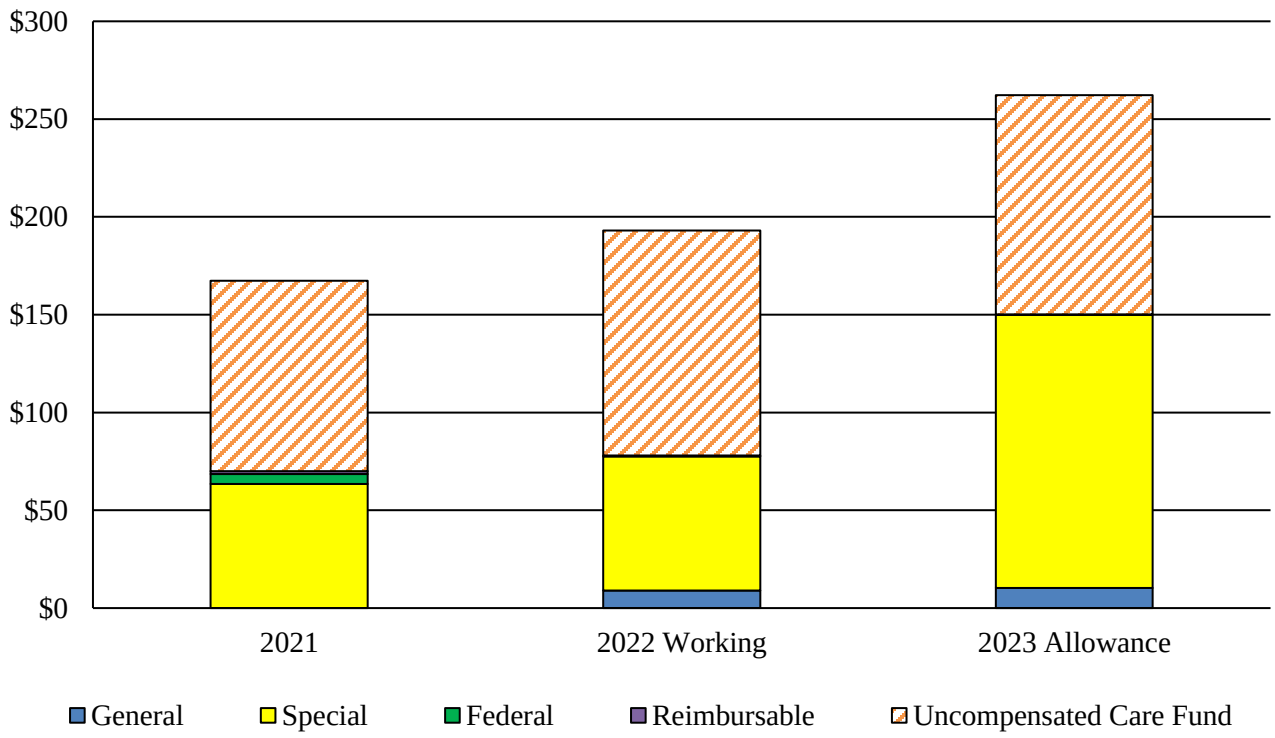
M00R01
Health Regulatory Commissions
Maryland Department of Health

Program Description

The Health Regulatory Commissions are three independent agencies within the Maryland Department of Health (MDH): the Maryland Health Care Commission (MHCC); the Health Services Cost Review Commission (HSCRC); and the Maryland Community Health 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.

Operating Budget Summary

Fiscal 2023 Budget Increases $69.2 Million, or 35.8%, to $262.2 Million
($ in Millions)



Note: The fiscal 2022 working appropriation includes deficiency appropriations. The fiscal 2022 working appropriation and fiscal 2023 allowance do not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which include cost-of-living adjustments, increments, bonuses, and may include annual salary review adjustments.

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- The increase in the fiscal 2023 allowance compared to the fiscal 2022 working appropriation is primarily driven by $65 million in new spending provided to MCRHC for two new grant programs established in statute: The Health Equity Resource Community (HERC) grants; and the Maryland Consortium on Coordinated Community Supports (Consortium) grants.

- For fiscal 2023 and 2024, the fund source of MCHRC operating grants is the Reinsurance Fund, which is operated by the Maryland Health Benefit Exchange (MHBE). The Reinsurance Fund also supports the HERC grants. Through fiscal 2022, MCHRC was funded through a distribution of the Carefirst premium tax exemption.

Fiscal 2022

Proposed Deficiency

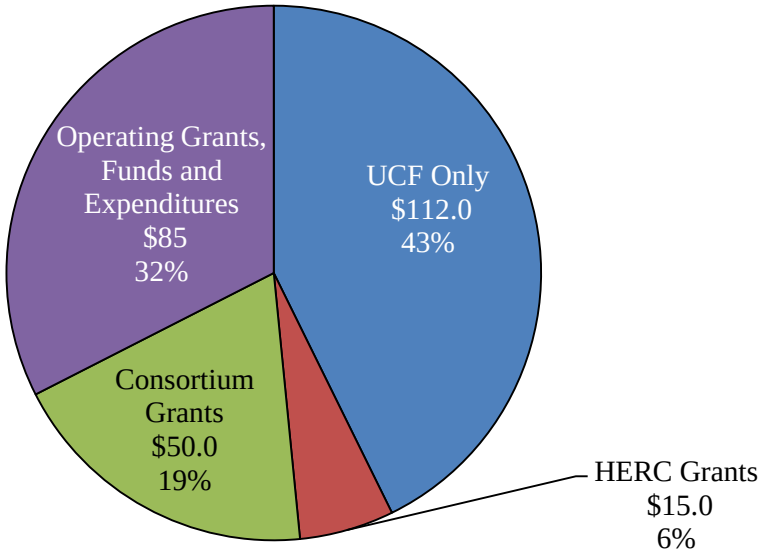
The fiscal 2023 allowance includes two proposed deficiency appropriations: one for MHCC to provide $4.0 million in general funds to the Maryland Trauma Physicians Fund; the other to HSCRC to provide $4.9 million in general funds to Chesapeake Regional Information System for our Patients (CRISP).

The general funds for CRISP support CRISP infrastructure initiatives at MDH. HSCRC advises that these funds will be transferred elsewhere in the health department.

Fiscal 2023 Overview of Agency Spending

The fiscal 2023 allowance totals over $262.2 million, almost entirely in special funds. As shown in **Exhibit 1**, the single largest component of the budget is the Uncompensated Care Fund (UCF) with $112 million. The UCF is managed by HSCRC but paid out to the acute general hospitals that provide a disproportionate amount of uncompensated care. It is one of the many funds and funding distributed by the Health Regulatory Commissions. New funding this year includes two sizable grant programs to be administered by MCHRC, HERC and Consortium grants. These grants and the associated programs and resources are discussed in greater depth in Key Observation 1.

Exhibit 1
Overview of Agency Spending
Fiscal 2023 Allowance
($ in Millions)



