M00R01
Health Regulatory Commissions
Maryland Department of Health

Program Description

The Health Regulatory Commissions are three independent agencies within the Maryland Department of Health: 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.

Operating Budget Summary

Fiscal 2022 Budget Increases $14.2 Million, or 8.6%, to $179.8 Million

Note: The fiscal 2021 appropriation includes deficiencies, planned reversions, and general salary increases. The fiscal 2022 allowance includes contingent reductions and annualization of general salary increases.

- Of the $14.2 million increase, $17 million is attributed to the Uncompensated Care Fund (UCF), budgeted at levels higher than fiscal 2021 working appropriation.

- This increase is offset by a contingent reduction to MCHRC of $4.4 million due to a Budget Reconciliation and Financing Act (BRFA) of 2021 provision switching the funding priorities in the use of the Carefirst premium tax exemption.

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Fiscal 2021

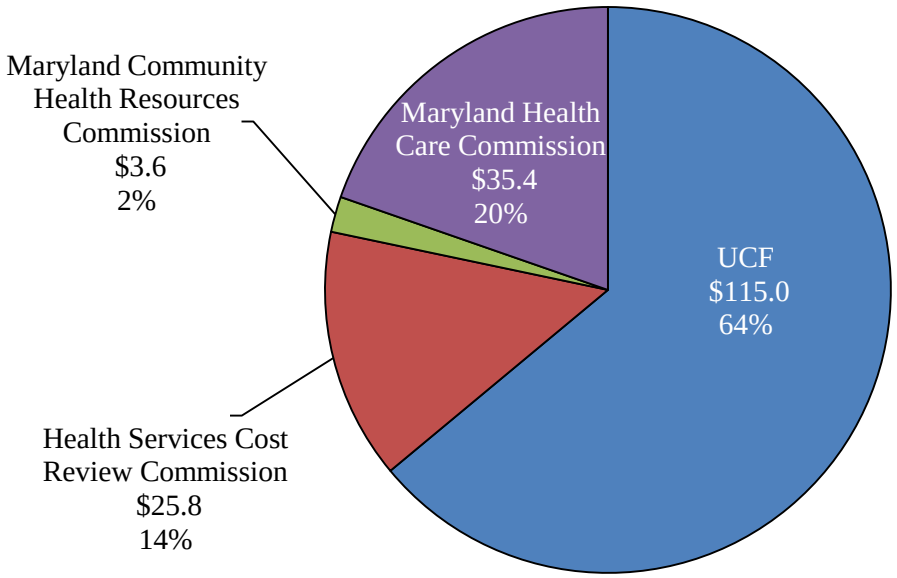
July 1, 2020 Board of Public Works Reductions

At the July 1, 2020 meeting of the Board of Public Works (BPW), the Governor proposed, and BPW approved, a reduction in unemployment insurance across State government. This resulted in a special fund reduction of $33,687 across all of the health regulatory commissions: $16,118 from MHCC; $16,527 from HSCRC; and the remaining $1,042 from MCHRC.

Fiscal 2022 Overview of Agency Spending

The fiscal 2022 allowance totals over $184.2 million, almost entirely in special funds. As shown in **Exhibit 1**, the single largest component of the budget is the UCF with $115 million, nearly two-thirds of the total funds. The UCF is managed by HSCRC but paid out to the acute general hospitals that provide a disproportionate amount of uncompensated care.

Exhibit 1
Overview of Agency Spending
Fiscal 2022 Allowance
($ in Millions)



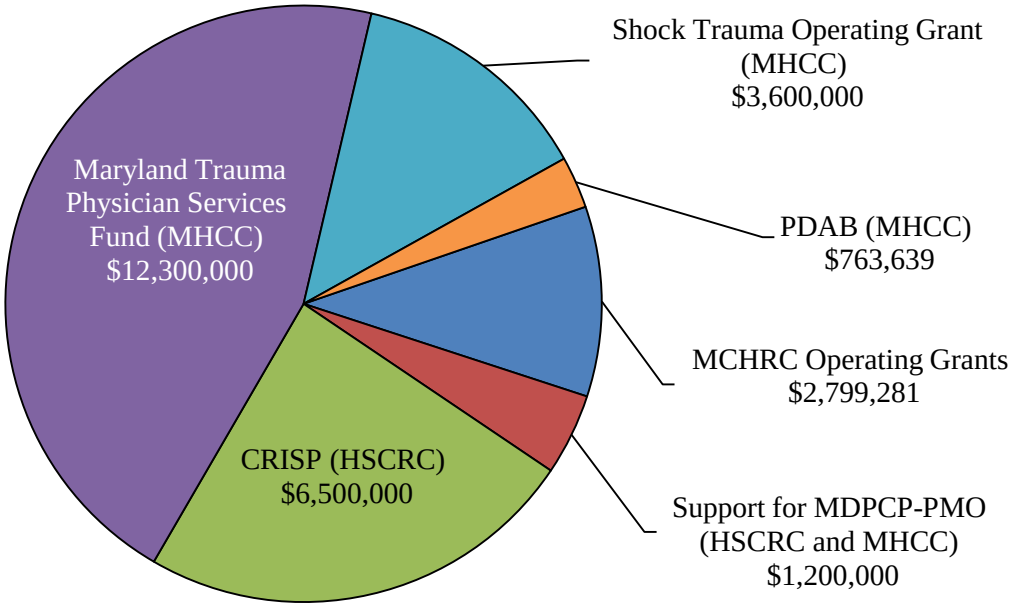
UCF: Uncompensated Care Fund

Note: Numbers may not sum due to rounding. The fiscal 2022 allowance includes contingent reductions and annualization of general salary increases.

Source: Governor's Fiscal 2022 Budget Books

The fiscal 2022 budget includes a contingent reduction to MCHRC, discussed further in this analysis, which would effectively reduce the amount available for the MCHRC grants from $7.2 million to $2.8 million for fiscal 2022. **Exhibit 2** shows the various funds supported through the health regulatory boards, reflecting the contingent reduction for MCHRC.

Exhibit 2
Funds Managed by Health Regulatory Commissions
Fiscal 2022



CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resource Commission
MDPCP: Maryland Primary Care Program
MHCC: Maryland Health Care Commission
PDAB: Prescription Drug Affordability Board
PMO: Program Management Office

Note: Reflects contingent reductions

Source: Governor's Fiscal 2022 Budget Books

In addition to the funds and grants, MHCC also supports the new Prescription Drug Affordability Board, created by the General Assembly in 2019. Collectively, this grouping of other expenditures make up over $27 million in the budgeted allowance of the health regulatory boards, or 42% of total expenditures aside from the UCF after accounting for contingent reductions.

Proposed Budget Change

Aside from the UCF increase, MHCC and HSCRC support for the Maryland Primary Care Program (MDPCP) increases by $100,000 from each commission. Other operating expenditures ultimately increase in MHCC; operating expenses decrease by an offsetting amount at HSCRC. The MCHRC budget is largely unchanged aside from the contingent reduction. These changes are reflected in **Exhibit 3**.

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

How Much It Grows:	Special Fund	Reimb. Fund	Total
Fiscal 2020 Actual	$147,874	$68	$147,942
Fiscal 2021 Working Appropriation	$165,219	$400	$165,619
Fiscal 2022 Allowance	$179,229	$561	$179,790
Fiscal 2021-2022 Amount Change	$14,010	$161	$14,171
Fiscal 2021-2022 Percent Change	8.5%	40.2%	8.6%

Where It Goes:	Change
Personnel Expenses	
Increase in regular employee compensation driven by 4 new positions – 3 in MHCC and 1 in HSCRC	$574
Employee and retiree health insurance	182
Annualization of fiscal 2021 general salary increase	163
Turnover adjustments	-262
Other fringe benefit adjustments	-12
Health Services Cost Review Commission	
Increase in Uncompensated Care Fund	17,000
Increase in CRISP operating expenditures	300
HSCRC's share of MDPCP PMO expenditures	100
Reduction in contractual employee expenditures, driven by former contractual HSCRC Deputy Director moving to regular employee	-102
Maryland Health Care Commission	
Maryland Trauma Physician Services Fund	300

Where It Goes:	**Change**
Increase in contractual employee expenditures to assist with surveys of health care facilities, communications, and the CON process	134
Shock Trauma Operating Grant	100
MHCC's share of MDPCP PMO expenditures	100
Maryland Community Health Resource Commission	
Reduction in amount budgeted for MCHRC grants in fiscal 2022	-9
Contingent reduction to MCHRC operating expenditures	-4,364
Other Changes	
Operating expenditures across health regulatory commissions	-34
Total	**$14,171**

