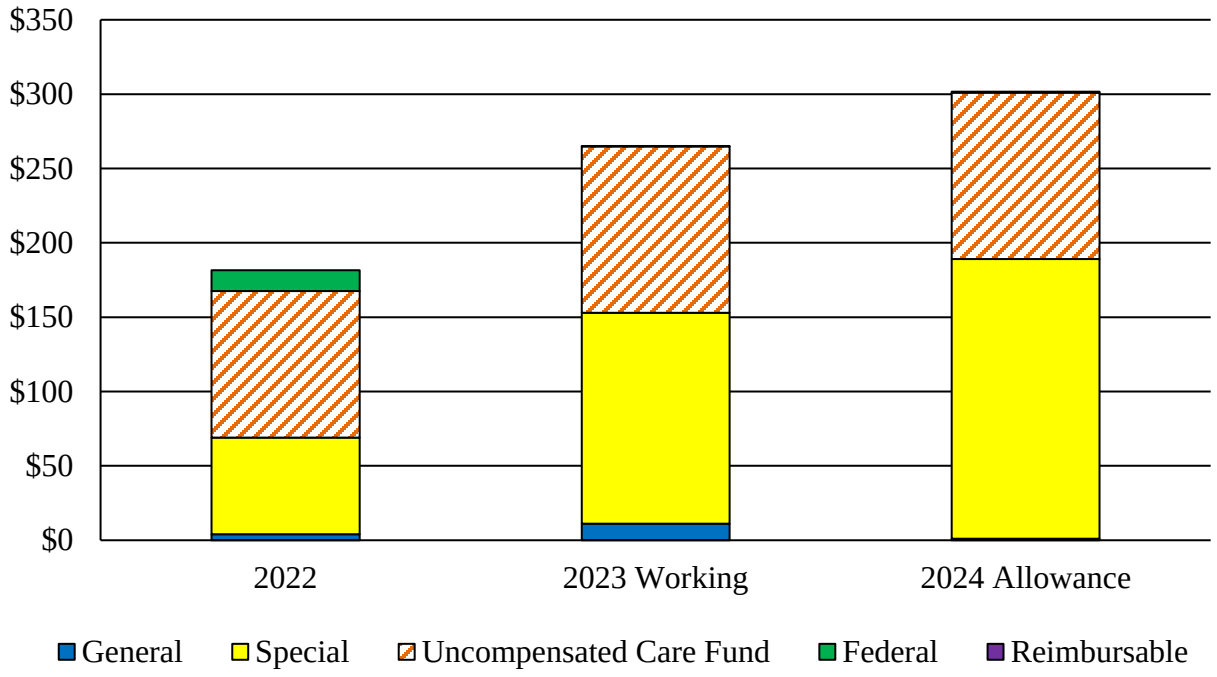
M00R01
Health Regulatory Commissions
Maryland Department of Health

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, 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 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 2024 Budget Increases by $36.5 Million, or 13.8%, to $301.6 Million
($ in Millions)



Note: The fiscal 2023 working appropriation includes deficiency appropriations including this agency's share of a deficiency appropriation budgeted in the Statewide Account within the Department of Budget and Management (DBM). Fiscal 2024 salary enhancements are budgeted in the Statewide Account within DBM.

For further information contact: Anne P. Wagner Email: Anne.Wagner@mlis.state.md.us

- The fiscal 2024 allowance increases by $36.5 million compared to the adjusted fiscal 2023 working appropriation primarily due to $35 million in additional special funds budgeted for the Consortium on Coordinated Community Supports (Consortium), as established in Chapter 36 of 2021 and amended by Chapter 713 of 2022.

- Various special funds continue to support Health Regulatory Commissions spending, with the Uncompensated Care Fund (UCF) accounting for the largest share of total fiscal 2024 expenses at $112 million. The fiscal 2024 allowance includes $85 million in special funds from the Blueprint for Maryland's Future Fund for the Consortium, meeting the mandated funding level. Remaining special funds largely come from user fees assessed on health care payors, hospitals, nursing homes, and health care practitioners, among other special fund sources.

Fiscal 2023

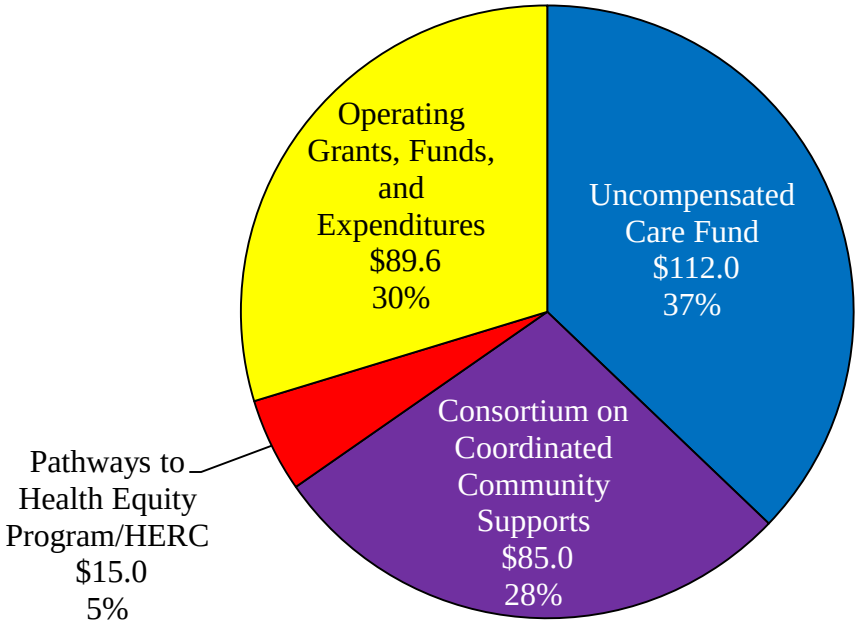
To prepare for implementation of the 9-8-8 hotline at the federal level and projected increase in call volumes and need for crisis services, narrative in the 2022 *Joint Chairmen's Report* (JCR) requested that MHCC conduct an independent analysis of the behavioral health crisis response system. As part of these efforts, MHCC was asked to procure a contract with a health research and analytics company to conduct a needs assessment and gap analysis of the crisis response services continuum. Furthermore, the narrative requested that MHCC convene a workgroup with the MDH Behavioral Health Administration and other stakeholders to inform the evaluation and work of the health research and analytics vendor that would eventually lead to interim and final reports to be submitted to the budget committees. As of February 15, 2023, MHCC reported that it had not procured a vendor or convened a workgroup to complete the requested reports. **The department should explain why it has not made progress in completing the independent analysis of the behavioral health crisis response system, procuring a health research and analytics vendor, convening a stakeholder workgroup, and preparing an interim report on these activities.**

Fiscal 2024 Overview of Agency Spending

The fiscal 2024 allowance for MDH Health Regulatory Commissions totals $301.6 million, almost entirely in special funds. As shown in **Exhibit 1**, the single largest component of the budget is the UCF at $112 million, accounting for 37% 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 for regulated services for which patients' out-of-pocket expenses are not anticipated to be paid. Aside from the UCF, MCHRC administers two grant programs that make up the next two largest shares of spending – the Consortium (28%, or $85 million) and the Pathways to Health Equity program (5%, or $15 million).