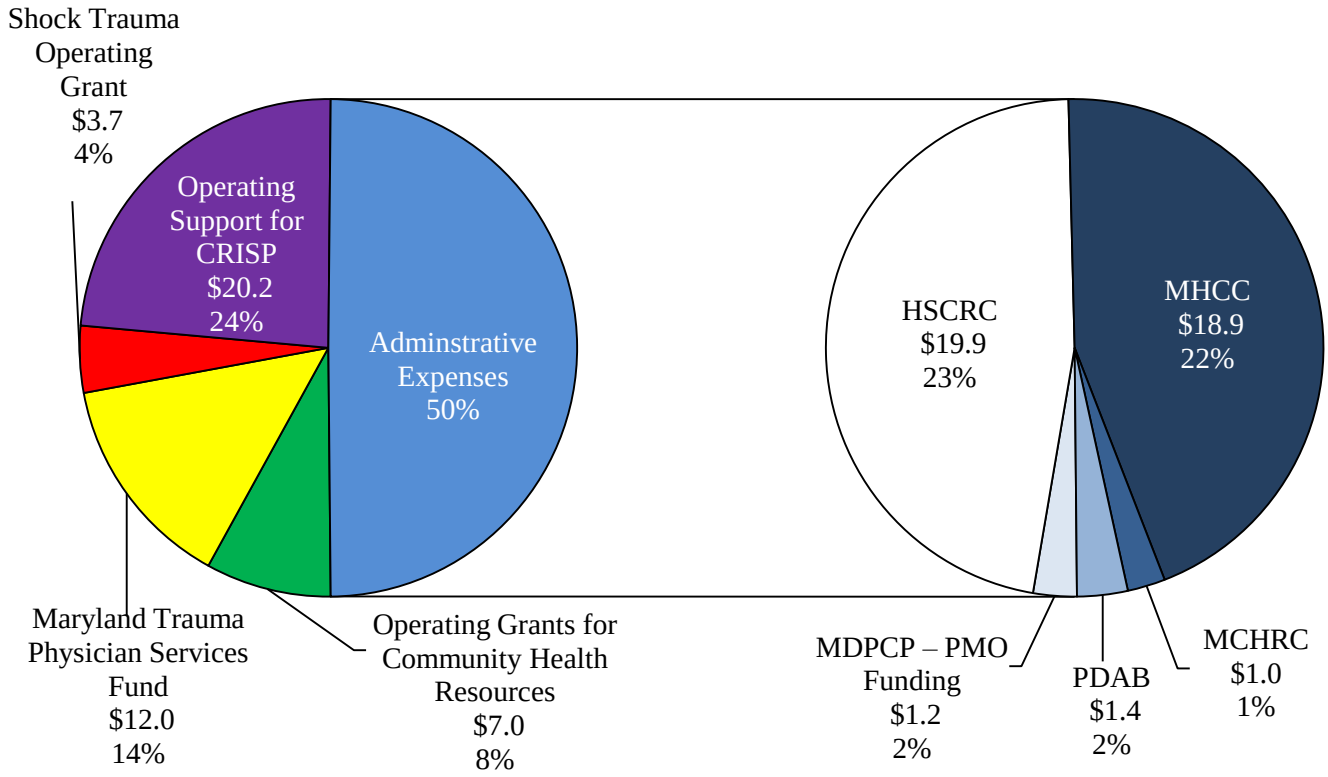
HERC: Health Equity Resource Community
UCF: Uncompensated Care Fund

Note: The fiscal 2023 allowance does not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which include cost-of-living adjustments, increments, bonuses, and may include annual salary review adjustments.

Source: Governor's Fiscal 2023 Budget Books

Exhibit 2 below sets aside the large UCF fund and the two new MCHRC grants to focus on the operating expenditures and operating grants for the rest of Health Regulatory Commissions, totaling $85.2 million (32% of the total budget). The Health Regulatory Commissions also provide support for other aspects of the State's health care system including the State's designated health information exchange, CRISP; various safety net health providers through MCHRC; and trauma services through MHCC.

Exhibit 2
Operating Expenditures
Fiscal 2023 Allowance
($ in Millions)



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

Note: The fiscal 2023 allowance does not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which include cost-of-living adjustments, increments, bonuses, and may include annual salary review adjustments.

Source: Governor's Fiscal 2023 Budget Books

Approximately 50% of this portion of the budget is dedicated to administrative expenses. MHCC and HSCRC have the most robust administrative offices and have the largest staffs, relative to the other offices funded throughout this budget. Administrative expenses also includes providing support for the Maryland Primary Care Program (MDPCP) – Program Management Office (PMO). The funding for MDPCP reflected in the regulatory commissions budget is $600,000 from the HSCRC fund and $600,000 from the MHCC fund, which support reimbursable funds for the PMO in the Medicaid program. In addition to the $1.2 million in reimbursable funds from the regulatory commissions, the MDPCP – PMO also receives $839,537 in general funds and $707,435 outside of the Health Regulatory Commissions' fiscal 2023 allowance. MDPCP and its role in the State's Total Cost of Care (TCOC) model are discussed in greater depth in Key Observation 3.

The relatively new Prescription Drug Affordability Board (PDAB), established by Chapter 692 of 2019 is also contained in the regulatory commissions' budget. Beginning with the fiscal 2023 budget, PDAB is budgeted separately from MHCC, which provided initial start-up support for the new board but is still included within this analysis.

Proposed Budget Change

As previously mentioned, the largest increases for the regulatory commissions are the $65 million in new grant and funding responsibility for MCHRC (discussed in Key Observation 1). Additionally, **Exhibit 3** separates out PDAB, which as previously mentioned, is now budgeted separate from the other commissions.

Exhibit 3
Proposed Budget
Maryland Department of Health – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2021 Actual	$0	$160,838	$4,975	$1,535	$167,349
Fiscal 2022 Working Appropriation	8,899	183,599	0	561	193,058
Fiscal 2023 Allowance	10,214	251,845	0	177	262,235
Fiscal 2022-2023 Amount Change	$1,315	$68,246	$0	-$384	$69,177
Fiscal 2022-2023 Percent Change	14.8%	37.2%		-68.5%	35.8%

Where It Goes:	**Change**
Personnel Expenses	
Employee and retiree health insurance	$651
5 new positions in MCHRC to manage the two new grant programs	538
Social Security and employees' retirement system	64
Turnover adjustments	16
Salary and wage adjustments	-8
Other fringe benefit adjustments	7
Maryland Community Health Resources Commission	
Maryland Consortium on Coordinated Community Supports, established by Chapter 36 of 2020	49,755
HERC grants, established by Chapter 741 of 2021	15,000
MCHRC administrative expenses	-18
MCHRC operating grants	-203
Health Services Cost Review Commission	
CRISP operating support, partially offset by fiscal 2022 deficiency. All CRISP funding are anticipated to be transferred out by budget amendment for fiscal 2023	8,815
IT-related contracts for the hosting and analyzing of hospital data	1,144
HSCRC administrative expenses	-18
Budgeted decrease in UCF	-3,000
Prescription Drug Affordability Board	
Repayments to MHCC for initial staffing and support of PDAB	400
Administrative expenses, offset by funding formerly in MHCC	107
Maryland Health Care Commission	
MHCC administrative expenses	128
Shock Trauma operating grant	100
Reduction to contributions to Maryland Trauma Physician Services Fund, driven by fiscal 2022 deficiency	-4,300
Total	**$69,177**

CRISP: Chesapeake Regional Information System for our Patients
HERC: Health Equities Resource Communities
HSCRC: Health Services Cost Review Commission
IT: information technology
MCHRC: Community Health Resources Commission
MHCC: Maryland Health Care Commission
PDAB: Prescription Drug Affordability Board
UCF: Uncompensated Care Fund

Note: Numbers may not sum to total due to rounding. The fiscal 2022 working appropriation includes deficiency appropriations. The fiscal 2022 working appropriation and fiscal 2023 allowance do not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which include cost-of-living adjustments, increments, bonuses, and may include annual salary review adjustments.

Personnel Data

	FY 21 Actual	FY 22 Working	FY 23 Allowance	FY 22-23 Change
Regular Positions	108.90	112.90	117.90	5.00
Contractual FTEs	7.70	9.59	11.28	1.69
Total Personnel	**116.60**	**122.49**	**129.18**	**6.69**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	4.61	4.08%
Positions and Percentage Vacant as of 12/31/21	8.00	7.09%
Vacancies Above Turnover	3.39	3.01%

- The fiscal 2023 allowance includes 5 new regular positions, all of which are attributed to MCHRC's new grant programs. Of these positions, 3 will support the HERC grants and the remaining 2 will support the Consortium grants. The HERC positions are a program manager, policy analyst, and administrative support. For the Consortium, MCHRC will be hiring a program manager and policy analyst.