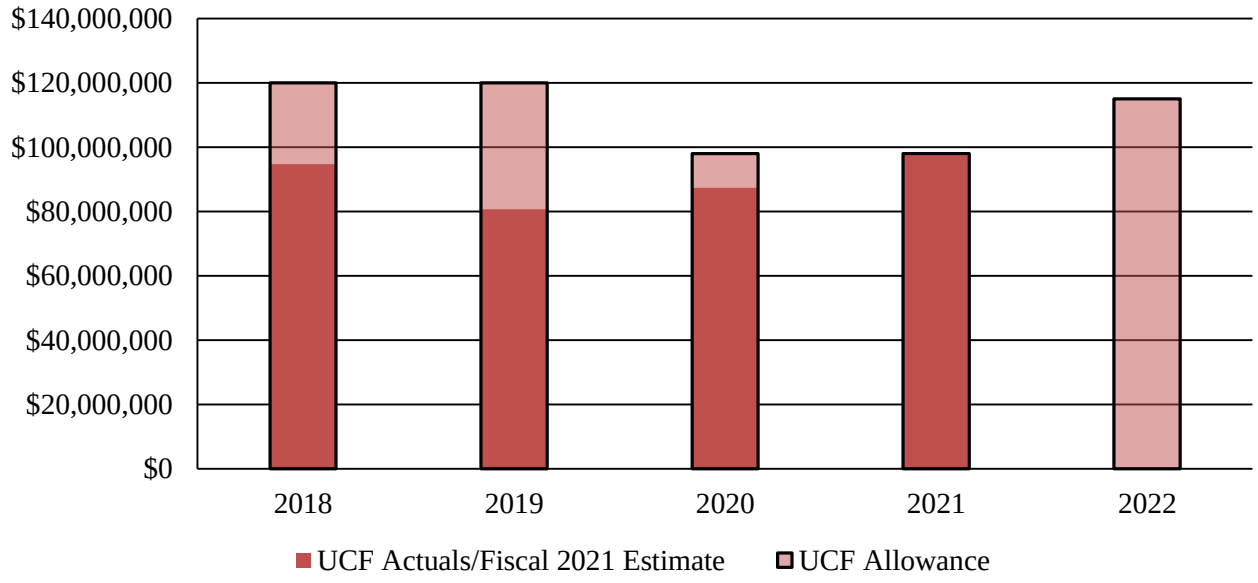
CON: Certificate of Need
CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resource Commission
MDH: Maryland Department of Health
MDPCP: Maryland Primary Care Program
MHCC: Maryland Health Care Commission
PMO: Program Management Office

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

Uncompensated Care Fund

As previously mentioned, the payments to hospitals from the UCF flow through the HSCRC budget. The UCF is a special fund that 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. The UCF is often budgeted at higher than anticipated levels of spending. **Exhibit 4** shows the amount appropriated in the UCF for the last five fiscal years and provides the actual amount expended by the UCF when closing fiscal 2018 to 2020.

Exhibit 4
UCF Expenditures
Allowance v. Actual Amounts
Fiscal 2018-2022



UCF: Uncompensated Care Fund

Source: Governor's Fiscal 2022-2020 Budget Books

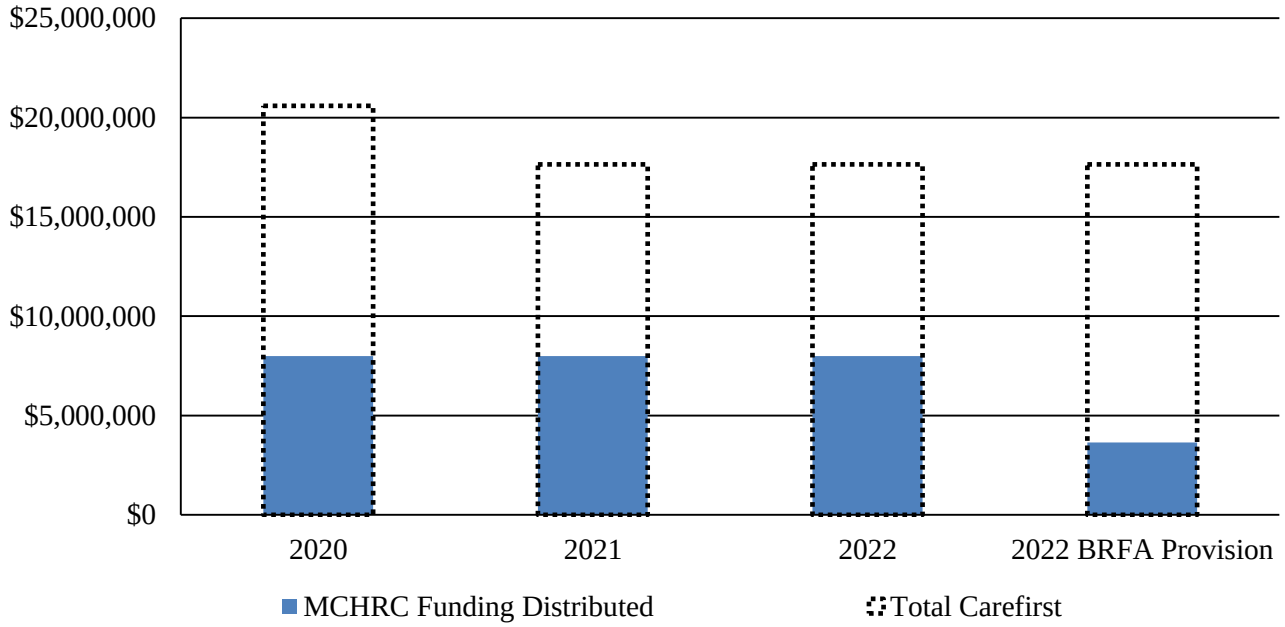
However, as shown, actual UCF expenditures increased from fiscal 2019 to 2020 by roughly $7 million, or 8%. HSCRC reports that the UCF is currently on track to spend $97.5 million in fiscal 2021, right up to the spending authority for fiscal 2021, and 12% higher than fiscal 2020 actuals. The fiscal 2022 allowance reflects a continued increase in the UCF. HSCRC attributes rising uncompensated care generally to increasing deductibles and cost sharing in the private insurance market and the uncertainty of the labor market, unemployment, and the speed of the post-COVID-19 economic recovery.

BRFA Provision

The Governor's budget as introduced includes a contingent reduction for MCHRC. This is contingent on a BRFA provision that would change the allocation of the Carefirst premium tax credit exemption. The Carefirst premium tax credit funds both MCHRC and the Senior Prescription Drug Assistance Program (SPDAP). Under current law, the first $8 million from the Carefirst funding supports MCHRC, and the remaining supports SPDAP. This change in allocations makes SPDAP funding a $14 million floor rather than a cap, and MCHRC funding a cap rather than a floor. In recent years, the Carefirst funding has steadily decreased, as shown in **Exhibit 5**, and is anticipated to be

$17.6 million for fiscal 2022. This decrease is due in large part to a statutory change eliminating the donut hole subsidy required of Carefirst when the donut hole was closed at the federal level.

Exhibit 5
Carefirst Funding Allocation and MCHRC funding
Fiscal 2020-2022



BRFA: Budget Reconciliation and Financing Act
MCHRC: Maryland Community Health Resource Commission

Source: Maryland Department of Health; Department of Budget and Management

Exhibit 5 also highlights the noticeable decrease in funds available to MCHRC under the proposed BRFA provision. The MCHRC budget is divided between operating expenditures (totaling $836,999 in fiscal 2022) and the remaining $7.2 million on grants to safety-net providers in the State. Given the fairly small operating expenses at present for MCHRC, the Department of Legislative Services (DLS) would expect this contingent reduction to predominately reduce the amount of funds available for grants.

A second BRFA provision increases the Medicaid Deficit Assessment by $35 million for fiscal 2021 and all following years. The Medicaid Deficit Assessment does not flow through the HSCRC budget; however, it is responsible for setting hospital rates that would reflect this increase. The fiscal 2021 rates approved by HSCRC currently reflect the proposed BRFA increase to the deficit assessment in the current fiscal year.

Personnel Data

	FY 20 Actual	FY 21 Working	FY 22 Allowance	FY 21-22 Change
Regular Positions	109.90	108.90	112.90	4.00
Contractual FTEs	7.20	7.87	9.59	1.72
Total Personnel	**117.10**	**116.77**	**122.49**	**5.72**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.78	4.23%
Positions and Percentage Vacant as of 12/31/20	5.00	4.59%
Vacancies Above Turnover	0.22	0.36%

- Of the 4 new positions in the Health Regulatory Commissions, three are in MHCC: 1 new research methodologist for the Center for Information Services and Analysis; and 2 new program managers – 1 in each of the Center for Quality Measurement and Reporting and Center for Health Care Facilities Planning and Development.

