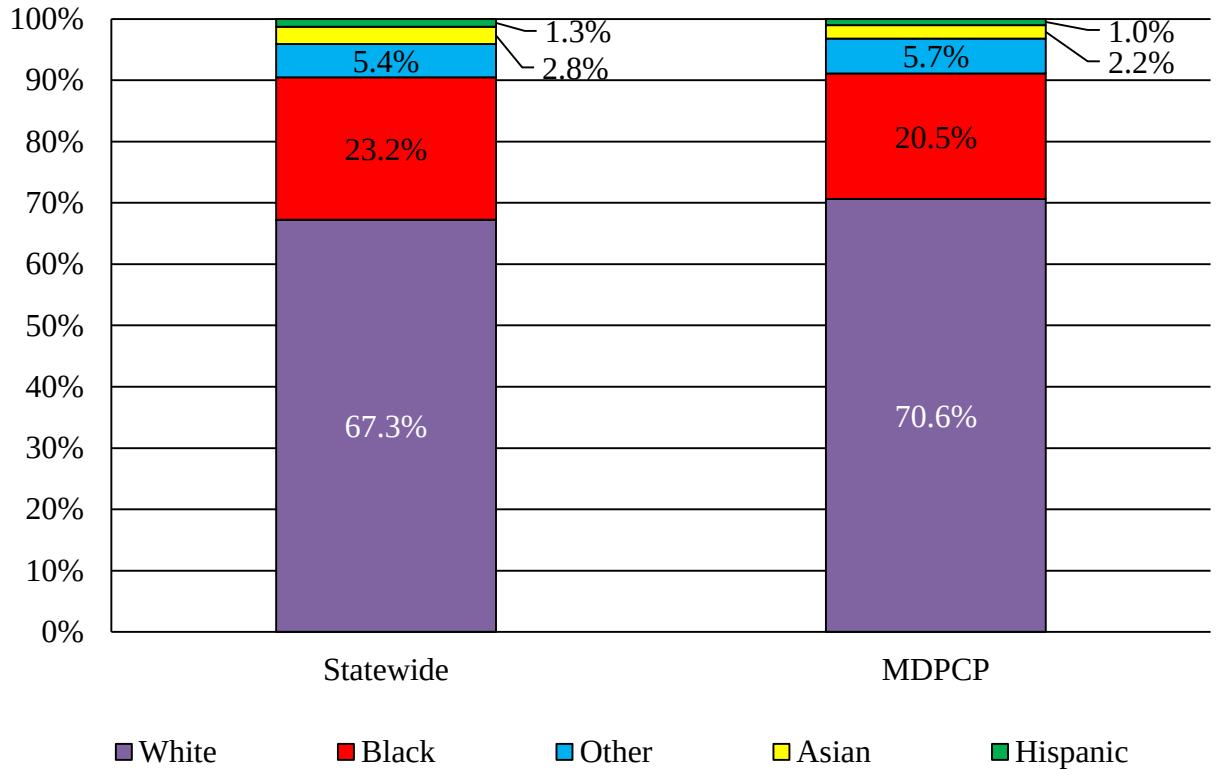
MDPCP: Maryland Primary Care Program

Note: Calendar 2019 and 2020 cost evaluation outcomes differ from previous reports due to changes in the comparison group, attribution algorithm, and risk adjustment algorithm.

Source: Health Services Cost Review Commission; Maryland Department of Health

The most recent evaluation of the MDPCP also included a consideration of the racial makeup of the participants in the program compared to statewide Medicare beneficiaries. As shown in **Exhibit 7**, as of December 2022, the MDPCP served a slightly larger share of White Medicare beneficiaries than the statewide Medicare population by 3.3 percentage points. Beginning in calendar 2022, MDPCP also collected data on the racial and ethnic diversity of participating primary care providers, albeit reporting this information is optional. Only 31.8% of practices (581 providers) reported on provider ethnicity and only 29.7% of practices (589 providers) reported on provider race. An overall breakdown of provider diversity in Maryland was not available for comparison due to voluntary reporting as well. As a result, the ability to compare information on participating providers to the overall diversity of providers operating in Maryland is limited.