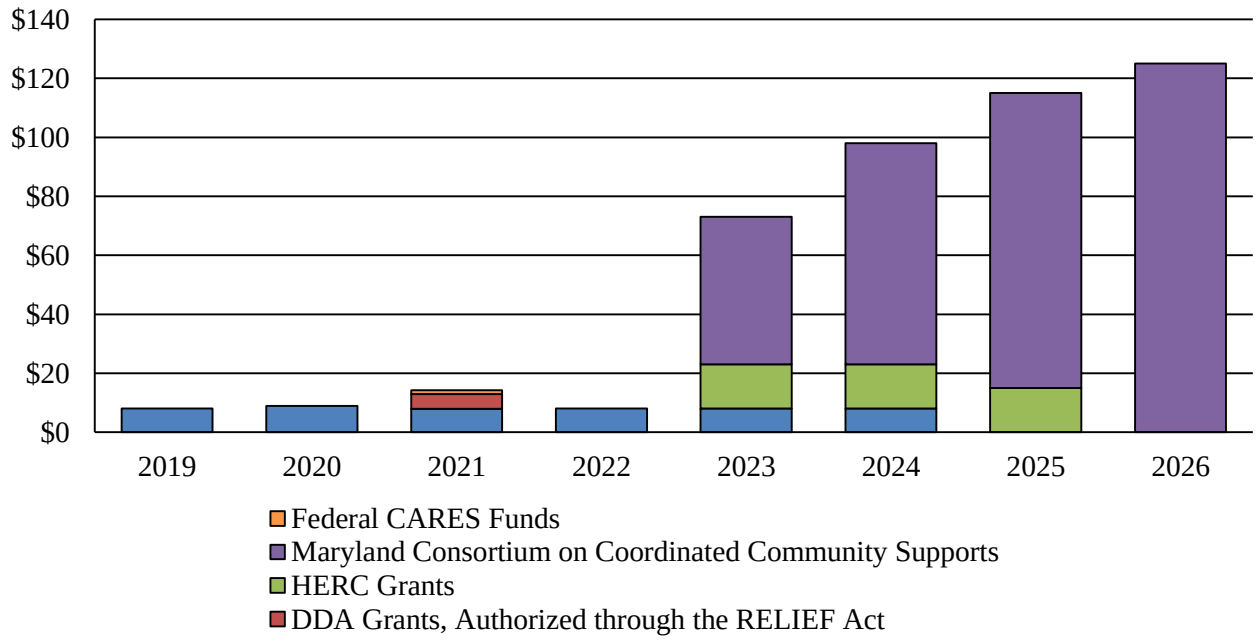
- The additional contractual full-time equivalents (FTE) in the fiscal 2023 allowance are largely attributed to 1.50 FTE added by MHCC to assist with the processing of certificates of need. The other 0.69 FTE increase is attributed to additional hours required by MCHRC contractual staff for the administrative support and staffing of the Council for School-Based Health Centers.

Key Observations

1. New Grant Programs Administered by MCHRC

The increase in the fiscal 2023 allowance for Health Regulatory Commissions is driven by two new grant funds to be administered by MCHRC: (1) The Maryland Consortium on Coordinated Community Supports (Consortium) established by Chapter 36 of 2020; and (2) the HERCs established by Chapter 741 of 2021. These two funds and programs add $65 million in funds to the MCHRC budget, which has averaged under $10 million annually between fiscal 2019 and 2022. **Exhibit 4** shows the historical spend for MCHRC for the prior five fiscal years, including the fiscal 2023 allowance.

Exhibit 4
Historical and Projected MCHRC Expenditures
Fiscal 2019-2026
($ in Millions)



CARES: Coronavirus Aid, Relief, and Economic Security Act
DDA: Developmental Disabilities Administration
HERC: Health Equity Resource Community
MCHRC: Maryland Community Health Resources Commission

Note: Out-year spending reflects current legislative mandates.

Source: Governor's Fiscal 2023 Budget Books; Department of Legislative Services

As shown, not only do these two new programs meaningfully exceed previous levels of spending for MCHRC but also will soon be the only source of funding available to MCHCR. Traditionally, MCHRC has exclusively 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 the opioid crisis. This funding was available through the Carefirst premium tax credit exemption. These funds were shared between MCHRC and the Senior Prescription Drug Assistance Program (SPDAP), with MCHRC traditionally receiving the first $8 million for its grants and general administration.

As the Carefirst funding had decreased in recent years, this fund's ability to support both MCHRC and SPDAP waned, resulting in Chapter 150 of 2021, the Budget Reconciliation and Financing Act (BRFA), to include provisions addressing these projected deficits. These BRFA provisions required $8 million transfers from MHBE's Reinsurance Fund to MCHRC in fiscal 2023 and 2024 only (the Reinsurance Fund is derived from premium tax credit assessments. This is also the fund source of the HERC grants, discussed more later in this analysis). The BRFA of 2021 also dedicated all of the Carefirst premium tax exemption to SPDAP. Given funding for operating grants for MCHRC is not identified beyond fiscal 2024, these traditional grants are not reflected in Exhibit 4. **The department should comment on the future availability of funding for MCHRC operating grants after fiscal 2024.**

Maryland Consortium on Coordinated Community Supports

The single largest new grant for the MCHRC budget, both in fiscal 2023 and in the out-years is the Consortium grants. The Consortium was established by Chapter 36 (The Blueprint for Maryland's Future (the Blueprint)). As shown, funding for the Consortium is mandated to grow from $50 million in fiscal 2023 to $125 million by fiscal 2026. After fiscal 2026, the funding is required to stay at $125 million annually, at which point this will likely be the largest fund in the budget for the Health Regulatory Commissions, surpassing the amounts traditionally spent by the HSCRC's UCF.

The Consortium, as specified in Chapter 36, has 20 members and includes 13 members designated or appointed by various aspects of State government or associations in Maryland. In addition to the 13 specified members, the Governor appoints 3 members to the Consortium, each representing the community behavioral health community, local departments of social services, and the local health department. The remaining 4 members appointed by the Maryland General Assembly, through either the Speaker of the House or Senate President, include 2 members of the public and 2 with specified educational expertise. The Consortium is to be staffed by MCHRC, including the 2 new positions discussed earlier.

The Blueprint legislation tasks the Consortium with developing a statewide framework for the creation of a coordinated community supports partnership, implementing a related grant program, evaluating a payment reimbursement program for providers, and developing a program for uninsured students. These tasks are aimed at meeting student behavioral health needs and other related challenges in a holistic, nonstigmatized and coordinated manner. Included in this statutory direction is the development of a model for expanding behavioral health services in schools, including exploring

service reimbursement through public or private payors, a sliding services fee scale and/or hospital's community benefit participation.

In addition, in consultation with the Maryland State Department of Education, the Consortium must develop best practices for the creation of a positive classroom for all students. Also, the Consortium, in consultation with the National Center on School Mental Health (housed at the University of Maryland, Baltimore Campus), Maryland Longitudinal Data System Center, and Accountability and Implementation Board (also created by the Blueprint), must develop accountability metrics to evaluate the grants awarded by the Consortium. The Consortium is also required by statute to submit an annual report on the activities of the Consortium, including the creation of coordinated community supports partnerships and grants awarded to coordinated community supports partnerships. The first report is required to be submitted on July 1, 2022, and subsequent reports each July thereafter.

The Blueprint legislation also created a special fund for this purpose, the Coordinated Community Supports Partnership Fund. However, the Governor's fiscal 2023 allowance funds the mandated appropriation with funding from the broader Blueprint for Maryland's Future Fund.

HERC Program

The other significant source of new funding and expenditures was authorized through Chapter 741 (the Maryland Health Equity Resource Act). This Act creates the Pathways to Heath Equity Fund and an advisory committee for HERCs. HERCs are defined in the statute to be a contiguous geographic area that:

- demonstrates measurable and documented health disparities and poor health outcomes;
- is small enough to allow for the incentives offered under the bill to have a significant impact on improving health outcomes and reducing health disparities, including racial, ethnic, geographic, and disability-related health disparities;
- is designated by MCHRC as specified; and
- has a minimum population of 5,000 residents.

To receive a designation as a HERC, a nonprofit community-based organization, a nonprofit hospital, an institution of higher education, a federally qualified health center (FQHC), or a local government agency must (1) apply to MCHRC on behalf of the area to receive the designation and (2) include FQHCs or other community-based organizations to provide health or wraparound support services within the HERC. By October 1, 2022, MCHRC must issue a request for proposals to designate areas as HERCs.