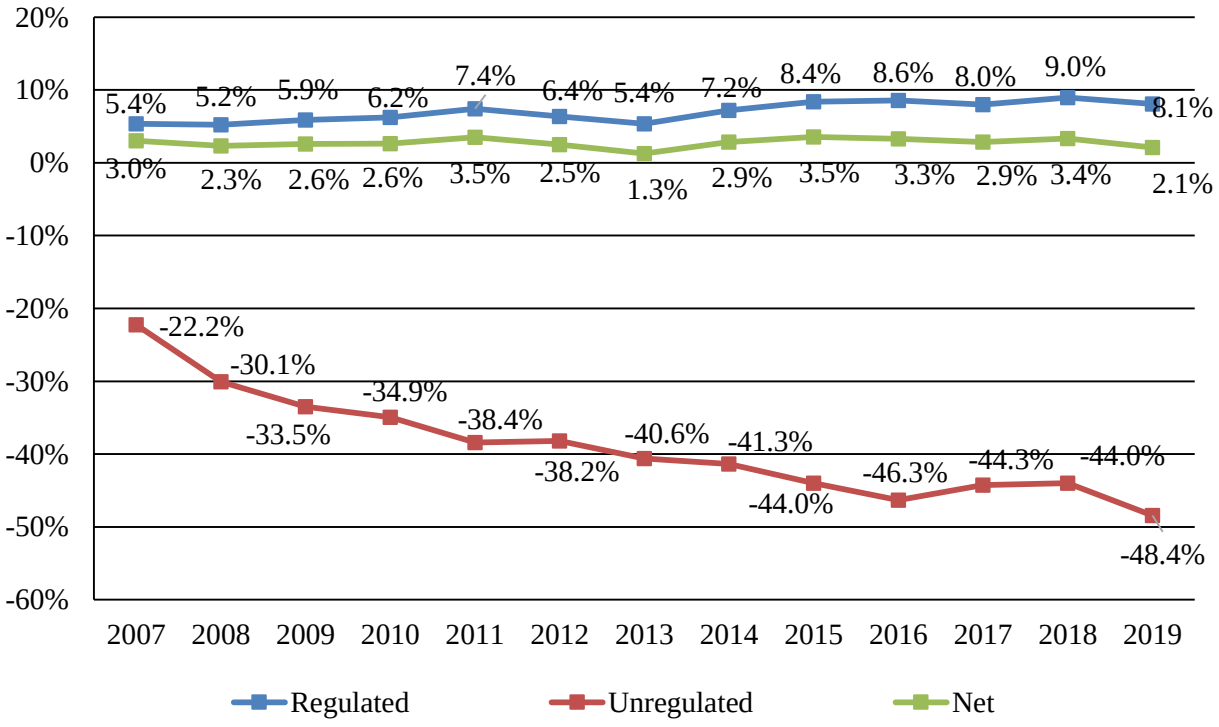
- The fourth new position is a HSCRC Associate Director III who was previously a contractual full-time equivalent.

Key Observations

1. Hospital Profits and Additional Assistance during COVID-19 Pandemic

During the 2020 session, DLS expressed concerns about the level of hospital profits in the State under the regulated rate system. In particular, DLS illustrated that hospitals generate profits on regulated rates such that they offset losses on unregulated services. To address these concerns, the budget committees adopted committee narrative requesting a report on hospital profits. In this report, HSCRC acknowledged that regulated operating margins have increased over time, were accelerated by implementations of global budgets in 2014, and are offset by losses in unregulated services. HSCRC also highlighted that operating profits for Maryland hospitals have been below the national average in every year from 2007 to 2018. **Exhibit 6** shows Maryland hospitals regulated, unregulated, and net operating profits as presented in the *Joint Chairmen's Report* (JCR) response by HSCRC.

Exhibit 6
Maryland Hospital Profit Margins
Fiscal 2007-2019



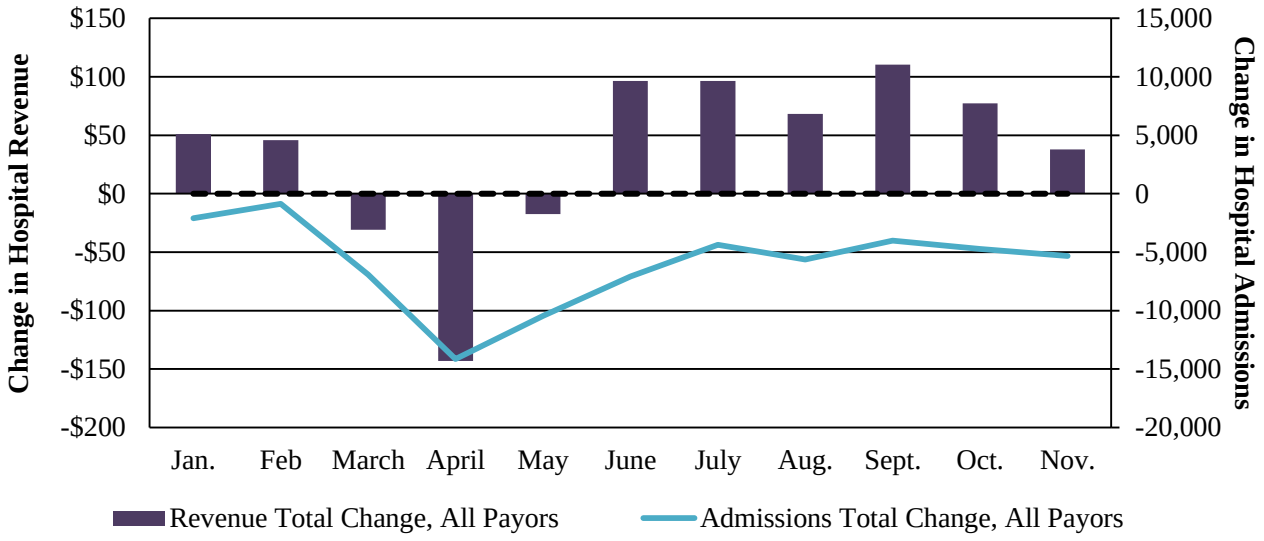
Source: Health Services Cost Review Commission

As shown, while unregulated services have significant losses, regulated profits have been such that the hospitals are still able to turn an overall profit year over year. HSCRC attributes the unregulated losses to physician subsidies and population health investments. Regarding physician subsidies, HSCRC notes that in rate year 2019, 81.2% of total losses were driven by these subsidies. They also note that they do not currently have data to identify these losses by physician specialty but are revising cost filings to determine the subsidies that are germane to hospital operations. Regarding the population health improvement, HSCRC notes that under the total cost of care (TCOC) model, Maryland and the State's hospitals are ultimately accountable for total population health improvements (discussed further in this analysis). If in fact regulated rate profits are offsetting unregulated population health losses, this conforms with the goals set for the State under TCOC. HSCRC also notes that they are in the process of revising cost filings to better determine the extent to which these population health losses are in fact aligned with the TCOC model goals. **HSCRC should comment on progress made within the hospital financial data submissions to better align unregulated hospital losses with the TCOC model performance.**

Hospital Profits, Operations, and Provider Relief during the COVID-19 Pandemic

Upon the onset of the COVID-19 pandemic in March 2020, hospital actual admissions decreased noticeably due to either the outright restriction of nonessential procedures under the Governor's executive orders or individuals choosing to delay care to avoid hospital settings. **Exhibit 7** compares the dollars and admissions from all payers in calendar 2020 to the average values for that same month from calendar 2019 and 2018.

Exhibit 7
Hospital Admissions and Revenue, All Payors
Calendar 2020 vs. 2019 and 2018 Averages
($ in Millions)



Source: Health Services Cost Review Commission

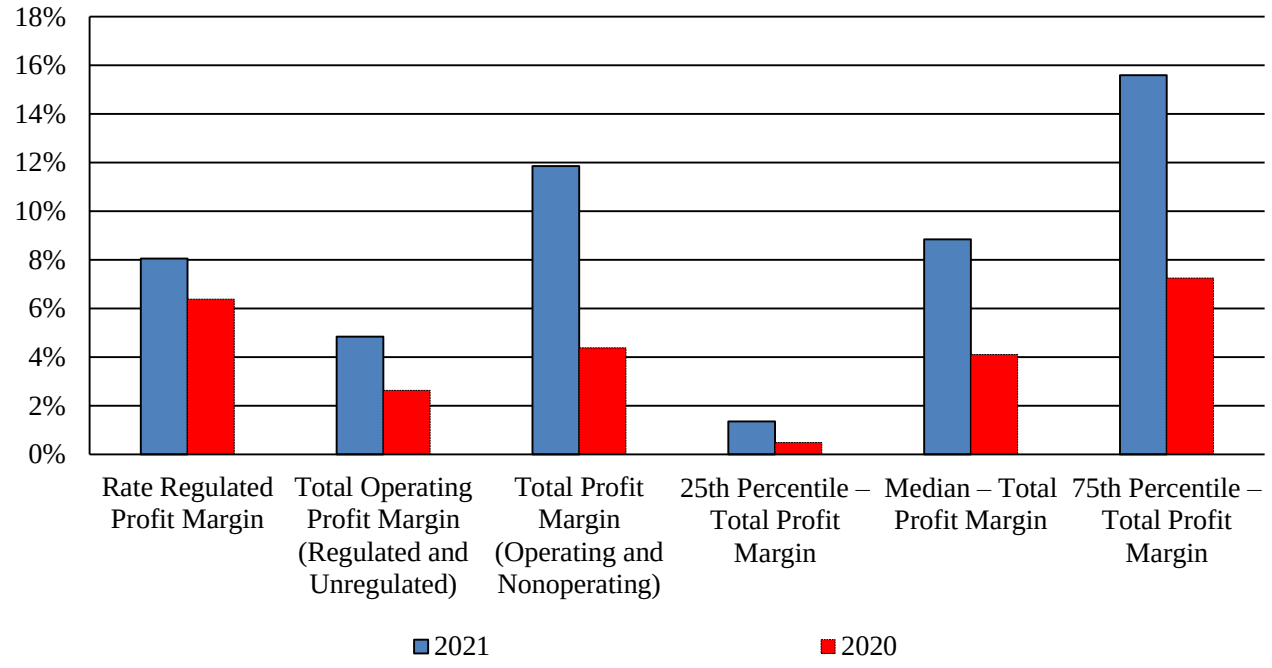
As shown, while admissions have yet to return to prior year level, inpatient revenues have rebounded much more quickly and are currently above recent years. This is in large part due to HSCRC allowing hospitals to carry over unused Global Budget Revenue (GBR) capacity from fiscal 2020 (when utilization fell) into fiscal 2021 and charge up to this higher GBR target. This has provided the hospitals with financial stability during the downturn in admissions due to the pandemic.