Exhibit 7
Racial Diversity of MDPCP Participants Compared to Statewide Medicare Beneficiaries
December 2022



MDPCP: Maryland Primary Care Program

Source: Health Services Cost Review Commission

HSCRC's response to the 2023 JCR outlined multiple changes that MDPCP has implemented to improve the racial diversity of the program, such as allowing and recruiting Federally Qualified Health Centers to enroll as primary care providers in the program in calendar 2021. MDPCP also reported that Medicaid is in the process of becoming a MDPCP-aligned payer in calendar 2023, which would assist the program in reaching low-income and disabled individuals. The MDPCP Project Management Office within MDH also discussed outreach efforts to encourage recruiting of nonparticipating providers from racially and ethnically diverse backgrounds.

Population Health Efforts under TCOC

Statewide Integrated Health Improvement Strategy Goals and Regional Partnership Catalyst Program

The TCOC model also includes population health goals that broadly align with the State's other initiatives in overall health improvement for Marylanders. One instance of this interaction is through the Regional Partnership Catalyst program (Catalyst program or Catalyst funding). The Catalyst program took effect January 1, 2021, and will continue through December 2025. This funding is intended to align with the population health measures submitted to CMMI as a part of TCOC through the Statewide Integrated Health Improvement Strategy (SIHIS) goals.

Catalyst funding is budgeted at roughly $45 million annually, for a total five-year investment of $225 million. Of these funds, $57.8 million support diabetes prevention and $79.1 million support behavioral health crisis services aligned with the SIHIS goals for diabetes prevention and reduction in overdose fatalities, respectively. HSCRC has decided to end this investment in diabetes prevention and management programs in June 2024 after three and a half years due to low performance and concerns over the long-term sustainability of the programs. The remaining 20% was originally allocated toward the third total population health goal, maternal and child health. However, for fiscal 2021 only, HSCRC authorized staff to direct this funding to the COVID-19 Long-Term Care Partnership Grant Program to improve infection control and care management practices between hospitals and long-term care facilities.

HSCRC reported that from fiscal 2022 to 2025, $10 million annually will be directed to support maternal and child health interventions led by the Medicaid Program, the Medicaid managed care organizations, and MDH's Prevention and Health Promotion Administration (PHPA). Although these funds are derived through hospital rates, they initially did not pass through HSCRC's budget, and the BRFA of 2021 included a provision to allow these funds to be contributed to the newly established Maternal and Child Health Population Health Improvement Fund under Medicaid and PHPA. Ultimately, this funding will total $72 million after accounting for 50% federal matching funds claimed for Medicaid expenditures. The fiscal 2025 allowance does not currently reflect the $8 million in special funds from the Maternal and Child Health Population Health Improvement Fund within the Medicaid budget, but MDH indicated that it is working with the Department of Budget and Management to allocate that funding and associated federal matching funds.

Outcome-based Credits

A separate population health initiative under the TCOC model is outcome-based credits, which provide the State an opportunity to earn financial credits for the TCOC savings target as an incentive for improving specified population health measures. HSCRC is required to propose three outcome-based credits, but as of January 2024, the Centers for Medicare and Medicaid Services have only approved one credit related to the State's efforts to prevent diabetes cases. Although not directly linked to SIHIS goals or the MDPCP, the credits can align with established SIHIS focus areas, as is evidenced by the first credit relating to diabetes prevention. As of

January 25, 2024, HSCRC reported that the results for the calendar 2022 credit related to diabetes prevention have not been finalized, and the credit approval process is expected to be completed by mid-February 2024.