The Maryland Health Equity Resource Act also established the Pathways to Health Equity Fund. The grants from this fund may only be used to support areas designated as HERCs by providing grants to specified entities to reduce health disparities, improve health outcomes, provide drug

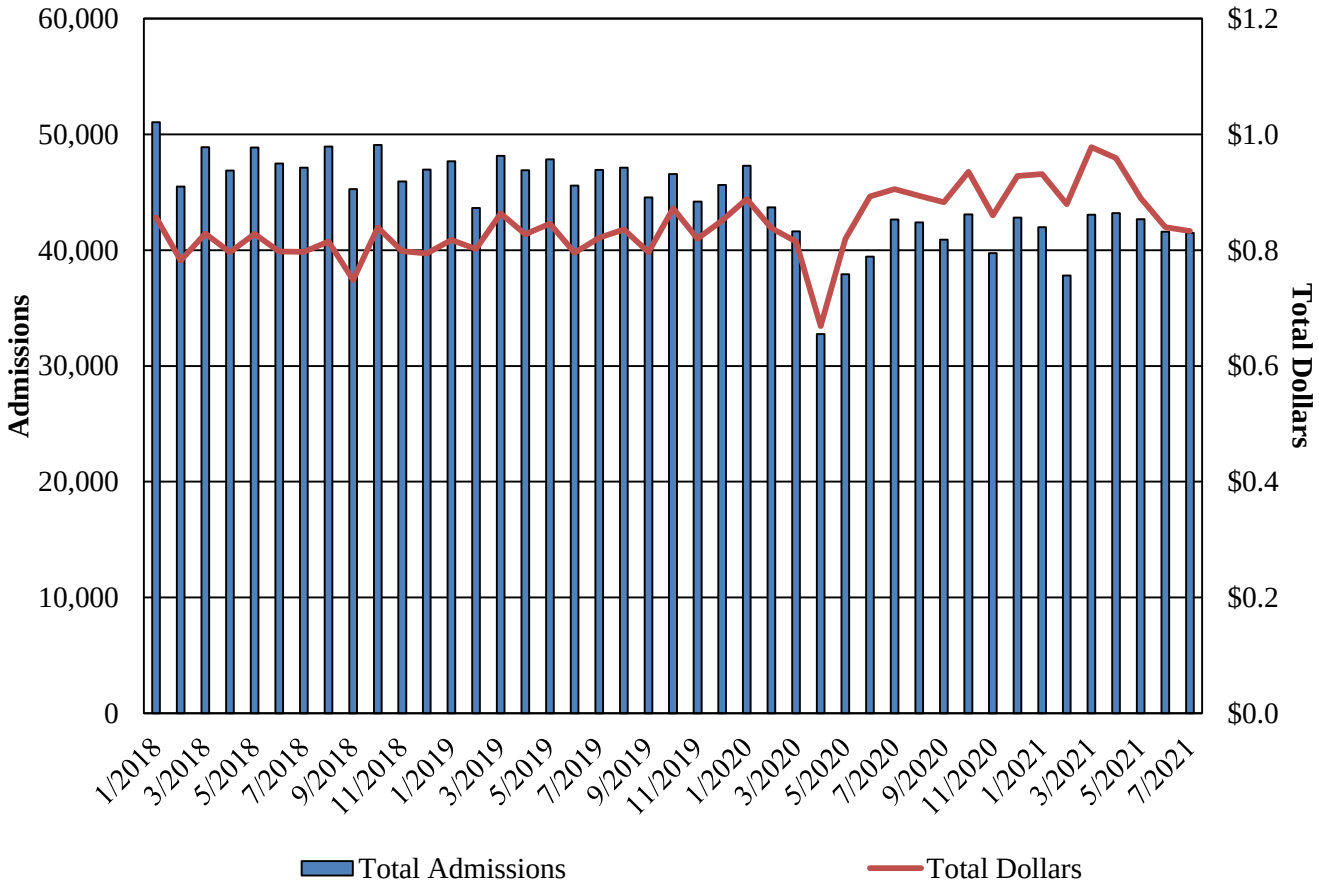
treatment and rehabilitation, and reduce health costs and hospital admissions and readmissions. Chapter 741 designated that funding resulting from Chapter 39 of 2021 (RELIEF Act) be deposited into the Pathways to Health Equity Fund for fiscal 2022. However, this funding is not yet reflected in MCHRC's fiscal 2022 appropriation. Further, MCHRC has advised that the Pathways funds are slated to be awarded in February 2022, necessitating the availability of these funds. Out-year support for the fund established under this Act are derived from MHBE's Reinsurance Fund, particularly from the provider assessment. **MDH should comment on the availability and status of the initial HERC funding authorized by the RELIEF Act.**

The HERC legislation also includes a reporting requirement, with reports required on or before December 15 of each year. Included in this requirement, MCHRC is to report on the number and types of grants to each HERC; various evidenced-based outcomes of the granting activities; and data on race, ethnicity, and socioeconomic status of those impacted.

2. Support for Hospitals during COVID-19 Pandemic

HSCRC through its administration of Maryland's unique hospital financing model has been able to provide stability to the State's hospitals. During the initial onset of the pandemic, hospital volumes decreased sharply with the limitations on certain hospital procedures to maintain adequate bed capacity. Even after certain restrictions were lifted individuals may have chosen to delay certain kinds of care out of abundance of caution. **Exhibit 5** shows the hospital volumes and revenue from January 2018 to July 2021. Data used throughout this section was accessed by the Department of Legislative Services (DLS) from HSCRC in October 2021. As was discussed in the Health Regulatory Commissions fiscal 2022 budget analysis, although revenues and admissions across all payors immediately spiked downward, all-payor revenues recovered much more quickly than admissions and, in some instances, exceeded prior-year amounts.

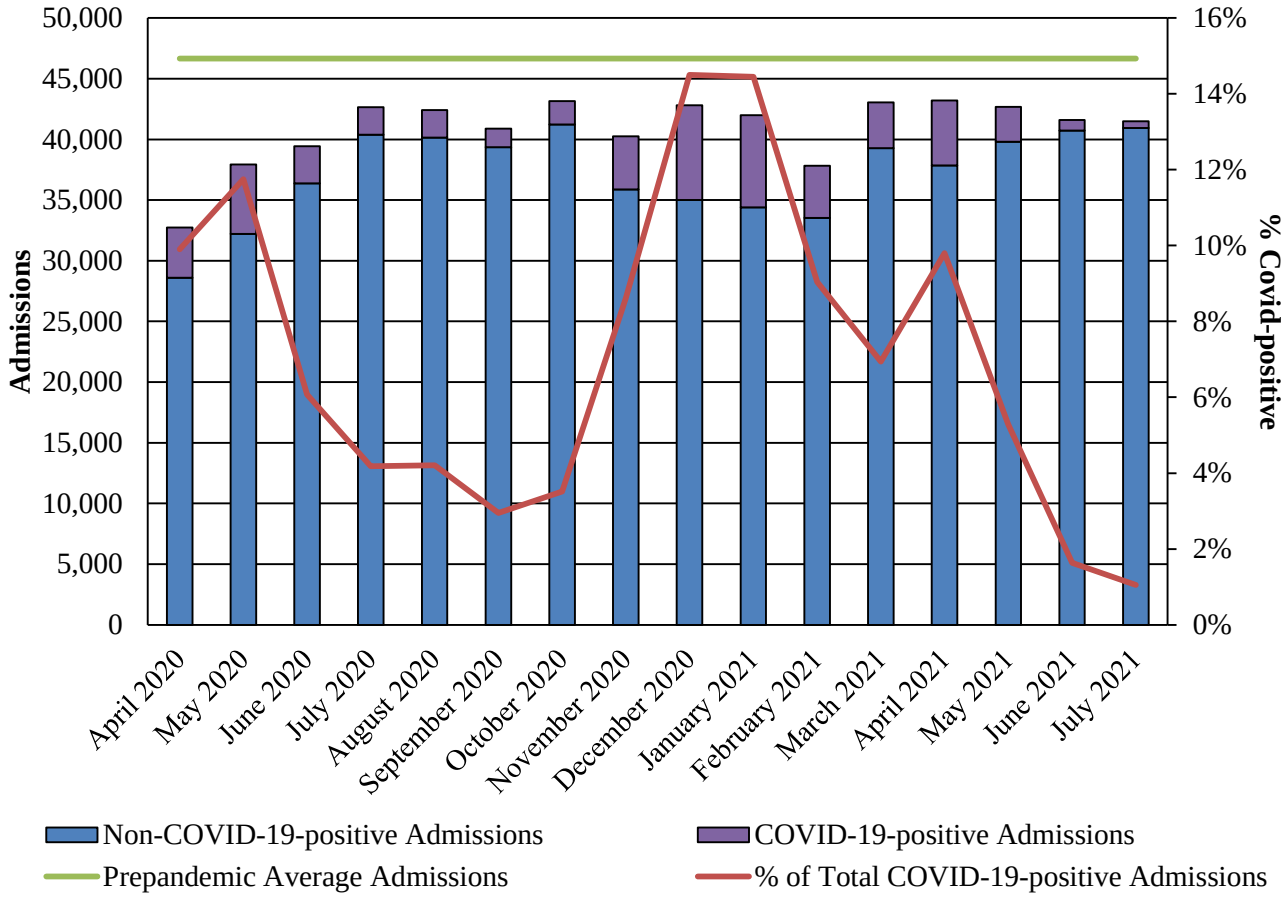
Exhibit 5
Hospital Volumes and Revenue
January 2018 to July 2021
($ in Billions)



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

Of course, the pandemic and the treatment of COVID-19-positive patients had particular revenue and volume impacts associated with it for the hospitals. HSCRC's hospital data contained flags for patients who had a confirmed COVID-19-positive test during their visit or at discharge. The share that these admissions represented in the first 16 months of the pandemic are shown in **Exhibit 6**. Although during certain peaks in the COVID-19 pandemic, COVID-19-positive patients represented well over 10% of total admissions, it was still not enough volume to drive hospital admissions above traditional levels.