Exhibit 1
Overview of Agency Spending
Fiscal 2024 Allowance
($ in Millions)

Total Expenditures: $301.6 Million



HERC: Health Equity Resource Communities

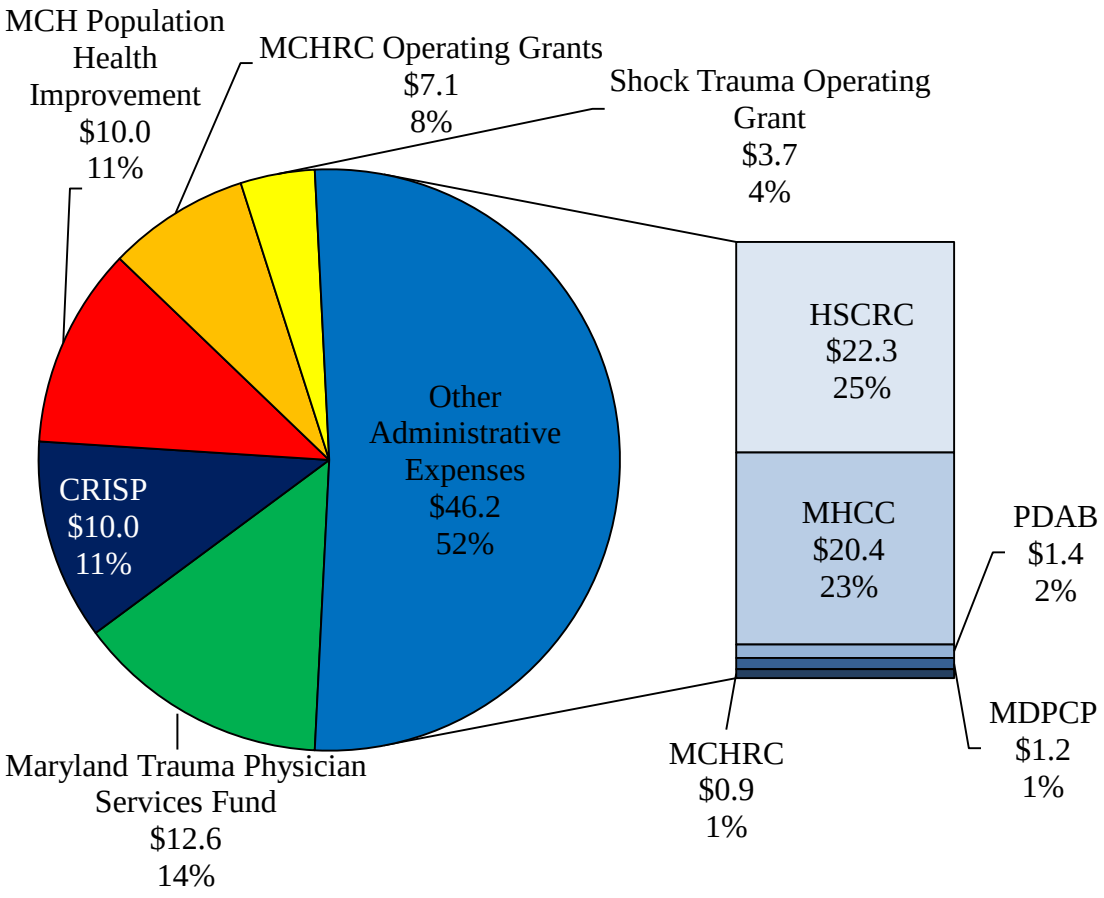
Note: Fiscal 2024 salary enhancements are budgeted in the Statewide Account within the Department of Budget and Management.

Source: Department of Budget and Management

Exhibit 2 shows the remaining $89.6 million in operating expenditures and grants (accounting for 29.7% of the total allowance) excluding the UCF under HSCRC and the two largest MCHRC grant programs. Of this funding, $33.4 million, or 37.3%, supports grants for health care programs and initiatives, such as trauma services through MHCC, maternal and child population health initiatives managed by HSCRC, and MCHRC operating grants. The Health Regulatory Commissions also support other aspects of the State's health care system, including the designated health information exchange, Chesapeake Regional Information System for our Patients (CRISP).

Exhibit 2
Health Regulatory Commissions Operating Expenditures
Fiscal 2024 Allowance
($ in Millions)

Total Expenditures: $89.6 Million



CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Services Cost Review Commission
MCH: maternal and child health
MCHRC: Maryland Community Health Resources Commission
MDPCP: Maryland Primary Care Program
MHCC: Maryland Health Care Commission
PDAB: Prescription Drug Affordability Board

Note: Excludes spending under the Uncompensated Care Fund, Consortium on Coordinated Community Supports, and Pathways to Health Equity program. Fiscal 2024 salary enhancements are budgeted in the Statewide Account within the Department of Budget and Management.

Source: Department of Budget and Management

Administrative expenses make up the remaining $46.2 million (52%) of this portion of the budget, with MHCC and HSCRC each supported by more than $20 million in operating costs. The Health Regulatory Commissions budget includes $1.2 million in administrative expenses for the Maryland Primary Care Program (MDPCP) – Program Management Office. These costs are split evenly between the HSCRC fund and MHCC fund and support an equivalent amount of reimbursable funds for the Program Management Office in the Medicaid program. MDPCP and its role in the State's Total Cost of Care (TCOC) model are discussed in further detail in Key Observation 1.

Proposed Budget Change

As shown in **Exhibit 3**, the fiscal 2024 allowance increases by $36.5 million compared to the adjusted fiscal 2023 working appropriation after accounting for the Health Regulatory Commissions' distribution of the statewide deficiency for the 4.5% cost-of-living adjustment provided in November 2022. The increase is primarily driven by $35 million in additional funds for the Consortium to meet the mandated funding level required in Chapter 713. The fiscal 2024 allowance further increases by $11.7 million in special funds under HSCRC for maternal and child health initiatives supporting the population health component of the TCOC model (further discussed in Key Observation 1) and other operating costs. However, a $10.2 million reduction in general funds for CRISP operating support partially offsets this increase.