HSCRC's other planned outcome-based credits include measures related to opioid use disorder and hypertension, but both proposals have experienced delays. The opioid use disorder credit proposal is expected to be submitted in the first quarter of calendar 2024. HSCRC indicated that a work plan for the credit proposal focused on hypertension is expected in the second quarter of calendar 2024. **HSCRC should comment on the fiscal impact of delayed proposal submission and approval of the two remaining outcome-based credits.**

Planning and Implementation of a New Model

Planning for the next model that will follow TCOC is already underway. HSCRC indicated that it conducted initial stakeholder engagement, beginning in calendar 2023, to develop a new Maryland Model. According to initial model negotiation and implementation timelines, HSCRC anticipates continued planning for the new Maryland Model involving stakeholder outreach and the tentative submission of a progression plan to CMMI in calendar 2024. **HSCRC should discuss the federal review process and timeline for implementing a new Maryland Model and comment on the initial goals and components of a new model that have been discussed with stakeholders.**

4. PDAB Cost Review Process

Chapter 692 of 2019 established PDAB, requiring the board to make specified determinations, collect data, and identify specified prescription drug products that may cause affordability issues. PDAB is authorized to conduct a cost review of each identified drug product, and, if warranted, must draft a plan of action for Legislative Policy Committee or Governor and Attorney General review and approval that includes the criteria to set upper payment limits for prescription drug products that are purchased:

- by or on behalf of a unit of State or local government;
- through a health benefit plan on behalf of a unit of State or local government; or
- by the Medicaid program.

In its annual report issued in December 2023, PDAB defined cost review as a study of specified statutory and regulatory factors to assess whether use of the prescription drug product has led or will lead to affordability challenges for the State health care system or high out-of-pocket costs for patients. Under the cost review study process, PDAB can identify prescription drugs to refer to the prescription drug affordability stakeholder council for cost review. Eligible prescription drugs for review must be selected at an open meeting and meet the following statutory requirements:

- brand name drugs or biologics that, as adjusted for inflation, have a launch wholesale acquisition cost (WAC) of $30,000 or more per year or course of treatment;

- brand name drugs that have a WAC increase of over $3,000 or more in any 12-month period or course of treatment;

- biosimilar drugs that have a launch WAC that is not at least 15% lower than the brand biologic;

- generic drugs that, as adjusted for inflation, have a WAC of $100 more and a WAC increase of 200% or more over a specified period; and

- other prescription drug products that may create affordability challenges, in consultation with the Prescription Drug Affordability stakeholder council.

Regulations regarding the cost review study process were finalized on December 25, 2023. PDAB indicated that implementation of the cost review process is expected to begin in early calendar 2024, with the first set of cost reviews to be conducted by the end of calendar 2024.

Operating Budget Recommended Actions

1. Adopt the following narrative:

   Evaluation of the Maryland Primary Care Program (MDPCP) and Update on Outcome Based Credits: Given the role of the MDPCP in transforming care in the State under the Total Cost of Care (TCOC) model, the committees request that the Health Services Cost Review Commission (HSCRC), in consultation with the MDPCP Project Management Office within the Maryland Department of Health (MDH), provide 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. Further, given the anticipated benefits that the outcome-based credits have on total cost of care metrics, the committees request information on the amount that outcome-based credits have discounted costs and MDPCP's contribution to the achievement and maximization of the current and future outcome-based credits and other population health goals. HSCRC should also provide an update on the timing of federal approval for the two remaining outcome-based credits and results for the outcome-based credit related to diabetes prevention.