In addition to the change to fiscal 2021 GBRs, the federal data analyzed by DLS reports that to date, Maryland hospitals received nearly $1.4 billion in federal assistance through the provider relief fund. HSCRC has issued guidance that it will assign a prorated share of the provider relief fund to regulated revenues based on prior year regulated revenues reported. This prorated amount of provider relief fund support will then be offset against acceptable GBR charges. Those hospitals with a total value of provider relief funds below the approved fiscal 2020 GBR will be allowed to carry over the revenue variance into fiscal 2021.

As of December 16, 2020, HSCRC estimates that the net increase in allowable charges, after accounting for provider relief fund dollars, will total roughly $250 million. At the time, hospitals had received only $1.2 billion from the provider relief fund, and DLS would anticipate further federal support, decreasing State support through GBR. HSCRC also expanded rate corridors and implemented a COVID-19 surge policy to further provide hospital stability in both fiscal 2020 and 2021.

Given these policies, HSCRC is reporting that hospitals are actually more profitable thus far in fiscal 2021 than the equivalent period for fiscal 2020. **Exhibit 8** compares regulated, operating, and total profit margins from July to November in fiscal 2020 and 2021.

Exhibit 8
Profit Margins from Monthly Financial Statements
July to November Fiscal 2020 v. 2021



Source: Health Services Cost Review Commission

HSCRC notes that these margins are produced from unaudited monthly financial reports, and most hospitals have reflected provider relief fund dollars in these reports. As shown, even the hospitals with the slimmest of total profit margins are still exceeding prior year values. As previously mentioned, HSCRC will ultimately review hospital charges, as well as provider relief fund dollars and offset federal hospital support against charges to GBR.

Overall, these monthly financial statements from July to November report that in fiscal 2021, 36 hospitals have a total profit for a net of $418 million. **Appendixes 2** and **3** show the individual hospitals regulated, unregulated, and net profits as a percent and total dollars, respectively.

2. Total Cost of Care and Maryland Primary Care Program

In July 2018, Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) agreed to the terms of a new 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 will continue for 10 years, provided that the State meets the requirements of the agreement.

Under TCOC, Maryland commits to reaching an annual Medicare 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) expenditures. 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.

The Centers for Medicare and Medicaid Services (CMS) certified the State's performance in program year one (calendar 2019) under TCOC to HSCRC in June 2020. CMS certified that Maryland was able to meet all of the goals outlined under TCOC. **Exhibit 9** identifies the measures used to evaluate the State's performance and the certified results.

Exhibit 9
TCOC Year One Performance
Calendar 2019

	Goal Under TCOC	Maryland 2019 Performance	Meeting Goal?
Annual Medicare Savings Target	The State is required to produce annual savings in Maryland Medicare TCOC of $120 million for Model Year (MY) 1	$340.6 million in savings, $110.3 million of which can be applied to MY 2	Yes
TCOC Guardrail	The State must not exceed growth in National Medicare TCOC per beneficiary by more than 1% for any given model year and must not exceed the National Medicare TCOC per beneficiary by any amount for two or more consecutive MYs	0.4 percentage points below the national growth rate in calendar 2019	Yes

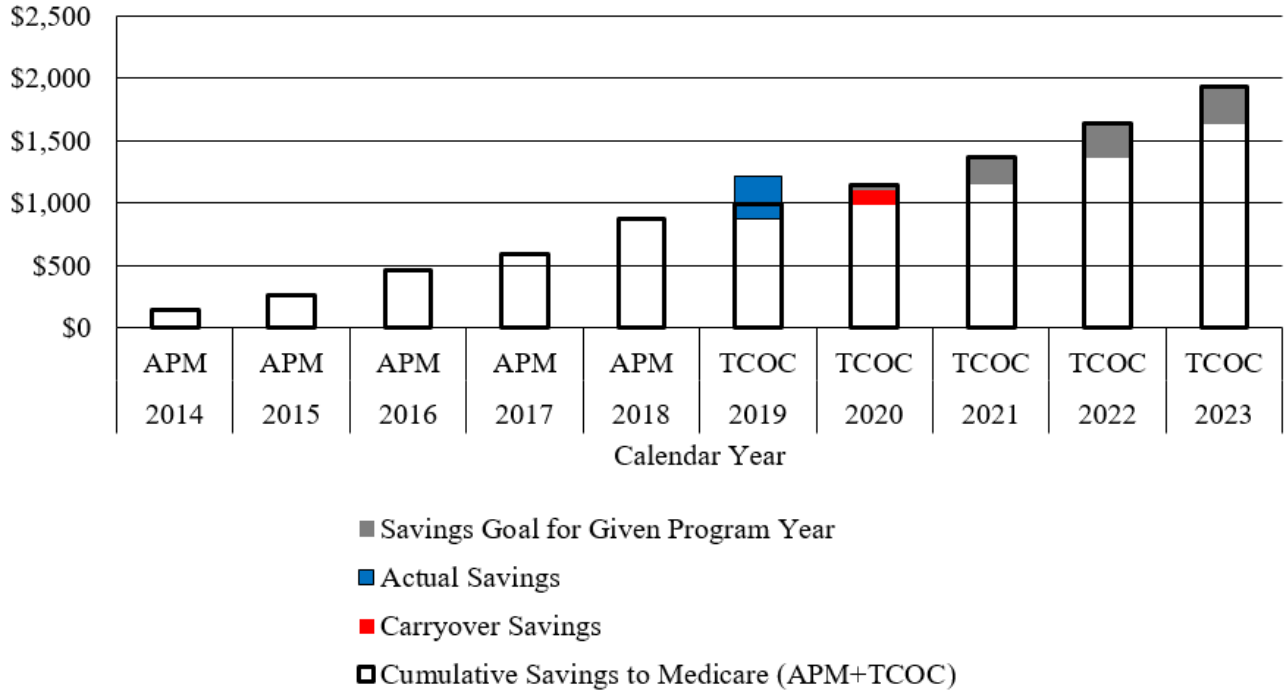
	Goal Under TCOC	Maryland 2019 Performance	Meeting Goal?
All-payer Revenue Limit	The all payer growth limit must be less than or equal to 3.58% per capita annually	2.5% All-payer hospital revenue growth in calendar 2019	Yes
Hospital-acquired Conditions	The State must maintain improvements seen under the All-payer Model (APM) by not exceeding the calendar 2018 Potentially Preventable Conditions (PPC) rates for 14 PPCs that comprise Maryland's Hospital Acquired Condition program in a given performance year	0.13 percentage point average reduction in the All-Payer PPC rate since calendar 2013	Yes
Readmissions	The State must maintain the improvements achieved under the APM on the aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate for Medicare fee-for-service (FFS) beneficiaries, such that regulated Maryland Hospitals have achieved equal to or less than the national readmission rate for Medicare FFS beneficiaries at the end of performance year one	Maryland's readmission rate of 15.45% is below the national readmission rate of 15.96% in calendar 2019	Yes
Hospital Revenue Population-based Payment	The State is required to facilitate the movement of regulated revenue for Maryland residents into population-based payment reimbursements, with 95% of all regulated revenue for Maryland residents paid according to a population-based payment methodology	98% of Regulated Revenues are under Maryland's "Rate Setting System" for calendar 2019	Yes

TCOC: total cost of care

Source: Health Services Cost Review Commission

One of the most encouraging results under program year one was the Annual Medicare Savings. As mentioned previously, TCOC aims to ultimately achieve cumulative savings to CMS of $1,934 million. To meet this goal, the target for program year one was $120 million. Maryland was able to well exceed this goal, achieving savings totaling $340.6 million, $220.6 million over the goal for calendar 2019. Under the contract, Maryland is able to apply half of this excess savings ($110.3 million) to the savings target for program year two. **Exhibit 10** shows the cumulative savings goals from APM and TCOC and applies the excess savings to be carried over into calendar 2020.