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

How Much It Grows:	**General Fund**	**Special Fund**	**Federal Fund**	**Reimb. Fund**	**Total**
Fiscal 2022 Actual	$4,000	$163,601	$14,000	$0	$181,601
Fiscal 2023 Working Appropriation	11,214	253,677	0	189	265,080
Fiscal 2024 Allowance	1,000	300,033	0	560	301,593
Fiscal 2023-2024 Amount Change	-$10,214	$46,356	$0	$371	$36,513
Fiscal 2023-2024 Percent Change	-91.1%	18.3%		195.6%	13.8%

Where It Goes:	**Change**
Personnel Expenses	
Annualization of 4.5% cost-of-living adjustment that took effect November 1, 2022	$230
Salaries and fringe benefits for 2 new positions supporting the Consortium on Coordinated Community Supports, in accordance with Chapter 713 of 2022	148
Employee retirement	54
Other fringe benefit adjustments	27

Where It Goes:	**Change**
Other salary adjustments for existing positions, decreasing partially due to 1 position transfer within MDH	-29
Turnover adjustments (increases from 4.08% to 4.38%)	-169
Employee and retiree health insurance	-295
Maryland Community Health Resources Commission (MCHRC)	
Consortium on Coordinated Community Supports (special funds from the Blueprint for Maryland's Future Fund)	34,707
MCHRC operating grants	97
MCHRC administrative expenses	-46
Health Equity Resource Community grants awarded through the Pathways to Health Equity Program, established by Chapters 741 and 742 of 2021	-95
Health Services Cost Review Commission (HSCRC)	
Maternal and child health population health initiatives	10,000
Contract for inpatient and outpatient data reviews	816
Main frame data processing expenditures	678
HSCRC administrative expenses	164
Data analysis and repository contracts related to hospitals' medical and financial records	-106
CRISP operating support (general funds)	-10,214
Maryland Health Care Commission (MHCC)	
Maryland Trauma Physician Services Fund	600
Other MHCC administrative expenses	246
Center for Analysis and Information Services contracts, driven by database development costs	-247
Prescription Drug Affordability Board (PDAB)	
PDAB administrative expenses	10
Second year of repayment to MHCC for initial staffing and support, as required by Chapters 4 and 28 of 2021	-100
Other Changes	
Rent	18
Cost allocations	14
Contractual personnel costs, including annualization of a 4.5% general salary increase and a net increase of 0.38 FTE	6
Total	**$36,513**

CRISP: Chesapeake Regional Information System for our Patients
FTE: full-time equivalent
MDH: Maryland Department of Health

Note: The fiscal 2023 working appropriation includes deficiency appropriations including this agency's share of a deficiency appropriation budgeted in the Statewide Account within the Department of Budget and Management (DBM). Fiscal 2024 salary enhancements are budgeted in the Statewide Account within DBM. Numbers may not sum to total due to rounding.

Maryland Consortium on Coordinated Community Supports

Chapter 36 of 2021 (the Blueprint for Maryland's Future – Implementation) established the Consortium under 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 technical assistance to local school systems to support positive classroom environments and close achievement gaps; and

- provide expertise in developing best practices in the delivery of behavioral health and wraparound services.

According to the Consortium's first annual report submitted in December 2022 in response to committee narrative in the 2022 JCR and as mandated, the Consortium includes 24 members and first started meeting in August 2022. Since then, four subcommittees have been formed and have met regularly. Chapter 713 altered the Consortium's membership to increase the number of required agency representatives and require that MCHRC receive 2 additional new positions to staff the Consortium.

Part of the Consortium's charge is to administer the Coordinated Community Supports Partnerships grant program. The fiscal 2023 working appropriation and fiscal 2024 allowance meet the required funding levels of $50 million and $85 million for these grants, respectively. Chapter 713 increased mandated funding levels for the program, starting with $85 million in fiscal 2024 rather than the original funding level of $75 million. Under the new mandates, the Governor must appropriate $110 million in fiscal 2025 and $130 million in fiscal 2026 and beyond.

As of December 2022, the Consortium was developing the first call for proposals under the Coordinated Community Supports Partnerships grant program and was expecting to issue the call for proposals in early calendar 2023. MDH should provide an update on the timeline for issuing a fiscal 2023 call for proposals and distributing Coordinated Community Supports Partnerships grants.

MCHRC Operating Grants

Prior to fiscal 2023, before the Coordinated Community Supports Partnerships and Pathways to Health Equity grant programs were established, MCHRC mainly funded the State's safety net providers who were operating programs targeting various health priorities. The current funding priorities for these grants are diabetes and chronic disease prevention; maternal and child health; and behavioral health services, including opioid crisis response activities. Operating grants and MCHRC's administrative expenses had been supported with available funding through the Carefirst premium tax credit exemption. These funds were shared between MCHRC and the Senior Prescription Drug Assistance Program (SPDAP) under the Medical Care Programs

Administration. MCHRC traditionally received the first $8 million for its grants and general administration.

The ability of the Carefirst premium tax exemption to support both MCHRC and SPDAP waned over time, resulting in Chapter 150 of 2021 (the Budget Reconciliation and Financing Act (BRFA)), which dedicated all Carefirst premium tax exemption funding to SPDAP and diverts $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. Both the fiscal 2023 working appropriation and fiscal 2024 allowance provide the $8 million from this health insurance provider assessment. MCHRC will need to compete for general funds for operating grants and administrative expenses beginning in fiscal 2025, if it is the desire for MCHRC to continue to provide operating grants separate from the other programs.

Personnel Data

	FY 22 Actual	FY 23 Working	FY 24 Allowance	FY 23-24 Change
Regular Positions	112.90	116.90	117.90	1.00
Contractual FTEs	8.40	11.28	11.66	0.38
Total Personnel	**121.30**	**128.18**	**129.56**	**1.38**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	5.08	4.38%
Positions and Percentage Vacant as of 12/31/22	13.00	11.12%
Vacancies Above Turnover	7.92	

- The fiscal 2024 allowance provides 2 new regular positions under MCHRC for a total of 4 positions supporting the Consortium, as required by Chapter 713. A transfer of 1 epidemiologist position from MCHRC to another MDH office partially offsets the new positions.

- Overall, the Health Regulatory Commissions reported 13 vacant positions as of December 31, 2022, more than double the number of vacancies needed to meet the budgeted turnover expectancy. Of these positions, 6 had been vacant for more than one year. MHCC accounts for just under half of the vacant positions with 6 vacancies as of December 31, 2022, in line with that commission having the most staffing support at 55.9 total authorized positions.