Exhibit 6
COVID-19-positive Admissions
April 2020 to July 2021

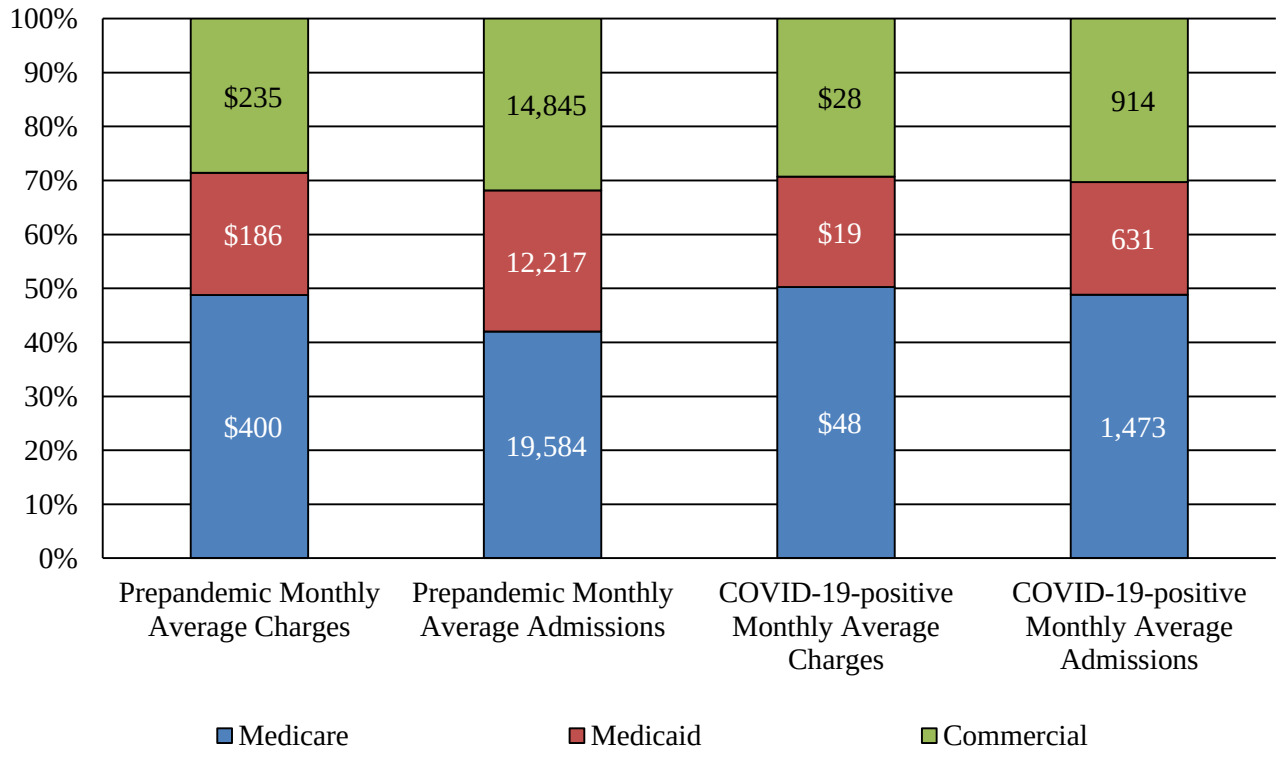


Note: The exhibit only considers individuals who had tested positive for COVID-19. During the course of the pandemic, individuals in hospital settings with known COVID-19 exposures represented a much higher share of admissions throughout the pandemic. Overall hospital capacity throughout the pandemic was reduced due to staff shortages. Further, additional care for COVID-19 patients occurred at alternative care sites.

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

Exhibit 7 takes the data from January 2018 to July 2021 used in the prior analysis and compares the monthly averages in admissions and revenue by payor in the State for the period before the pandemic (January 2018 to March 2020) to the COVID-19-positive patient admissions and their associated charges from the 16 subsequent months for which data is available. Of COVID-19-positive admissions, Medicare patients took up a larger share of hospital admissions than they traditionally occupied during the months prior to the pandemic, while those on Medicaid represented a relatively smaller share.

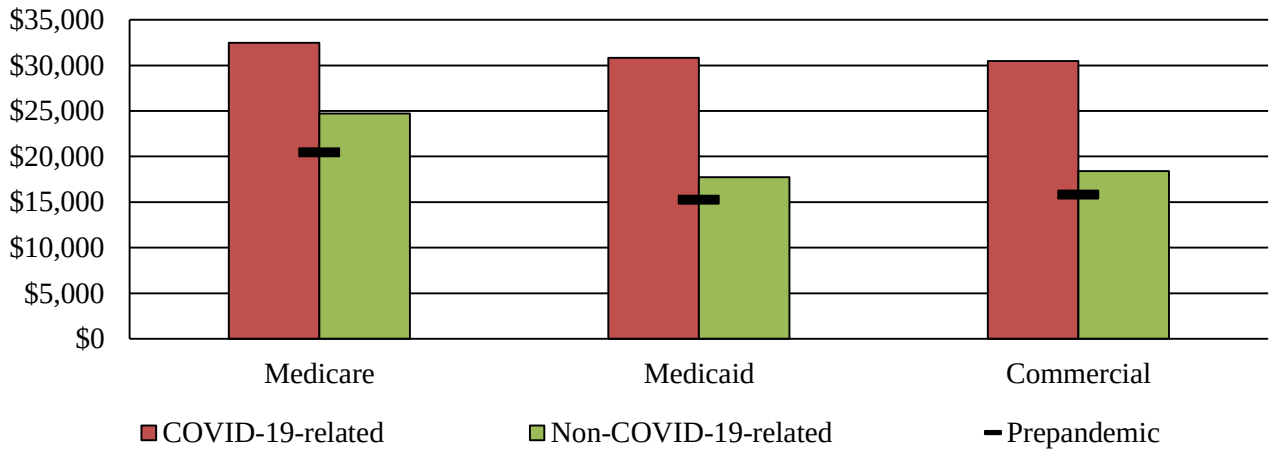
Exhibit 7
Comparison of Hospital Charges for COVID-19 Cases
January 2018 to March 2020 and April 2020 to July 2021
($ in Millions)



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

Exhibit 8 uses this same dataset to calculate the average cost per admission for each payor type before and during the pandemic period. This analysis of charges reveals that charges associated with COVID-19-positive hospitalizations were much higher than all-cause admissions prior to the pandemic on a per admission basis. However, as shown in Exhibit 8 as well, the charges of all services were more expensive on a per admission basis than prior to the pandemic due to certain financial stabilities and flexibilities from HSCRC, detailed further throughout this section.