Exhibit 10
APM and TCOC Cumulative Savings Goals
Calendar 2014-2023
($ in Millions)



APM: all-payer model
TCOC: total cost of care
Note: Savings goals under TCOC are annual targets. Cumulative savings shown for reference.
Source: Health Services Cost Review Commission

As shown, Exhibit 10 highlights that the excess savings from calendar 2019 provides substantial assistance in meeting the calendar 2020 goals under TCOC, with the State only needing to produce $46 million in further savings.

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). The MPA is a scaled positive or negative adjustment to each hospital's Medicare payments relative to a per capita TCOC benchmark. If the TCOC performance for the hospital's attributed population exceeds this TCOC benchmark, then the hospital's global budget will be adjusted downward in future rate years to account for the Medicare costs in excess of the TCOC benchmark. The MPA serves the following purposes for accountability under the TCOC model:

- is a direct link between nonhospital costs and payments to hospitals;
- allows the State to hold hospitals accountable for their contribution in decreasing TCOC; and
- provides an incentive to hospitals to focus on other aspects of the health care delivery system.

The MPA is also separate from the global budget calculation used for hospital rates and revenue, and the MPA allows the State to focus on Medicare savings, as is the target under the TCOC model, rather than adjustments to all payer rates made through GBRs.

For calendar 2018, the percent of each hospital's Medicare revenue at risk under MPA was 0.5%. For calendar 2019 and 2020, the revenue at risk was increased to 1.0%, and the HSCRC staff recommend this same level of reward or penalty for calendar 2021. Under the first year of the MPA, 12 hospitals achieved the full amount of revenue at risk; and, in the second year (calendar 2019), 11 hospitals did so. Only 3 hospitals achieved the full MPA in both years (Doctor's Community, MedStar St. Mary's, and MedStar Union Memorial). Alternatively, 6 hospitals lost the full 0.5% MPA in calendar 2018, and only 3 hospitals did so in calendar 2019, with none of the hospitals who lost the full amount in calendar 2018 repeating in calendar 2019. In total, 27 hospitals in both years achieve positive MPA adjustments, with 19 and 18 hospitals receiving negative adjustments in calendars 2018 and 2019, respectively. **Appendix 4** shows the MPA results for each hospital in the State over the first two years of the program.

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, 4 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 (ED) visits and hospital readmissions. Currently, 21 hospitals participate in ECIP. Participating hospitals in HCIP and ECIP are listed in **Appendix 5**.

Outcome and Population Measures

In addition to the Medicare savings targets discussed previously, TCOC aims to include total population health goals and outcome measures. These measures were submitted to CMS through the Statewide Integrated Health Improvement Strategy (SIHIS) proposal in December 2020. In addition to diabetes, the State has proposed added measures to address opioid use disorders and maternal and child health through SIHIS.

The diabetes program is currently associated with outcome-based credits to TCOC savings. 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.

SIHIS notes that the State intends to propose similar outcome-based credits for opioid use dependence, and they are currently under development by the HSCRC staff. HSCRC acknowledges that the selection of maternal and child health as the third population health target is unable to be translated into savings to the Medicare program and therefore unlikely to be tied to outcome-based credits in the future. Rather, improvements made to maternal and child health highlight the ability of the State under TCOC to address and improve the health of all Marylanders. **Appendix 6** shows the State's goals, measures, target populations, and five- and eight-year targets as outlined in SIHIS across these three total population health goals.

CMS has 90 days to approve SIHIS as submitted by the State or by March 14, 2021. At the time of this writing, SIHIS has yet to be formally approved by CMS.

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 ED 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.

The MDPCP reports for calendar 2021, 562 practices were participating, representing all counties in Maryland. This is nearly 100 additional practices over the 476 participating in program year two. 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. In the first track, monthly care management fee payments range from $6 to $50 PBPM, which increase to $9 to $100 in Track Two. The MDPCP also includes a performance-based incentive of up to $2.50 to $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 7** provides information on the requirements for each function by track.

The 2020 JCR directed HSCRC to analyze the MDPCP with a particular focus on the cost savings from reduced utilization in higher cost care settings and compare these savings with the additional payments given to primary care providers that impact Maryland's model goals under TCOC. To conduct this analysis, HSCRC compared those practices participating in the MDPCP with those that did not and found that the cost trends for these two groups were very similar in calendar 2018 and 2019, pointing to little cost savings from the program. Further, when accounting for the additional provider payments associated with the MDPCP, the costs of these payments eclipsed any savings associated with the program.

The report estimates that 40% of Maryland Medicare beneficiaries are associated with an MDPCP practice and that the care management fees associated with these providers totaled $104 million in 2020, up 62.5% from $64 million in fees for 2019. Across the different methods of attribution used by HSCRC, they found that when considering care management fees, practices participating in the MDPCP had higher per beneficiary per month costs than similar practices that do not participate in the program. The report goes on to note that it is likely that the program may take more than the two years analyzed to show cost-saving impacts of advanced primary care in reducing hospital utilization and other high-cost healthcare utilization that the program seeks to avoid. Given that this is indeed likely the case and that this preliminary analysis conducted by HSCRC found that the MDPCP is currently increasing costs, **DLS recommends adopting narrative for the continued reporting on the MDPCP. The reporting should include comparisons of the MDPCP additional FFS payments and costs savings attributed to avoidable hospital or ED utilization by individuals receiving primary care services through the MDPCP.**

3. New Catalyst Grant Program

At the November meeting of HSCRC, staff presented the final recommendations for the Regional Partnership Catalyst Grant Program (Catalyst Grant Program or Catalyst Grants). This program, established by HSCRC to be effective January 1, 2020, follows from the Regional Partnership Transformation Grant Program (Transformation Grant Program) created in 2015 by HSCRC that expired on June 30, 2020.

The new Catalyst Grant Program is a five-year competitive grant program to fund hospital-led teams that work across statewide geographic regions to develop interventions to address the key health priorities identified as part of the SIHIS Population Health domains discussed previously in the Outcome and Population Measures of this analysis as well as Appendix 6. HSCRC reported 18 proposals submitted (nine for each of the diabetes and behavioral health target areas) that were evaluated by a stakeholder evaluation group that included the other two health regulatory commissions, several agencies within MDH, the Opioid Operational Command Center, and the Chesapeake Regional Information System for our Patients as well as subject matter experts from the American Diabetes Association and the National Association of State Mental Health Program Directors. HSCRC evaluated proposals based on (1) alignment with the TCOC model and population health priorities; (2) widespread engagement and collaboration; (3) an evidence-based approach; (4) outreach and engagement approaches; (5) innovation; (6) an implementation plan; (7) sustainability; and (8) budget.

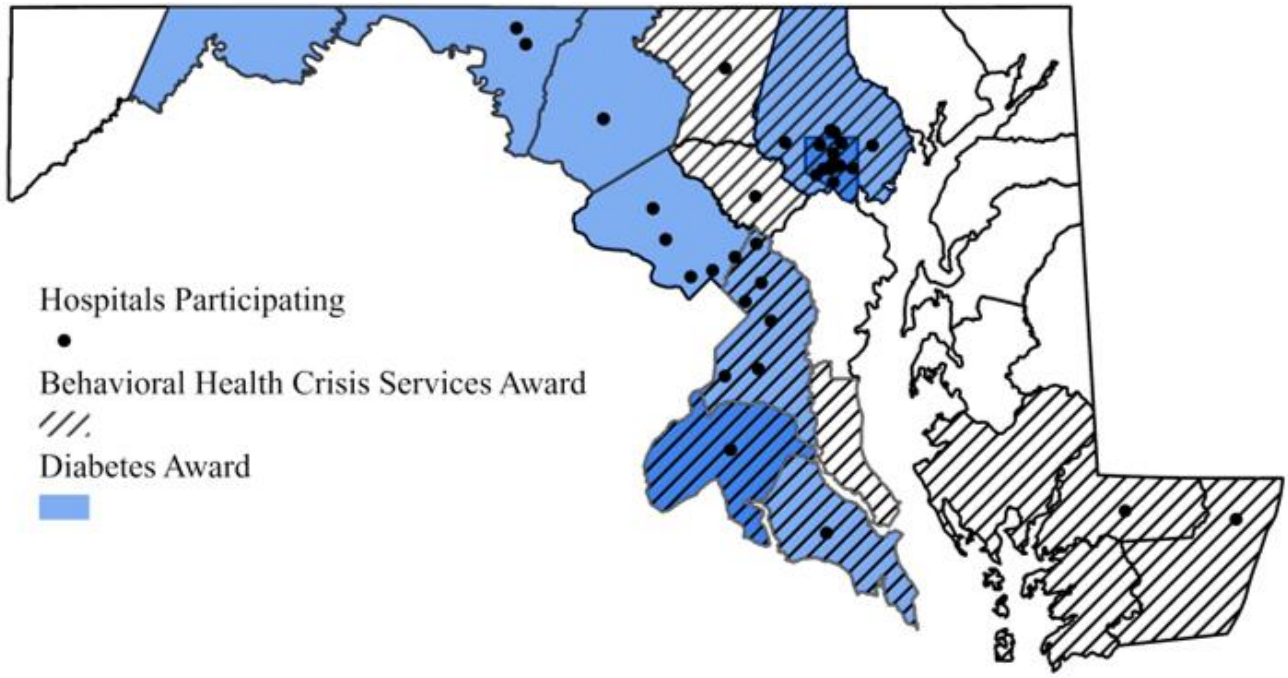
These grants are funded at roughly $45 million annually, for a total five-year investment of $225 million. Of these funds, $86.3 million will be for diabetes prevention and $79.1 million for behavioral health crisis services aligned with the SIHIS goals for diabetes prevention and reduction in overdose fatalities, respectively. The remaining 20% is to be allocated toward the third total population health goal that, at the time, was undetermined but is now known to be 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. Beyond fiscal 2021, the commission advises that this funding will be available for partnerships meeting the maternal and child health population goal. At the December 2020 HSCRC meeting, the commissioners unanimously approved the funding recommendations for the nine partnerships presented by staff.