Key Observations

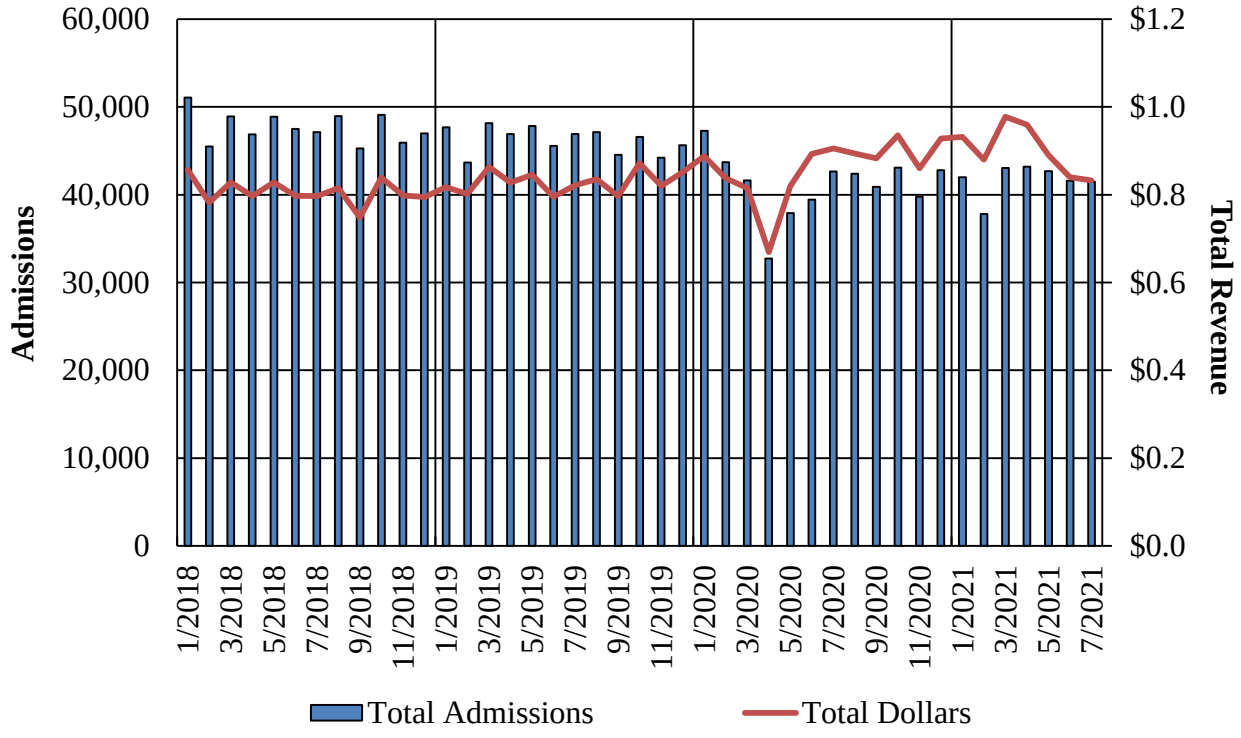
1. COVID-19 Pandemic Impacts on Hospitals and Rate Setting

Maryland's hospital financing is unique in that the all-payer hospital rate setting system has required HSCRC to set rates since the 1970s. In calendar 2014, Maryland entered an agreement with the federal government allowing HSCRC to regulate population-based revenues (commonly referred to as global budgets) for acute care hospitals. HSCRC sets global budget revenue (GBR) for each hospital as an annual revenue target that accounts for factors such as inflation, population changes, and hospital quality and efficiency metrics. Hospitals meet the target by charging rates totaling the global budget. The successor to the 2014 agreement, the TCOC model, began in January 2019 and continued the use of GBR. Key Observation 1 further discusses the TCOC model overall. Together, the TCOC model and all-payer hospital rate setting system together make up the Maryland Health model.

Narrative in the 2022 JCR requested that HSCRC submit a report on the benefits of the Maryland Health model on hospitals' financial stability during the COVID-19 pandemic, the costs associated with the pandemic (including costs of COVID-19 treatment and indirect costs for hospital operations), and federal and State financial assistance provided to hospitals.

In a response to the JCR submitted in October 2022, HSCRC indicated that the Maryland Health model generally creates a stable and predictable revenue system for hospitals, which was a particularly important benefit during the pandemic. During the initial onset of the pandemic, hospital volumes decreased sharply due to limitations on certain hospital procedures to maintain adequate bed capacity and increased gradually as demand for certain kinds of care was still reduced. **Exhibit 4** shows hospital volumes and revenue from January 2018 to July 2021. Although revenues and admissions across all payors immediately fell at the start of the COVID-19 public health emergency in April 2020, all-payor revenues recovered much more quickly than admissions and, in some instances, exceeded prior year amounts. Changes in patient volumes do not correlate with changes in revenue in Maryland hospitals because these hospitals are reimbursed based on fixed global budgets.

Exhibit 4
Hospital Volumes and Revenue
January 2018 to July 2021
($ in Billions)



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

Unexpected COVID-19 Costs Affecting Hospitals

HSCRC's response to the committee narrative discussed the severe decline in patient volumes and resulting revenue loss from the restriction on elective and non-urgent medical procedures and patients' delayed care for non-COVID-19 medical conditions as a national trend. The report described two other financial challenges causing increased costs for U.S. hospitals during the COVID-19 pandemic. Due to the timing of report submission, HSCRC could not provide any detail on actual fiscal 2022 financial data.

- ***Increase of COVID-19 Patients as a New Patient Type***: In Maryland, HSCRC set hospital rates on a granular level (such as per patient day or laboratory test). Services for COVID-19 patients used those same rates and therefore reflected the cost of providing the service to respond to the increase in direct costs for caring for COVID-19 patients, a new patient type.

Hospitals received reimbursement for all direct COVID-19 costs if they did not reach their GBR.

In calendar 2020, the decline in non-COVID-19 patient revenue offset the costs of COVID-19-related services, and all hospitals received full reimbursement for COVID-19 direct costs. According to HSCRC, patient revenue in calendar 2021 across hospitals statewide fell below the hospitals' collective GBR and could have caused a loss of $48 million in COVID-19 patient revenue. However, HSCRC allowed hospital revenues to roll forward to a future year so they were made whole for COVID-19 patients.

- ***Additional Overhead and Direct Costs:*** The COVID-19 pandemic led to heightened overhead expenses as HSCRC recorded a 19% increase in hospital administration costs between fiscal 2020 and 2021. Additional costs under administration included preparing space for patient surges, increasing workforce support to retain and reward staff throughout the pandemic, and purchasing personal protective equipment. HSCRC found that hospitals generally offset these added costs with savings from volume declines and other cost management strategies.

Federal and State Support for Hospitals Throughout the COVID-19 Pandemic

The federal government provided significant assistance to hospitals nationally through various stimulus legislation and public health response programs, with the largest source of financial support being the Provider Relief Fund (PRF). HSCRC reported that, as of October 2022, Maryland hospitals had received $1.3 billion in PRF support. The vast majority of this funding was allocated to hospitals subject to GBR. Therefore, HSCRC took PRF revenue into account for rate setting and offset GBR undercharge for each hospital by the amount of PRF received. HSCRC consulted Maryland hospitals on their PRF awards and concluded that $1.1 billion of total federal assistance received would be applicable for rate setting. HSCRC did not use other federal stimulus funds distributed directly to hospitals to offset GBR. Hospitals nationwide and in Maryland also received federal assistance from the suspension of a 2% Medicare payment reduction that would have been in effect May 1, 2020, through March 31, 2022.