Exhibit 8
Total Charge Per Admission
January 2018 to March 2020 and April 2020 to July 2021

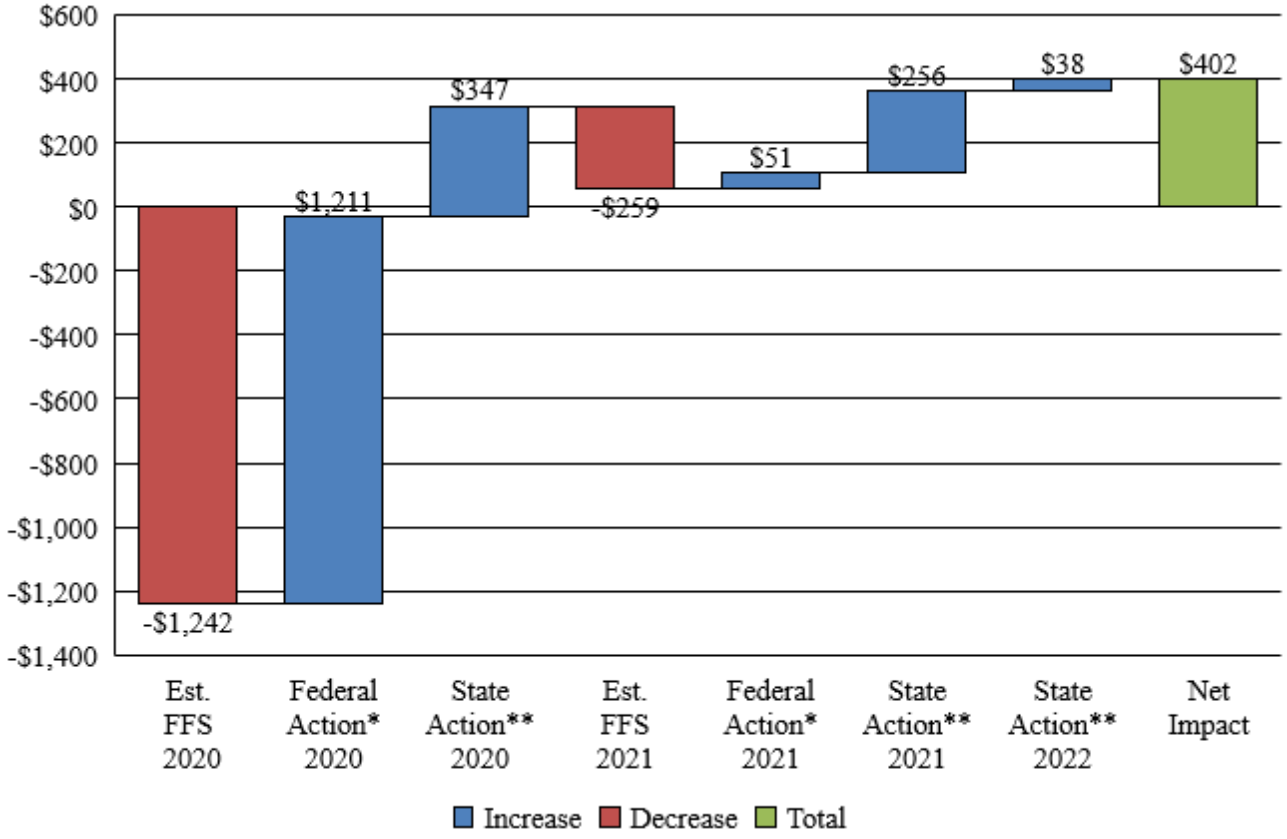


Source: Health Services Cost Review Commission; Department of Legislative Services

Various HSCRC actions during fiscal 2020 and 2021 provided additional stability for hospitals, but also increased charges on a rate basis. In fiscal 2020, HSCRC expanded the rate corridors; rate corridors traditionally allow hospitals to charge +/- 5% of unit rates to account for changes in volume to meet global budget revenue (GBR). For the final quarter of fiscal 2020, HSCRC allowed the hospitals to charge up to 10% of GBR unit rates. This expanded charging capacity in the rate corridors was offset against federal dollars provided from the Provider Relief Fund but allowed the hospitals to maintain or grow revenue on lower volume, leading to the revenues and volumes moving in opposite directions seen in Exhibit 5 and the cost per admission increase shown in Exhibit 8. In addition to the expansion of rate corridors, HSCRC allowed hospitals to carry over unused GBR capacity from fiscal 2020 (when utilization fell) into fiscal 2021 and charge up to this higher GBR target.

In terms of continued hospital support, HSCRC will allow hospitals to continue to roll undercharges from fiscal 2021 into 2022. However, HSCRC has currently only announced this plan for 55% of the undercharges, totaling $127 million across the hospitals. This also only impacts those hospitals with undercharges from fiscal 2021, which are the hospitals that have had a more acute volume impact in recent years. On December 21, 2021, Governor Lawrence J. Hogan Jr. announced $50 million to support hospital staffing, which is part of this release of undercharges. An additional action providing support for the hospitals for fiscal 2022 is a 0.2% increase to the annual update factor to account for staffing pressures at Maryland hospitals, valued at an estimated $38 million. Between federal actions such as the provider relief funds and HSCRC stability support, HSCRC estimates that from fiscal 2020 to present, the State's hospitals have gained over $400 million in financial support, even when accounting for projected revenue losses under a fee-for-service (FFS) structure. **Exhibit 9** shows these various puts and takes on hospital financials since the onset of the pandemic.

Exhibit 9
Revenue Impact of COVID-19 Pandemic on Maryland Hospitals
Fiscal 2020-2022
($ in Millions)



FFS: fee-for-service

* Federal Action reflect provider relief fund dollars distributed by the federal government directly to hospitals throughout various COVID-19 relief packages.
** State Action reflect mechanics of Global Budget system, including Rate corridor expansion, regulated rate increases, carrying of underchanges, *etc.*

Note: Exhibit does not consider the additional expenses incurred by Maryland hospitals during the pandemic, including but not limited to personal protective equipment needs, staffing costs, and changes to hospital footprints. This exhibit also does not include additional $25 million for COVID-19 response from the American Rescue Plan Act of 2021 funds brought into Maryland Department of Health – Administration by fiscal 2022 budget amendment.

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

Fiscal 2021 was a particularly profitable period for hospitals in the State. This was discussed in the analysis for the Health Regulatory Commissions during the 2021 legislative session using

preliminary unaudited financials, however HSCRC reports that this remained true when the hospitals closed fiscal 2021. In fiscal 2021, hospital systems collectively had an operating margin of 3.75%, well over the 1% and 1.94% achieved in fiscal 2020 and 2019, respectively. These health systems include nonregulated businesses and entities affiliated with the State's hospitals, and the finical reports submitted included the impact of the federal Provider Relief Funds.

It is important to note that fiscal 2022 is incomplete, both in terms of what the potential revenue lost may be from continued downturn in volumes, additional federal dollars (including the $2 billion in provider relief funds released nationwide in January 2022), or further regulated rate-based actions unaccounted for at present. **Given the State's unique hospital financing system and its net-positive impact on hospital financial stability, DLS recommends adopting committee narrative requesting a report on the impact of the COVID-19 crisis to date on Maryland hospitals. Specifically, this report should include discussion of the benefits of the Maryland model on hospital operations and stability when compared to the nation and costs associated with hospital operations during the crisis, including the actual costs of COVID-19 treatment by the State's rate payors, and the challenges or increased costs needed to maintain adequate staffing levels at Maryland hospitals.**

3. TCOC and MDPCP Update

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.