The funding will be provided to hospitals selected with upward adjustments to hospital rates equal to the grant amounts awarded. This is the same process through which the prior transformation grants were funded and distributed. **Appendix 8** shows the awardees, amounts, hospitals associated, and brief summary for each of the nine programs selected during the five-year grant cycle that have been recommended to the commission.

In total, 22 hospitals throughout the State are participating in the Diabetes Catalyst Grant partnerships, and 23 hospitals are participating in one of the three partnerships for Behavioral Health Crisis Reponses. Partnerships include a single hospital leading the program to as many as 17 with the Greater Baltimore Regional Integrated Crisis System. It is also of note that 10 hospitals are ultimately participating in both the diabetes and the behavioral health crisis response track, leaving 35 unique hospitals participating in one or both tracks of the new program.

Given the location of the hospitals participating in the Catalyst Grants, certain areas of the State have more programs active than others. **Exhibit 11** shows the distribution of Catalyst Grants throughout the State, with both Baltimore City and Charles County having three programs selected (two diabetes grants and one behavioral health crisis response grant active for each). Participating hospitals are also shown.

Exhibit 11
Catalyst Grant Distribution



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

As shown, the Capital Region, Baltimore Metropolitan Region, and Southern Maryland are well covered; while there are no programs operating in the mid- and upper-eastern shore, Anne Arundel, Garrett, or Harford counties.

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 and the prior findings that the MDPCP has yet to produce cost savings, 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, 2021

Appendix 1
2020 *Joint Chairmen's Report* Responses from Agency

The 2020 *Joint Chairmen's Report* (JCR) requested that the Maryland Department of Health (MDH) – Health Regulatory Commissions prepare four reports. Electronic copies of the full JCR responses can be found on the Department of Legislative Services (DLS) Library website.

- ***Update on the Findings and Recommendations Made Pertaining to the University of Maryland Medical System (UMMS) Payments to Board Members:*** Chapter 19 of 2020 (the fiscal 2021 Budget Bill) included language withholding $500,000 in special funds from the operating grant to the R Adams Cowley Shock Trauma Center pending the receipt of a report from UMMS on responses to findings and recommendations contained in specified audit reports. In a letter dated September 21, 2020, UMMS submitted a report reviewing the progress on the findings in two audits issued between December 2019 and March 2020. In its response to the budget committees and the Joint Audit and Evaluation Committee (JAEC), UMMS indicates that it has completed or implemented measures to address all of the audits. UMMS implemented a conflict of interest policy in May 2019 that includes an annual review of related-party transactions. However, the Office of Legislative Audit's review of this policy found that the review was delegated to the Board's Governance Committee when the external audit recommended that this be done by the entire board. While the budget committees released the funds withheld pending this report, the budget committees also requested a follow-up report to be submitted no later than December 1, 2020, that (1) affirms UMMS' intent to comply with the *Report of the Special Committee of the University of Maryland Medical System Board of Directors* recommendation that the full board review all related-party transactions as well as transactions conducted under this revised policy; (2) includes a copy of the amended UMMS corporate bylaws clarifying board member term limits; and (3) includes documentation detailing the process through which UMMS will monitor and notify appointing authorities of vacancies. MDH and the Department of Budget and Management did not make UMMS aware of this additional request until recently. At the time of this writing, UMMS reports working on this follow-up report. Chapters 18 and 19 of 2019 also require a calendar 2022 audit by JAEC of UMMS' board practices, where these remaining issues and progress on prior findings can be evaluated further.

- ***Report on the Hospital Medical Liability Market and Impacts on Total Cost of Care:*** Chapter 19 included language requesting that the Health Services Cost Review Commission (HSCRC) submit an independent actuarial analysis on Maryland's hospital medical liability market by September 15, 2020. In a letter dated June 17, 2020, HSCRC expressed concerns with this timeline, citing lack of specialty knowledge in medical liability and reinsurance within the commission, requiring outside procurement. HSCRC also believes that the scope of work requested for the study will exceed the $400,000 restricted in the budget for this report. These concerns prompted HSCRC to request an extension for this study to June 2021. The budget committees granted this extension request for June 30, 2021, but requested an interim report to be submitted by January 15, 2021. HSCRC has reported delays in the procurement of a

consultant due to COVID-19, further delaying the ability to submit an interim report as requested.

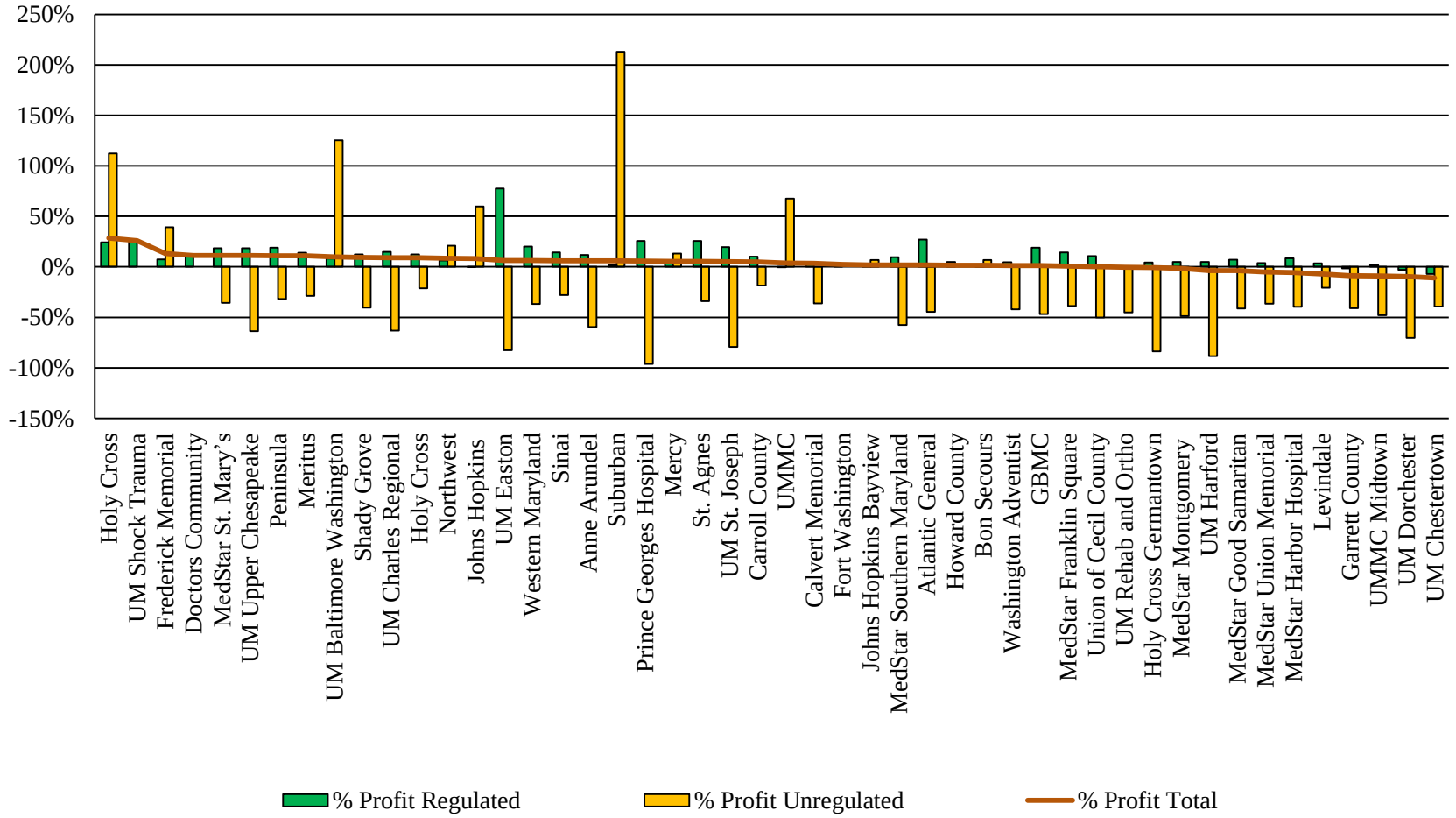
- ***Evaluation of the Maryland Primary Care Program:*** This report is discussed further in Key Observation 2.