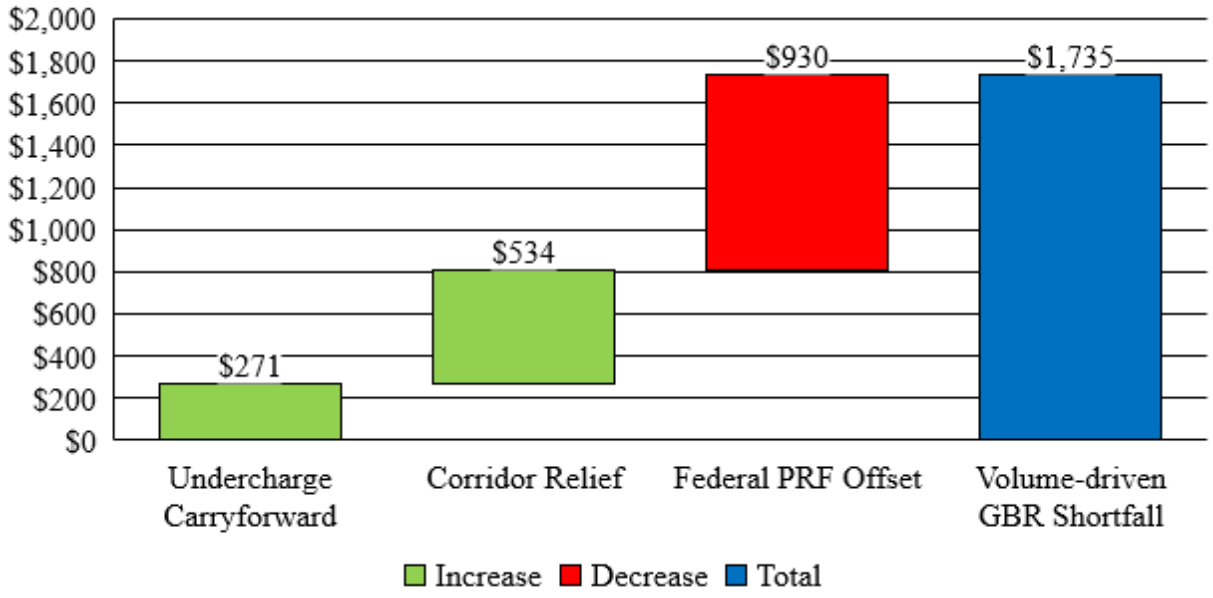
After accounting for the PRF federal offset, HSCRC implemented the following policies at the State level as part of a global budget guarantee to assist hospitals in meeting their GBR through rate setting. As shown in **Exhibit 5**, these combined measures assisted hospitals in making up the $1.7 billion shortfall in their total GBR over fiscal 2020 and 2021 while overall hospital utilization was reduced. HSCRC's GBR guarantee measures provided stability to hospitals during the COVID-19 pandemic but increased charges to consumers and payers on a rate basis in some cases:

- ***Corridor Relief:*** HSCRC allowed hospitals to raise rates higher than is normally permitted to better approach their GBR while patient volumes were reduced. This policy expanded rate corridors from +/- 5% of unit rates up to 20% of GBR unit rates for rate centers

providing 100% inpatient care and 10% for all other rate centers in the final quarter of fiscal 2020 and beginning of fiscal 2021.

- ***Carryover of Undercharges:*** The second component of the global budget guarantee was allowing hospitals to carryover the difference between their actual revenue and GBR into the next fiscal year in fiscal 2020 and 2021. This policy provided more flexibility to hospitals that could not meet their GBR and mitigated large rate increases for payers and consumers if hospitals needed to make up for low patient volume from the pandemic in one year.

Exhibit 5
HSCRC Global Budget Guarantee and Rate Setting Measures
Combined Fiscal 2020 and 2021
($ in Millions)



GBR: global budget revenue
HSCRC: Health Services Cost Review Commission
PRF: Provider Relief Fund

Note: Actions that increased charges to consumers and payers on a rate basis in some cases are labeled as increases. Offsetting hospital GBRs with federal PRF revenue is shown as a decrease because that discounts the amount of revenue hospitals would need to make up by increasing rates or increasing volume, and is therefore likely to have a negative impact on hospital rates.

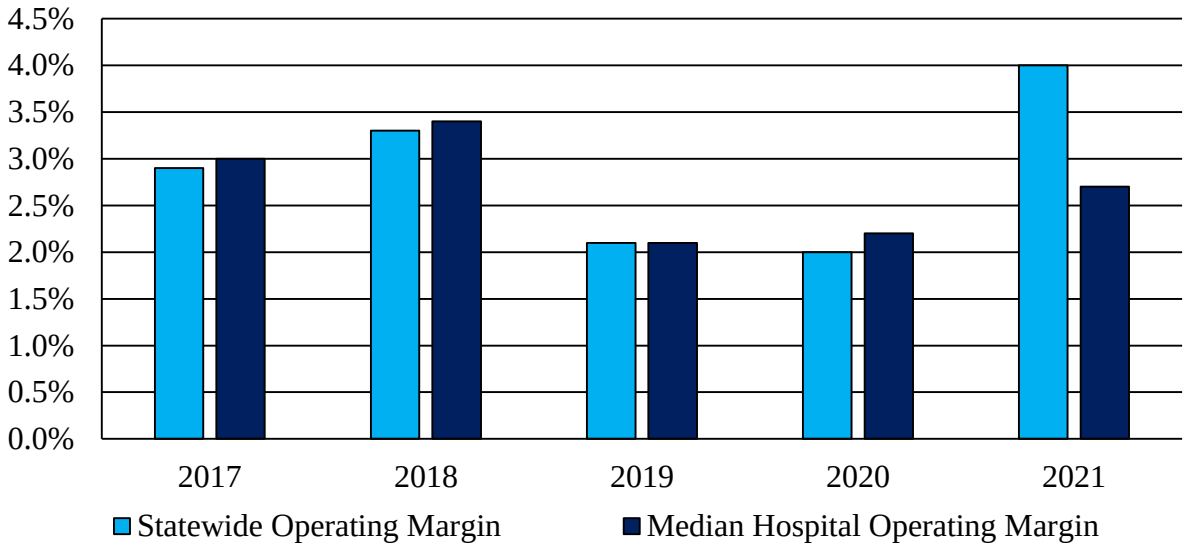
Source: Health Services Cost Review Commission; Department of Legislative Services

In addition to the global budget guarantee initiatives, HSCRC administered the following changes (if needed) to provide further stability to hospitals as the cost impact of the COVID-19 pandemic was still uncertain and had the potential to outpace GBRs.

- ***COVID-19 Surge Funding:*** Considering the uncertainty of how COVID-19 surges would impact hospital volume, HSCRC allowed hospitals to exceed projected volume in the GBR to meet the need for hospital services during a COVID-19 surge. Hospitals received $48 million in COVID-19 surge funding in fiscal 2021, offset by $16 million in federal fund assistance that was backed out of the GBR.

- ***COVID-19 Expense Adjustment:*** HSCRC indicated in its response to the committee narrative in the 2022 JCR that it would compare the increase in administrative costs resulting from the pandemic to savings from other sources of hospital revenue and the long-term financial stability from the Maryland Health model. Based on fiscal 2020 and 2021, HSCRC found that hospitals experienced expense growth outpacing regulated revenue growth. These costs were generally covered by other funding sources, as hospitals' operating margins for regulated services remained level in fiscal 2020 or substantially increased in fiscal 2021, as shown in **Exhibit 6**. HSCRC did not expect any substantial expense adjustments to be necessary considering the fiscal 2020 and 2021 results.