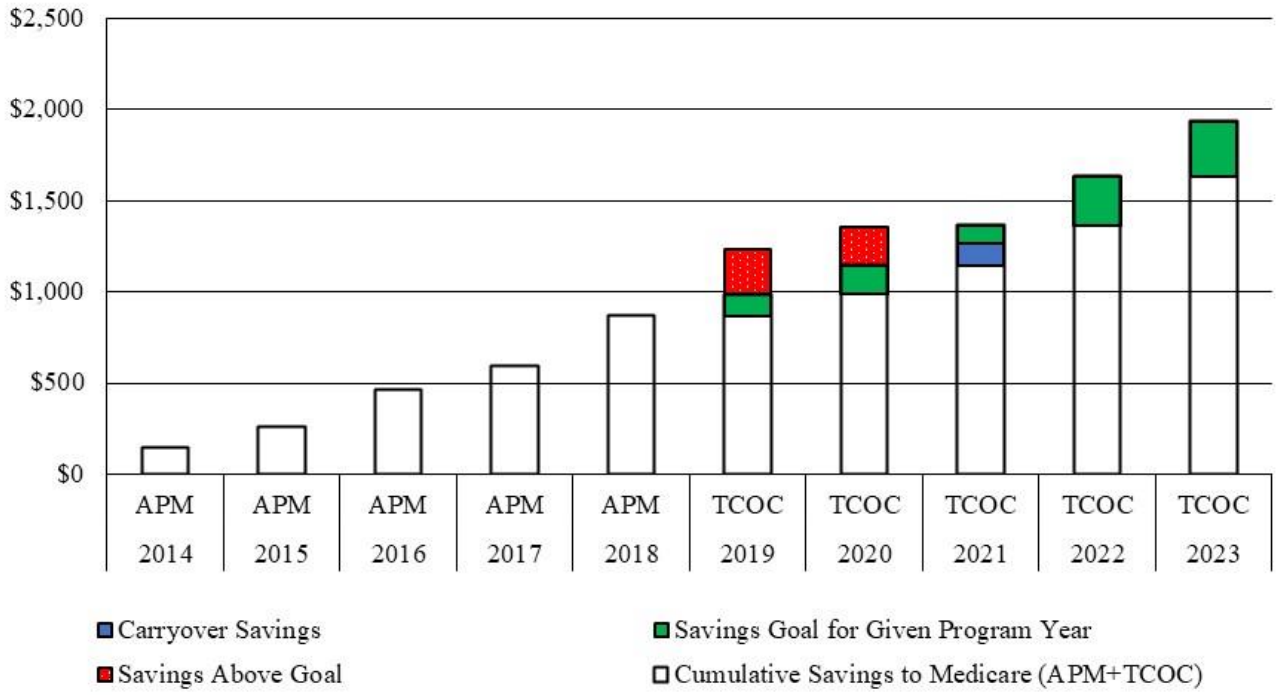
Under TCOC, Maryland commits to reaching an annual Medicare savings target of $300 million through the end of calendar 2023 (program year five) in Medicare Part A (*e.g.*, hospital services) and Part B (*e.g.*, doctor office visits, preventive services, and other nonhospital services) expenditures. Based 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 four), CMMI will assess the State's progress and determine if TCOC is on track to meet its savings goal. By the end of calendar 2022, the HSCRC anticipates having established a formula for the allowable Medicare cost growth rate for the remaining five years of TCOC.

Continued Success under the TCOC Model

In June 2021, CMMI certified the program requirements for the State for calendar 2020 (program year two). **Appendix 2** shows the State's performance on each of the goals evaluated by CMMI for TCOC in calendar 2019 and 2020. The State has met or exceeded each of the goals in both calendar 2019 and 2020.

Of note, the State significantly surpassed the goals regarding annual Medicare savings in each certified model year, reaching savings of $364.9 million in calendar 2019 and $390.6 million in calendar 2020. The State has been able to carry a portion of additional savings into the following model years. The savings target for calendar 2021 is $222 million, over half of which the State has already been able to achieve given the savings level achieved in calendar 2020. Savings goals under the TCOC model and levels of savings achieved in shown in **Exhibit 10**.

Exhibit 10
APM and TCOC Savings to Medicare
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

While the State has routinely exceed savings targets as outlined under the TCOC contract, the TCOC growth rate outlined under the contract has proved more challenging for the State. The contract with the Centers for Medicaid and Medicare Services (CMS) requires that the State not exceed 1 percentage point above the national growth rate. The State was below the national Medicare growth

by 0.6 percentage points and 0.5 percentage points in the first two model years, respectively. However, HSCRC has reported that in calendar 2021 this is proving slightly more difficult. Data through July 2021 had the State 1.47 percentage points above the national growth rate (0.47 percentage points above the guardrail). However, data through September 2021 suggests a positive trend with the State moving closer to the national level, with the State 1.11 percentage points above the nation (0.11 percentage points above the guardrail). **HSCRC should comment on any data update available regarding the State progress in meeting the 2021 TCOC growth guardrail.**

Challenges with the growth guardrail for calendar 2021 can be largely attributed to the supports and financial stability that Maryland hospitals have enjoyed during the pandemic relative to other hospitals in the nation, including the State's unique global budgeting system, discussed in Key Observation 2.

Independent Evaluation of the TCOC Model

In July 2021, CMMI released the first report for the independent evaluation of TCOC, which used program data from calendar 2019 and 2020. The report found that hospital global budgets remained the largest financial incentive in TCOC, with 29% of hospitals participating in the Episode Care Improvement Program (which allows hospitals to link payments across providers for certain items and services furnished during an episode of care) and frequently partnering with post-acute care facilities. This largely positive evaluation also noted that Maryland is a traditionally higher-cost state for hospital prices and pointed toward room for improvement in both population health goals and quality measures.

MDPCP

The TCOC evaluation also looked at MDPCP, another aspect of TCOC. In the first two model years, 468 primary care practices and 21 Care Transformation Organizations joined MDPCP, reaching 29% of all eligible primary care physicians and 47% of Medicare FFS beneficiaries in the State. In 2019, CMS paid each participating MDPCP practice an average of $163,751 to support their transformation efforts, increasing a practice's total revenue (across all payers) by about 9%. Payments made through MDPCP count toward TCOC.

Given MDPCP's role in TCOC, the budget committees have requested evaluation of the program, with particular focus on whether care management fees are offset by cost savings elsewhere in the State's health care system. While the initial report submitted in calendar 2020 did not find cost savings, a subsequent report submitted in September 2021 suggested a cumulative reduction of 0.5% over the first two years, even after accounting for care management payments to providers. Aggregate savings for the program in 2020 were estimated at $16 million. Further, the September 2021 report found that patients associated with MDPCP providers had a cumulative reduction in inpatient hospital utilization of about 2% over the two program years. The report also projects program growth in calendar 2021, with 53% of all Medicare beneficiaries in the State being attributed to an MDPCP practice. These findings are shown in **Exhibit 11**.

Exhibit 11
MDPCP Evaluation Results Relative to 2018
Calendar 2019 and 2020

	Total Cost of Care			Inpatient Utilization		
	2019	**2020**	**Cumulative**	**2019**	**2020**	**Cumulative**
Beneficiaries with MDPCP Participating Providers	3.36%	-4.41%	-1.19%	-4.90%	-17.08%	-20.87%
Beneficiaries with Nonparticipating Providers	2.39%	-3.03%	-0.72%	-4.07%	-15.48%	-18.92%
Difference	**0.97%**	**-1.37%**	**-0.48%**	**-0.83%**	**-1.60%**	**-1.96%**

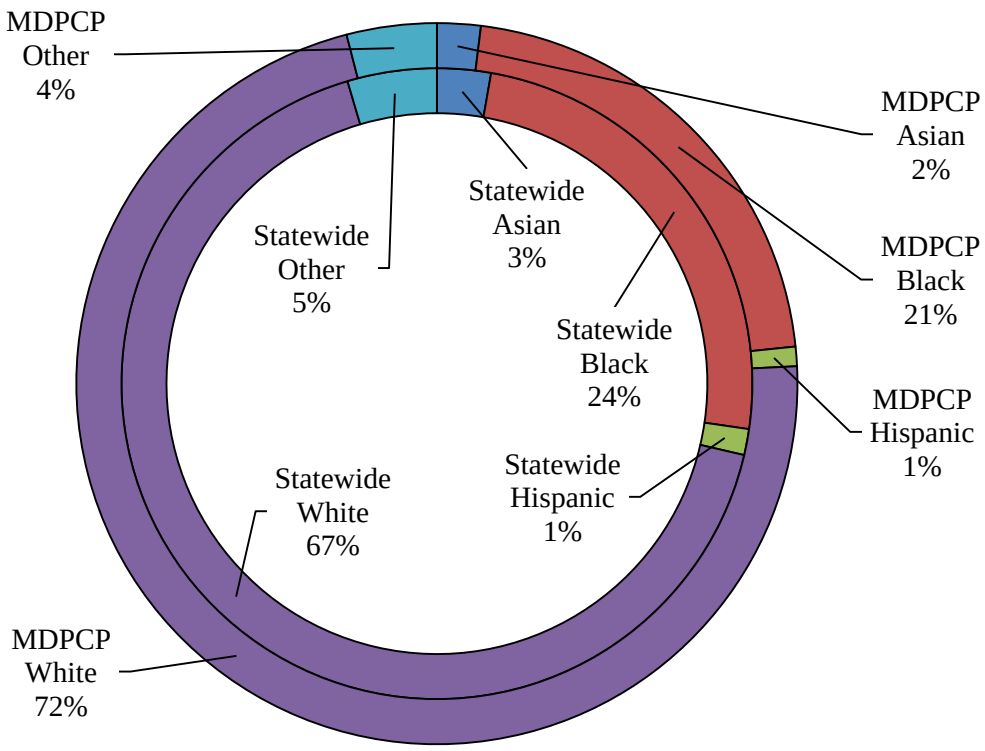
MDPCP: Maryland Primary Care Program

Source: Health Services Cost Review Commission

As shown, results of this evaluation are beginning to suggest modest cost savings, with a more noticeable impact in inpatient utilization. However, when looking at calendar 2020, both groups were of course impacted by the statewide and national hospital utilization trends during the COVID-19 pandemic that were discussed in Key Observation 2. **Given the modest impact shown thus far, volatility on overall utilization in calendar 2020, and the importance of this program to overall success under TCOC, DLS is recommending continued evaluation of MDPCP by HSCRC.**