- ***HSCRC Policy on and Management of Hospital Profits:*** This report is discussed further in Key Observation 1.

Appendix 2

Hospital Profits – as a Percent of Expenditures

Fiscal 2021 July through November



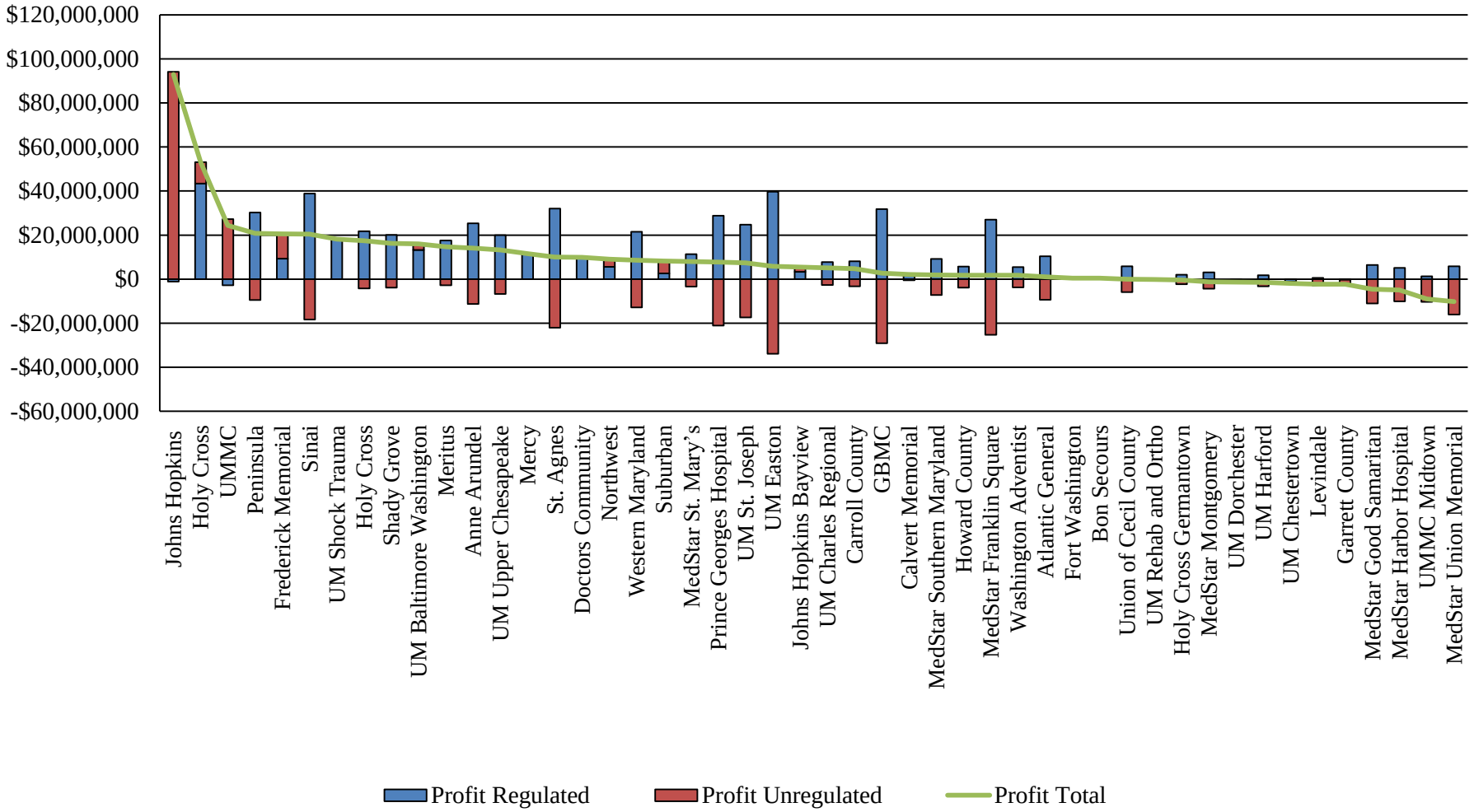
GBMC: Greater Baltimore Medical Center
UM: University of Maryland
UMMC: University of Maryland Medical Center

Source: Health Services Cost Review Commission

Appendix 3

Hospital Profits – Total Dollars

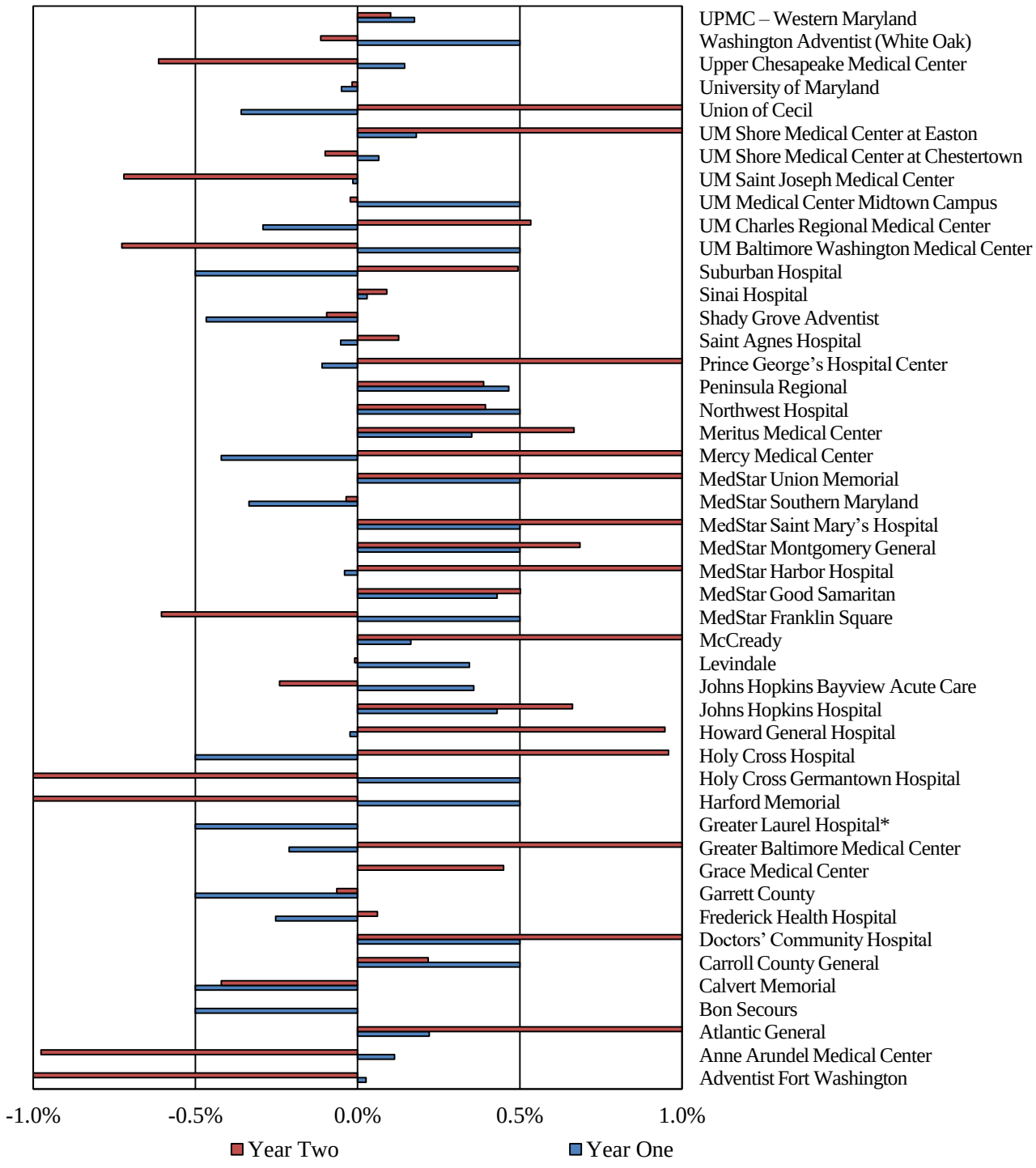
Fiscal 2021 July through November



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

Source: Health Services Cost Review Commission

Appendix 4
Medicare Performance Adjustment Results



UM: University of Maryland UPMC: University of Pittsburgh Medical Center

Source: Health Services Cost Review Commission

Appendix 5
Care Redesign Program Participation

	ECIP	HCIP
Anne Arundel Medical Center	X	
Atlantic General Hospital	X	
Doctors Community Hospital	X	
Frederick Memorial Hospital	X	
Greater Baltimore Medical Center	X	
Holy Cross Germantown	X	X
Holy Cross Hospital	X	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	
TidalHealth Peninsula Regional	X	X
University of Maryland Baltimore Washington Medical Center	X	
University of Maryland Charles Regional Medical Center	X	
University of Maryland St. Joseph Medical Center	X	
University of Maryland Upper Chesapeake Medical Center	X	
UPMC – Western Maryland Health Systems	X	X