Exhibit 6
Hospital Operating Margins
Fiscal 2017-2021



Note: Reflects both regulated and unregulated business of the Health Services Cost Review Commission (HSCRC) regulated entities. Margins for HSCRC-regulated business only show similar consistency across time.

Source: Health Services Cost Review Commission

Overall, HSCRC found that Maryland hospitals' financial stability was not negatively impacted by the COVID-19 pandemic through fiscal 2021 after accounting for several federal and State sources of assistance and the Maryland Health model keeping hospital revenues more stable than was seen in other states. Despite this finding, the fiscal 2023 working appropriation continues to provide financial relief for hospitals through a one-time $50 million special fund appropriation from the dedicated purpose account specifically for workforce support. Additionally, a budget amendment approved on January 9, 2023, appropriated $25 million in federal funds from the American Rescue Plan Act of 2021 for hospital grants to address urgent staffing needs and COVID-19 testing and therapeutics costs. The $75 million in total funds are budgeted under the MDH Office of the Secretary.

MDH should provide fiscal 2022 statewide and median hospital operating margins and comment on whether Maryland hospitals' financial position during the COVID-19 public health emergency continues to be stable based on final fiscal 2022 financial reports and preliminary fiscal 2023 financial reports. In addition, the department should provide an update on whether the $75 million in workforce and COVID-19 assistance included in the fiscal 2023 working appropriation will be taken into account in future rate setting.

2. TCOC Model and MDPCP

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 billion by the end of calendar 2023.

Most Targets Met in Calendar 2021

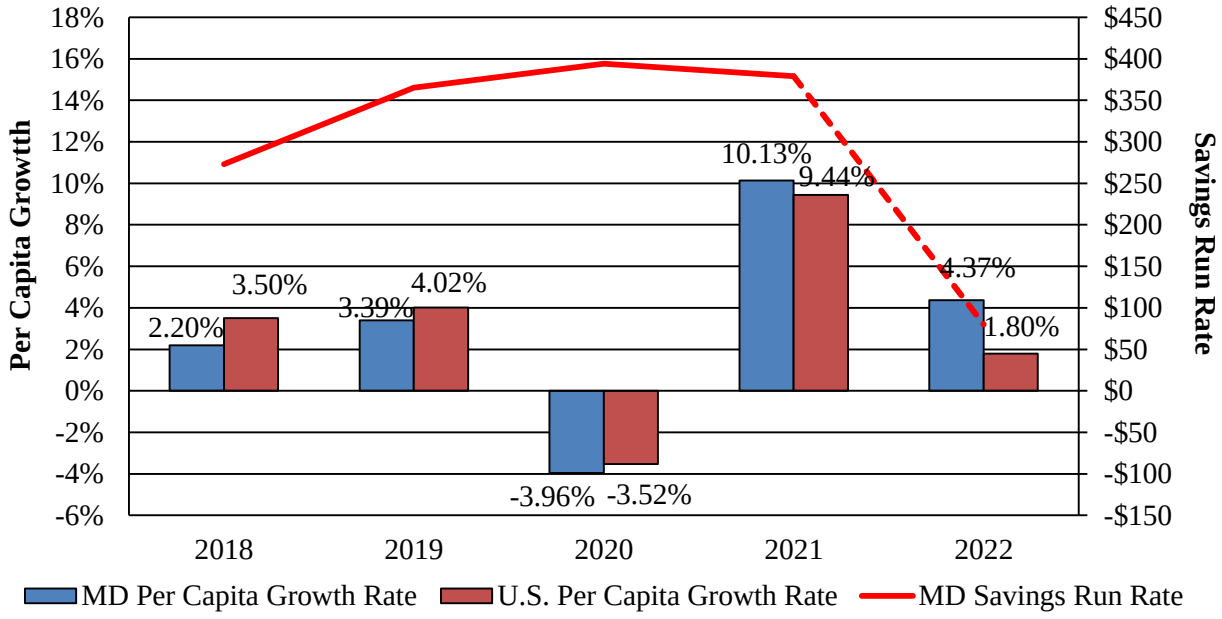
The State met or exceeded each of the goals evaluated by CMMI for TCOC in calendar 2019, 2020, and 2021, with exception to the performance target related to readmissions in calendar 2021. To meet that target, Maryland had to report a readmission rate for fee-for-service Medicare beneficiaries below the national rate each year. Maryland's readmission rate was 15.64% in calendar 2021, rising above the 15.41% national rate. HSCRC indicated that it requested a waiver from the Centers for Medicare and Medicaid Services (CMS) for that requirement in

calendar 2021 due to exogenous factors, namely the COVID-19 pandemic skewing results. **Appendix 2** shows the State's performance on each of the goals in calendar 2019 through 2021.

Corrective Action Taken Based on Projected Calendar 2022 Maryland Medicare Costs Outpacing National Medicare Costs

Under the TCOC model, Maryland must report certain levels of annual Medicare savings that increase each year. The savings target for model year 2022 is $267 million. As shown in **Exhibit 7**, Maryland reported over $267 million in Medicare savings each year from calendar 2018 to 2021, exceeding the annual savings targets. Maryland has been able to carry a portion of additional savings beyond the required level into the following year. Despite showing consistent success in prior years and collecting savings above the required targets, Maryland's projected calendar 2022 annual savings, based on data through May 2022, substantially decline by about $300 million. The remaining $80 million in savings that would count toward the calendar 2022 goal falls short of the $267 million savings target by $187 million.

Exhibit 7
Medicare Per Capita Growth and Total Savings
Calendar 2018-2022
($ in Millions)



MD: Maryland TCOC: Total Cost of Care

Note: The calendar 2022 cost and savings projections are based on data through May 2022.

Source: Health Services Cost Review Commission

Another cost-related target that Maryland must achieve each year to continue the TCOC model is referred to as the guardrail test and 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. Although Maryland's per capita Medicare spending growth was less than the national growth rate in calendar 2018 through 2020, Maryland approached, but still fell below, the upper limit of the guardrail test with 0.69% higher growth than the national growth rate in calendar 2021. The State is currently at risk of failing to meet the guardrail test in calendar 2022 as preliminary estimates show Maryland's per capita Medicare spending increasing by 4.4%, while the national growth rate is only 1.8%.

Maryland agreed to meet all targets in its TCOC contract with CMS, so failing to meet Medicare cost savings targets is 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. HSCRC has implemented or proposed 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 include:

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

- discounting Medicare payments, which would reduce hospital revenues by $64 million. This action has been approved by CMMI and has a March 2023 implementation date;

- 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. A 1% increase in the differential is estimated to yield $26 million in Medicare savings. This action has been approved by CMMI, with an anticipated implementation start date in April 2023; and

- reducing the Medicaid Deficit Assessment imposed on hospitals by $50 million in fiscal 2024 only. The fiscal 2024 allowance includes $50 million in general funds to backfill an equivalent reduction of special funds from the Medicaid Deficit Assessment, both contingent on HB 202/SB 201 of 2023 (BRFA).