Information Request	**Author**	**Due Date**
Evaluation of the MDPCP and status of outcome-based credits	HSCRC MDH	October 1, 2024

2. Adopt the following narrative:

   Consortium on Coordinated Community Supports Grants: Chapter 36 of 2021 (the Blueprint for Maryland's Future – Implementation) established the Maryland Consortium on Coordinated Community Supports within the Maryland Community Health Resources Commission (MCHRC) to develop coordinated community supports partnerships and administer grants to meet students' holistic behavioral health needs. The committees are interested in monitoring the over $110 million in Blueprint for Maryland's Future Fund expenditures for this purpose in fiscal 2024 and fiscal 2025. The committees request that MCHRC submit a report on consortium grants, including:

   - grantees, by jurisdiction and use of funding, that received consortium grants in fiscal 2024 and 2025 year to date;

   - the amount of Blueprint funding distributed as of July 1, 2024, remaining funds that were carried over for use in future fiscal years, and the amount of canceled funding that will be available for future awards;

- the number of students and schools to be served by each grantee or project;
- an update on the amount of consortium grant funding spent on new authorized uses that are contingent on the Budget Reconciliation and Financing Act of 2024; and
- the timing for award and distribution of grants using consortium funding allocated in fiscal 2025.

Information Request	**Author**	**Due Date**
Report on consortium grants	MCHRC	November 1, 2024

Appendix 1
2023 *Joint Chairmen's Report* Responses from Agency

The 2023 JCR requested that the Health Regulatory Commissions prepare three reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Criteria for Allocating Trauma Facility Funding:*** Section 19 in the fiscal 2024 Budget Bill added $9.5 million in general funds to the DPA to provide assistance to trauma facilities in Maryland. MHCC was required to (1) establish the criteria for allocating the funds among trauma centers and (2) submit a report on the allocation criteria 45 days before the transfer of any DPA funds. As of February 1, 2024, MHCC had not submitted this report. Further discussion of trauma center funding can be found in Key Observation 1.

- ***Regulations Related to Health Information Exchanges and Electronic Health Records:*** Chapters 248 and 249 required MHCC to adopt regulations for implementing connectivity to health information exchanges that restrict data of patients who have obtained legally protected health care. Language in the fiscal 2024 Budget Bill restricts funds until MHCC submits a letter to the budget committees confirming the submission of the regulations. Further discussion of the letter and regulations can be found in Key Observation 2 of this analysis.

- ***Evaluation of MDPCP:*** The committees requested that HSCRC provide information on the effectiveness of the MDPCP, comparing cost savings from reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives. For the fourth consecutive year, HSCRC found that the program had a net cost to TCOC model spending, rather than contributing to necessary Medicare savings. This program is discussed in Key Observation 3 of this analysis.

Appendix 2
Audit Findings

Audit Period for Last Audit:	July 9, 2018 – September 30, 2022
Issue Date:	January 2024
Number of Findings:	5
Number of Repeat Findings:	1
% of Repeat Findings:	20%
Rating: (if applicable)	N/A

Finding 1: **MHCC did not have sufficient procedures and controls over MTPSF payments and related collections.**

Finding 2: MHCC did not have sufficient procedures and controls over fees assessed on hospitals, nursing homes, insurance companies, and health care practitioners. As a result, user fees for two hospitals totaling $118,500 were not assessed, and nursing homes collectively were under assessed $717,000.

Finding 3: Redacted cybersecurity-related finding.

Finding 4: Redacted cybersecurity-related finding.

Finding 5: HSCRC did not always obtain required Board of Public Works approval for contract modifications prior to execution, and MHCC did not always ensure contract awards were published on *eMaryland Marketplace Advantage*, as required.