ECIP: Episode Care Improvement Program
HCIP: Hospital Care Improvement Program
UPMC: University of Pittsburgh Medical Center

Source: Health Services Cost Review Commission

Appendix 6
Total Population Health Goals Outlined in Statewide Integrated Health Improvement Strategy

Total Population Health	Diabetes	Opioids	Maternal and Child Health	
Goal	Reduce the mean body mass index (BMI) for adult Marylanders	Improve overdose mortality	Reduce severe maternal morbidity (SMM) rate	Decrease asthma-related emergency department visit rates for ages 2-17
Measure	State mean BMI	Annual change in overdose mortality as compared to a cohort of states with historically similar overdose mortality rates and demographics	SMM rate per 10,000 delivery hospitalizations	Childhood asthma-related emergency department (ED) visit per 1,000
Population	Residents over 18 years old in Maryland and control states	Residents of Maryland and control states	Women ages 15-49 years old with a delivery hospitalization	Children ages 2-17 years old
Data Source	Behavioral risk factor surveillance survey	National Vital Statistics System	HSCRC case mix data	HSCRC case mix data
Baseline (2018)	State mean BMI for 2018	Age-adjusted death rate of 37.2/100,000	242.5 SMM per 10,000 delivery hospitalizations	9.2 ED visit rate per 1,000 for ages 2-17
2023 Target (Year Five)	Achieve a more favorable change from baseline mean BMI than a group of control states	Achieve a more favorable trend in overdose mortality rate as compared to the weighted average of control states	219.3 SMM rate per 10,000 delivery hospitalizations	Achieve a rate reduction from 2018 baseline to 7.2 in 2023 for ages 2-17
2026 Final Target (Year Eight)	Achieve a more favorable change from baseline mean BMI than a group of control states	Achieve a more favorable trend in overdose mortality rate as compared to the weighted average of control states	197.1 SMM rate per 10,000 delivery hospitalizations	Achieve a rate reduction from the 2018 baseline to 5.3 in 2026 for ages 2-17

HSCRC: Health Services Cost Review Commission

Source: Health Services Cost Review Commission

Appendix 7
Maryland Primary Care Program Track Requirements

Function	Track 1 Requirements	Additional Track 2 Requirements
Access and Continuity	Empanel patients to care team	Ensure patients have regular access through at least one alternative strategy (telemedicine, group visits, *etc.*)
	Ensure 24/7 access to care team or practitioner with real-time access to the beneficiaries EHR	
Care Management	Ensure beneficiaries are risk stratified	Ensure beneficiaries in long-term care management are engaged in personalized care planning processes
	Ensure all beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, longitudinal care management	Ensure beneficiaries in longitudinal care have access to comprehensive medication management
	Ensure beneficiaries receive a follow-up interaction within a week of emergency department (ED) discharges, and within two business days for hospital discharges.	
	Ensure beneficiaries who have received this follow up after trigging events also receive 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 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

Function	Track 1 Requirements	Additional Track 2 Requirements
Planned Care for Health Outcomes	Improve performance on key outcomes (*e.g.*, cost of care, beneficiary experience, utilization rates)	

EHR: Electronic Health Record

Source: Maryland Primary Care Program

Appendix 8
Catalyst Grant Awardees and Amounts

Focus Area	Partnership Name	Region	Award Amounts	Hospitals in Proposal (Number of Hospitals)
Diabetes	**Saint Agnes and Lifebridge:** Recruiting, training, and supporting 12 certified Diabetes Prevention Program (DPP) coaches; improve healthy food access to food insecure patients	Baltimore City and Baltimore County	$5,962,333	Ascension Saint Agnes, Sinai Hospital, and Grace Medical Center (3)
	Baltimore Metropolitan Diabetes Regional Partnership: Centralized management for DPP and Diabetes Prevention Program $ Diabetes Self-Management Training (DSMT); expand DSMT sites; build information technology infrastructure for information transfer	Baltimore City	43,299,986	Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, University of Maryland Medical Center (UMMC) Downtown, UMMC Midtown, Howard County General Hospital, and Suburban Hospital (6)
	Nexus Montgomery: Increase supply and demand for DPP and DMST through increase capacity support and public outreach, respectively; increase referrals and case management	Montgomery County	11,876,430	Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, and White Oak Medical Center (4)
	Totally Linking Care: Increase the number of and referrals to DPPs and DSMTs; improve wrap-around services and technical assistance to support DPPs and DSMTs	Charles, Prince George's, and St. Mary's counties	7,379,620	University of Maryland (UM) Capital Region Health, MedStar Southern Maryland Hospital, MedStar St. Mary's Hospital, Adventist HealthCare Fort Washington Medical Center, and Luminis Doctors Community Hospital (5)
	Trivergent: Increase number of and recruitment/retention for DPP; expand virtual, in-person, and hybrid DSMT; integrate mental health and social need screenings	Allegany, Frederick, and Washington counties	15,717,413	Frederick Health Hospital, Meritus Medical Center, and University of Pittsburgh Medical Center Western Maryland (3)
	UM Charles Regional: Expand DSMT services; offer wrap-around services including nutrition, telehealth, transportation, *etc.*	Charles County	2,124,862	UM Charles Regional Medical Center (1)
Diabetes Subtotal			***$86,360,644***	***Hospitals: 22***

Focus Area	Partnership Name	Region	Award Amounts	Hospitals in Proposal (Number of Hospitals)
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System:** Establish a regional Care Traffic Control system by implementing a single hotline to manage mental health and substance use disorder crisis calls; expand mobile treatment crisis teams to divert patients from emergency department; piloting a Same Day Access program	Baltimore City and Baltimore, Carroll, and Howard counties	$44,862,000	Ascension Saint Agnes, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital, Grace Medical Center, Sinai Hospital, Northwest Hospital, Carroll Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Union Memorial Hospital, MedStar Franklin Square Medical Center, UMMC, UM St. Joseph Medical Center, UMMC Midtown, Mercy Medical Center, and Greater Baltimore Medical Center (17)
	Total Linking Care: Expand mobile crisis teams; improve crisis response technology within Prince George's County; establish crisis receiving facility accepting individuals 24/7/365	Prince George's and Southern Maryland	22,889,722	Adventist HealthCare Fort Washington Medical Center, MedStar Southern Maryland Hospital Center, UM Prince George's Hospital Center, and UM Laurel Medical Center (4)
	Peninsula Regional: Establish a regional behavioral health urgent care center (BHUCC); centralize and regionalize two mobile crisis programs with the BHUCC	Lower Eastern Shore	11,316,332	Peninsula Regional Medical Center, and Atlantic General Hospital (2)
Behavioral Health Subtotal			***$79,068,054***	***Hospitals: 23***
Total			**$165,428,698**	**Total Hospitals: 45** **Unique Hospitals: 35**

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Behavioral Health Subtotal			***$79,068,054***	***Hospitals: 23***
Total			**$165,428,698**	**Total Hospitals: 45**
				Unique Hospitals: 35

Source: Health Services Cost Review Commission

Appendix 9
Object/Fund Difference Report
MDH – Health Regulatory Commissions

Object/Fund	FY 20 Actual	FY 21 Working Appropriation	FY 22 Allowance	FY 21 - FY 22 Amount Change	Percent Change
Positions					
01 Regular	109.90	108.90	112.90	4.00	3.7%
02 Contractual	14.77	7.87	9.59	1.72	21.9%
Total Positions	**124.67**	**116.77**	**122.49**	**5.72**	**4.9%**
Objects					
01 Salaries and Wages	$ 14,735,023	$ 16,186,607	$ 16,668,733	$ 482,126	3.0%
02 Technical and Spec. Fees	811,605	734,109	783,545	49,436	6.7%
03 Communication	99,240	85,815	104,645	18,830	21.9%
04 Travel	141,973	321,992	330,912	8,920	2.8%
08 Contractual Services	119,359,728	135,728,609	153,083,127	17,354,518	12.8%
09 Supplies and Materials	92,574	83,083	89,951	6,868	8.3%
10 Equipment – Replacement	194,270	75,000	30,500	-44,500	-59.3%
11 Equipment – Additional	146,783	805,475	925,279	119,804	14.9%
12 Grants, Subsidies, and Contributions	11,900,924	10,672,095	11,063,001	390,906	3.7%
13 Fixed Charges	459,719	797,236	781,875	-15,361	-1.9%
Total Objects	**$ 147,941,839**	**$ 165,490,021**	**$ 183,861,568**	**$ 18,371,547**	**11.1%**
Funds					
03 Special Fund	$ 147,874,177	$ 165,090,021	$ 183,303,845	$ 18,213,824	11.0%
09 Reimbursable Fund	67,662	400,000	557,723	157,723	39.4%
Total Funds	**$ 147,941,839**	**$ 165,490,021**	**$ 183,861,568**	**$ 18,371,547**	**11.1%**

MDH: Maryland Department of Health

Note: The fiscal 2021 appropriation does not include deficiencies, targeted reversions, general salary increases, or across-the-board reductions. The fiscal 2022 allowance does not include contingent reductions or annualization of general salary increases.