MDPCP

Another component of the TCOC model is the 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.

As of January 2022, 508 primary care practices located across all 24 Maryland jurisdictions participated in the MDPCP, or an estimated 66% of all providers. 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 2022, about 50% of eligible Medicare beneficiaries in Maryland (374,000) were attributed to a provider under the MDPCP.

Given the role of the MDPCP in TCOC, the budget committees have 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 2022 JCR related to the MDPCP that was submitted in October 2022, HSCRC found that incentive payments under the program caused a net increase in costs every year from calendar 2019 through 2021. As shown in **Exhibit 8**, 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. **Considering the net increase in TCOC model costs, the Department of Legislative Services (DLS) recommends adopting committee narrative requesting a report from HSCRC evaluating the MDPCP. HSCRC should comment on potential changes to the MDPCP to make it cost effective given the disappointing financial results and the difficulty the State is having comply with the TCOC cost targets.**

Exhibit 8
MDPCP Performance Results, Relative to Calendar 2018
Calendar 2019-2021

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

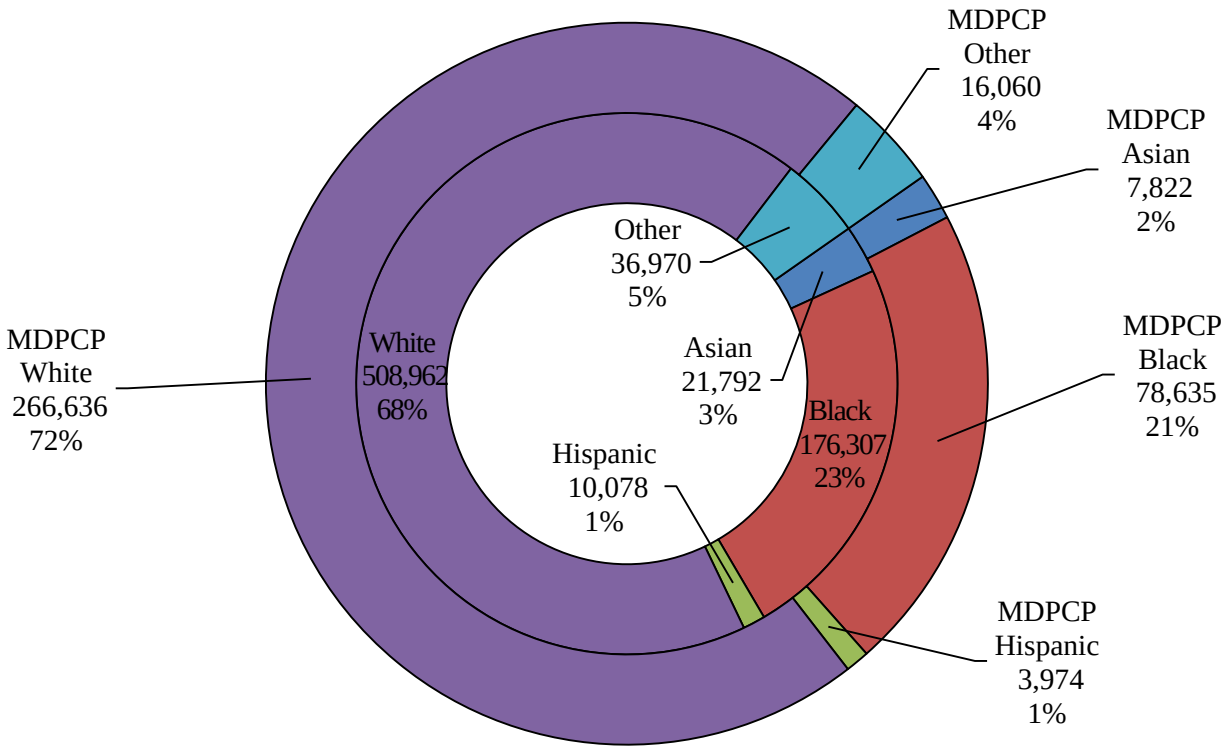
MDPCP: Maryland Primary Care Program

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

The most recent evaluation of MDPCP also included a consideration of the racial makeup of the participants in the program compared to statewide Medicare beneficiaries. As shown in **Exhibit 9**, as of December 2021, MDPCP served a larger share of White Medicare beneficiaries than the statewide Medicare population by 4 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, and only 36% of providers (183 practices) reported at least some of the data requested. The program evaluation detailed that diversity among physicians is both a Maryland and national issue and that minority providers often work in smaller practices, creating a higher barrier to entry to meet minimum program capabilities.

Exhibit 9
Racial Diversity of MDPCP Participants Compared to Statewide Medicare Beneficiaries
December 2021



Total MDPCP Participation: 373,127 Medicare Beneficiaries

MDPCP: Maryland Primary Care Program

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

HSCRC's response to the committee narrative 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.

Regional Partnership Catalyst Program, The Statewide Integrated Health Improvement Strategy, and Population Health

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). At the November 2020 meeting of HSCRC, staff presented the final recommendations for the Catalyst program. The Catalyst program took effect January 1, 2021, and continues through December 2025. These grants are intended to align with the population health measures submitted to CMS as a part of TCOC through the Statewide Integrated Health Improvement Strategy (SIHIS) goals. SIHIS goals and measures are listed in **Appendix 3**, including accomplishments for each goal during calendar 2021.

Catalyst funding is budgeted at roughly $45 million annually, for a total five-year investment of $225 million. Of these funds, $78.5 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. 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 2023 working appropriation includes $8 million within Medicaid and approximately $2 million within PHPA for Catalyst funds supporting maternal and child health initiatives. MDH's fiscal 2024 allowance provides $18.8 million in special funds departmentwide for this purpose, with $10 million budgeted under HSCRC. **MDH should comment on how it will spend the $18 million in special funds from the Maternal and Child Health Population Health Improvement Fund, particularly the $10 million budgeted within HSCRC in fiscal 2024.**

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, and as of October 2022, CMS had 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 was seen with the first credit relating to diabetes prevention. As a result of MDH reducing diabetes incidence by an average of 2.55 cases per 10,000 individuals compared to a control group in calendar 2020, Maryland could receive a $9.5 million credit for calendar 2021 TCOC savings (pending verification from CMS). HSCRC's other planned outcome-based credits include measures related to opioid use disorder and hypertension. As of October 2022, HSCRC planned to propose the two remaining credits in calendar 2023.

Operating Budget Recommended Actions

1. Adopt the following narrative:

   Evaluation of the Maryland Primary Care Program (MDPCP): Given the role of MDPCP in transforming care in the State under the Total Cost of Care (TCOC) model, the committees request information on the effectiveness of the program. In particular, this evaluation should focus on cost savings from MDPCP reducing unnecessary utilization or hospitalization for patients participating in MDPCP over the increased expenditures from provider incentives. The evaluation should include reporting on the racial and ethnic diversity of the program, any efforts to improve minority representation in the program, and improve data collection on racial and ethnic diversity of providers. The evaluation should also consider existing disparities in primary care access and ways in which the State can address these disparities. Further, given the anticipated benefits that the outcome-based credits have against MDPCP's care management fees, the committees are interested in aggregate costs of the care management fees against TCOC, the amount that outcome-based credits have discounted these expenses, and MDPCP's contribution to the achievement and maximization of the current and future outcome-based credits and other population health goals.