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

Appendix 3
Total Cost of Care Performance Results

	Calendar 2020/Program Year 2		Calendar 2021/Program Year 3		Calendar 2022/Program Year 4	
	Goal	**Performance**	**Goal**	**Performance**	**Goal**	**Performance**
Annual Medicare Savings*	$156 million	$390.6 million	$222 million	$378.1 million	$267 million	$269 million
TCOC Guardrail	Not to exceed national Medicare growth in TCOC by more than 1%	0.5% below national Medicare growth	Not to exceed national Medicare growth in TCOC by more than 1%	0.6% above national Medicare growth	**Not to exceed national Medicare growth in TCOC by more than 1%**	**0.9% above national Medicare growth (second consecutive year above)**
All-payer Revenue Limit	Growth ≤ 3.58% per capita annually	0.21%	Growth ≤ 3.58% per capita annually	2.37%	Growth ≤ 3.58% per capita annually	2.72%
Reductions in Hospital-acquired Conditions	Not to exceed calendar 2018 rates for potentially preventable conditions	0.06% average reduction below calendar 2018	Not to exceed calendar 2018 rates for potentially preventable conditions	0.13% average reduction below calendar 2018	Not to exceed calendar 2018 rates for potentially preventable conditions	0.2% average reduction below calendar 2018
Reduction in Readmissions	≤ national rate for FFS Medicare beneficiaries (15.55% for CY2020)	15.18%	**≤ national rate for FFS Medicare beneficiaries (15.37% for CY2021)**	**15.64%**	**≤ national rate for FFS Medicare beneficiaries (15.37% for CY2021)**	**15.56%**

	Calendar 2020/Program Year 2		Calendar 2021/Program Year 3		Calendar 2022/Program Year 4	
	Goal	**Performance**	**Goal**	**Performance**	**Goal**	**Performance**
Hospital Revenue Population Based Payment	At least 95% of regulated revenue paid according to population-based methodology	98%	At least 95% of regulated revenue paid according to population-based methodology	98%	At least 95% of regulated revenue paid according to population-based methodology	98%

*The State's overperformance in annual Medicare savings produces savings in the following model year, as outlined under the contract with the Center for Medicare and Medicaid Innovation.

Note: Bold denotes performance results that did not meet targets.

Source: Center for Medicare and Medicaid Innovation; Health Services Cost Review Commission

Appendix 4
Object/Fund Difference Report
MDH – Health Regulatory Commissions

Object/Fund	FY 23 Actual	FY 24 Working Appropriation	FY 25 Allowance	FY 24 - FY 25 Amount Change	Percent Change
Positions					
01 Regular	116.90	117.90	118.90	1.00	0.8%
02 Contractual	7.47	11.66	11.51	-0.15	-1.3%
Total Positions	**124.37**	**129.56**	**130.41**	**0.85**	**0.7%**
Objects					
01 Salaries and Wages	$ 18,091,084	$ 19,893,733	$ 21,001,453	$ 1,107,720	5.6%
02 Technical and Spec. Fees	648,305	1,019,562	932,480	-87,082	-8.5%
03 Communication	84,983	105,654	119,937	14,283	13.5%
04 Travel	111,431	339,835	344,737	4,902	1.4%
06 Fuel and Utilities	3,467	2,700	3,607	907	33.6%
08 Contractual Services	137,526,922	157,810,231	193,250,202	35,439,971	22.5%
09 Supplies and Materials	60,499	79,547	63,826	-15,721	-19.8%
10 Equipment – Replacement	194,468	25,500	64,500	39,000	152.9%
11 Equipment – Additional	128,879	1,726,525	1,286,725	-439,800	-25.5%
12 Grants, Subsidies, and Contributions	77,233,215	110,722,919	130,372,415	19,649,496	17.7%
13 Fixed Charges	635,579	817,702	850,584	32,882	4.0%
Total Objects	**$ 234,718,832**	**$ 292,543,908**	**$ 348,290,466**	**$ 55,746,558**	**19.1%**
Funds					
01 General Fund	$ 1,000,000	$ 2,000,000	$ 1,000,000	-$ 1,000,000	-50.0%
03 Special Fund	233,718,832	289,983,908	346,730,466	56,746,558	19.6%
09 Reimbursable Fund	0	560,000	560,000	0	0%
Total Funds	**$ 234,718,832**	**$ 292,543,908**	**$ 348,290,466**	**$ 55,746,558**	**19.1%**

Note: The fiscal 2024 appropriation does not include deficiencies. The fiscal 2025 allowance does not include statewide salary adjustments budgeted within the Department of Budget and Management.