Information Request	**Author**	**Due Date**
Evaluation of MDPCP	Health Services Cost Review Commission	October 1, 2023

Appendix 1
2022 *Joint Chairmen's Report* Responses from Agency

The 2022 JCR requested that MHCC, HSCRC, and MCHRC prepare five reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Behavioral Health Crisis Response System Study:*** As of February 12, 2023, MHCC had not submitted a report to the committees.

- ***Financial Restrictions on Access to Organ Transplant Lists:*** Due to concerns that financial requirements played a role in hospitals' eligibility determination for receiving organ donations, the committees requested that MHCC submit a report reviewing the existing policies governing the eligibility for receiving an organ donation and identifying reasons for denial of organ transplantation. MHCC reviewed the organ transplant policies for three hospitals and found that each met federal requirements to assess financial support available for a patient but did not require any financial targets for eligibility. The report also found that individuals are not removed from organ transplant waitlists for financial reasons; however, additional research would be needed to determine whether the financial screening process creates barriers to individuals accessing the organ transplant waitlists. Finally, MHCC was unable to collect data on the frequency and reasons for individuals not being added to the waitlists, so MHCC recommended further research and hospital surveys.

- ***The Maryland Model's Interaction with the Challenges of the COVID-19 Pandemic:*** Further discussion of COVID-19 impacts on Maryland hospitals and subsequent State and federal action can be found in Key Observation 1 of this analysis.

- ***Evaluation of the Maryland Primary Care Program:*** The Maryland Primary Care Program is discussed in Key Observation 2 of this analysis.

- ***Maryland Consortium on Coordinated Community Supports:*** Further discussion of the Consortium can be found in the fiscal 2024 budget section of this analysis.

Appendix 2
Total Cost of Care Performance Results

Performance Measures	Calendar 2019/Program Year 1		Calendar 2020/Program Year 2		Calendar 2021/Program Year 3	
	Goal	**Performance**	**Goal**	**Performance**	**Goal**	**Performance**
Annual Medicare Savings[1]	$120 million	$364.9 million	$156 million	$390.6 million	$222 million	$378.1 million
TCOC Guardrail	Not to exceed national Medicare growth in TCOC by more than 1%	0.6% below national Medicare growth	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
All-payer Revenue Limit	Growth ≤ 3.58% per capita annually	2.50%	Growth ≤ 3.58% per capita annually	0.21%	Growth ≤ 3.58% per capita annually	2.37%
Reductions in Hospital-acquired Conditions	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	0.06% average reduction below calendar 2018	Not to exceed calendar 2018 rates for potentially preventable conditions	0.013% average reduction below calendar 2018
Reduction in Readmissions	≤ national rate for fee for-service (FFS) Medicare beneficiaries (15.52% for calendar 2019)	14.94%	≤ national rate for FFS Medicare beneficiaries (15.55% for calendar 2020)	15.18%	**≤ national rate for FFS Medicare beneficiaries (15.37% for calendar 2021)**	**15.64%**

Performance Measures	Calendar 2019/Program Year 1 Goal	Calendar 2019/Program Year 1 Performance	Calendar 2020/Program Year 2 Goal	Calendar 2020/Program Year 2 Performance	Calendar 2021/Program Year 3 Goal	Calendar 2021/Program Year 3 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%

[1]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.
*Bold denotes performance results that did not meet targets.

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

Appendix 3
SIHIS Goals and Outcomes

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 (ED) visit rates for ages 2 through 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 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 through 49 years old with a delivery hospitalization	Children ages 2 through 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 through 17

	Total Population Health	Diabetes	Opioids	Maternal and Child Health	
2021 Milestones and Progress		Launched related Catalyst Program; expanded CRISP referrals; and incorporated quality measures for all MDPCP providers to track patient BMIs	Launched related Catalyst Program; expanded SBIRT into 200 MDPCP programs	Relaunched the Perinatal Quality Collaborative; piloted an SMM review process; completed the Maryland Maternal Strategic Plan; launched MCH investments under Medicaid and public health	Obtained population projections; developed asthma dashboard; incorporated asthma-related ED visits as a Title V measure and shifted funds to support asthma interventions; and launched MCH investments under Medicaid and public health
2023 Target (Year 5)		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 through 17
2026 Final Target (Year 8)		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 through 17

MCH: maternal and child health
SBIRT: Screening Brief Intervention and Referral to Treatment

Source: Health Services Cost Review Commission

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

Object/Fund	FY 22 Actual	FY 23 Working Appropriation	FY 24 Allowance	FY 23 - FY 24 Amount Change	Percent Change
Positions					
01 Regular	112.90	116.90	117.90	1.00	0.9%
02 Contractual	8.40	11.28	11.66	0.38	3.4%
Total Positions	**121.30**	**128.18**	**129.56**	**1.38**	**1.1%**
Objects					
01 Salaries and Wages	$ 16,998,005	$ 19,517,585	$ 19,942,920	$ 425,335	2.2%
02 Technical and Special Fees	712,722	988,053	1,019,562	31,509	3.2%
03 Communication	101,041	107,523	105,654	-1,869	-1.7%
04 Travel	37,079	343,017	339,835	-3,182	-0.9%
06 Fuel and Utilities	0	3,196	2,700	-496	-15.5%
08 Contractual Services	137,843,358	166,271,527	166,810,231	538,704	0.3%
09 Supplies and Materials	54,202	80,009	79,547	-462	-0.6%
10 Equipment – Replacement	166,521	25,500	25,500	0	0%
11 Equipment – Additional	50,677	1,048,117	1,726,525	678,408	64.7%
12 Grants, Subsidies, and Contributions	25,061,316	75,414,136	110,722,919	35,308,783	46.8%
13 Fixed Charges	575,599	795,687	817,702	22,015	2.8%
Total Objects	**$ 181,600,520**	**$ 264,594,350**	**$ 301,593,095**	**$ 36,998,745**	**14.0%**
Funds					
01 General Fund	$ 4,000,000	$ 11,213,545	$ 1,000,000	-$ 10,213,545	-91.1%
03 Special Fund	163,600,520	253,191,387	300,033,095	46,841,708	18.5%
05 Federal Fund	14,000,000	0	0	0	0.0%
09 Reimbursable Fund	0	189,418	560,000	370,582	195.6%
Total Funds	**$ 181,600,520**	**$ 264,594,350**	**$ 301,593,095**	**$ 36,998,745**	**14.0%**

Note: The fiscal 2023 appropriation does not include deficiencies. The fiscal 2024 allowance does not include salary adjustments budgeted within the Department of Budget and Management.