The most recent evaluation of MDPCP also included a consideration of the racial makeup of the participants in the program compared to the statewide beneficiaries. As shown in **Exhibit 12**, MDPCP has a larger share of White beneficiaries than the statewide Medicare population for 2020. Although part of the requested *Joint Chairmen's Report* (JCR) response was to include the racial and ethnic diversity of the MDPCP providers as well, HSCRC reported the data are not available.

Exhibit 12
Racial Diversity in MDPCP
Calendar 2020



MDPCP: Maryland Primary Care Program

Source: Health Services Cost Review Commission

Regional Partnership Catalyst Grant Programs, 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 Catalyst Grant Program. At the November 2020 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, 2021, through December 2026, follows from the Regional Partnership Transformation Grant Program (Transformation Grant Program) created in 2015 by HSCRC that expired on June 30, 2020.

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 Statewide Integrated Health Improvement Strategy (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.

Therefore, the funding currently in fiscal 2022 represents the first time that these grants have supported maternal and child health goals. HSCRC reports that from fiscal 2022 to 2025, $10 million annually will be directed to support maternal and child health interventions lead by the Medicaid Program, the Medicaid Managed Care Organizations, and MDH's Prevention and Health Promotion Administration (PHPA). The State's maternal health priorities were discussed in the MDH overview, and the programmatic use of the HSCRC dollars from the Catalyst Grant Program will be discussed in the PHPA analysis. Although these funds are derived through hospital rates, they do 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.

These grants are intended to be in alignment with the population health measures submitted to CMS as a part of TCOC through SIHIS. These goals and measures are listed in **Appendix 3**, including accomplishments for each goal during calendar 2021.

Another population health initiative under HSCRC and the TCOC model is population outcome-based credits. HSCRC ultimately will have three outcome-based credits, only one of which is currently available. The diabetes program, the credit currently available, has proven successful in the first year. HSCRC anticipates $5 million being credited against the State's TCOC goals under the model. HSCRC's other planned outcome-based credits include the opioid fatalities and hypertension. The HSCRC anticipates the opioid measure being rolled out within calendar 2022 while the hypertension outcome-based credit being finalized within calendar 2023. Specifically, these outcome-based credits are credited against MDPCP's care management fees. **DLS recommends adopting committee narrative requesting continued evaluations of MDPCP, which should have a discussion of the outcome-based credits, including the impact that these measures have on reducing total care management fees credited against the State's TCOC, and the MDPCP's program roll in achieving these credits and other population health goals.**

Operating Budget Recommended Actions

1. Adopt the following narrative:

   The Maryland Model's Interaction with the Challenges of the COVID-19 Pandemic: Maryland has long been a unique state in terms of hospital financing and regulations. During the COVID-19 pandemic, this system was able to provide financial stability and relief to the State's hospitals. The committees are interested in how the State's model impacted the State and State's hospitals in terms of stability and operations during the pandemic when compared with other hospitals in the nation during this crisis. Further, the committees are interested in the costs associated with the pandemic: both in terms of the treatment of COVID-19 hospitalizations by payor; and the indirect costs incurred in hospital operations during this period. Lastly, the committees are interested in the financial performance of the hospital industry in fiscal 2022 and any liabilities that the State's current hospital financing stability has presented to the ongoing success of the State's model agreement, the Total Cost of Care model. The committees request that the Health Services Cost Review Commission (HSCRC) submit a report addressing these areas.

Information Request	Author	Due Date
The Maryland model's response to the COVID-19 pandemic	HSCRC	October 1, 2022

2. 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 budget 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. 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, 2022

Updates

- ***Report on the Maryland Medical Liability Market:*** Chapter 19 of 2020, the fiscal 2021 Budget Bill, included language restricting the use of $250,000 in special funds from HSCRC to conduct an independent actuarial analysis of the State's hospital medical liability market. Prior to the 2021 session, HSCRC was granted an extension for the full report given the complexity of the issue and ensuring that the firm contracted for the report had the appropriate subject matter expertise and time to collect the data needed. The report was submitted to the budget committees July 2, 2021. The report analyzed and compared Maryland's medical professional liability (MPL) climate with other states, examined programs for reducing MPL costs in other states, evaluated the impact on Maryland's MPL climate of implementing the provisions of California's Medical Injury Compensation Reform Act and programs in other states designed to curb MPL costs (*e.g.*, birth injury funds), and made recommendations on how to stabilize the hospital liability market in Maryland. The report included data from surveys of Maryland hospitals, insurance company annual statements, and the National Practitioner Data Bank. The findings of this report were also shared with the members of the House Health and Government Operations Committee, House Judiciary Committee, the Senate Judicial Proceedings Committee, and the Senate Finance Committee on January 20, 2022.

Appendix 1
2021 *Joint Chairmen's Report* Responses from Agency

The 2021 JCR requested that HSCRC and MHCC prepare two reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Hospital at Home Model:*** The committees were interested in the expansion of the Hospital at Home model to provide alternatives to inpatient hospital care. While MHCC did not identify regulatory barriers, such as needing a certificate of need, it did highlight some potential reimbursement challenges of the expansion of this type of care, particularly under Maryland's unique rate setting structure. Specifically, HSCRC's authority to set rates is limited to outpatient services provided "at a hospital", inpatient hospital services, and emergency department services. HSCRC would need to create a bundled payment rate for outpatient services that Hospital at Home patients receive (such as the emergency department visit initiating the Hospital at Home intervention). The report also identified potential administrative barriers with CMS, including requirements for nursing care under Medicare or the possibility of needing to amend the State's Medicaid 1115 waiver. The commissions ultimately identified two options that would allow hospitals to bill for acute hospital care at home program services: (1) HSCRC and CMS could make regulatory changes in order to treat services provided outside of the hospital as traditional inpatient care; or (2) HSCRC could establish a new bundled payment rate for the hospital services provided at home. Both options would have the same clinical requirements but would be reimbursed differently.

- ***HSCRC Evaluation of MDPCP:*** The evaluation of MDPCP, the program itself, and its relation to the Maryland model is discussed in Key Observation 3.

Appendix 2
TCOC Performance Results

	Calendar 2019/Program Year One		Calendar 2020/Program Year Two	
	Goal	**Performance**	**Goal**	**Performance**
Annual Medicare Savings*	$120 million	$364.9 million	$156 million	$390.6 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
All-payer Revenue Limit	Growth ≤ 3.58% per capita annually	2.50%	Growth ≤ 3.58% per capita annually	0.21%
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
Reduction in Readmissions	≤ national rate for FFS Medicare beneficiaries (15.52% for calendar 2019)	14.94%	≤ national rate for FFS Medicare beneficiaries (15.55% for calendar 2020)	15.18%
Hospital Revenue Population-based Payment	At least 95% of regulated revenue paid according to population-based methodology	98.00%	At least 95% of regulated revenue paid according to population-based methodology	97.90%

*The State's overperformance in annual Medicare savings produces savings in the following model year, as outlined under the contract with CMMI. Savings carried over in calendar 2019 totaled $122.42 million and $117.3 million in calendar 2020.

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 BMI for adult Marylanders	Improve overdose mortality	Reduce severe maternal morbidity rate	Decrease asthma-related 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
2021 Milestones and Progress	Launch related Catalyst Grant Program; expand CRISP referrals: and incorporate quality measures for all MDPCP providers to track patient BMIs	Launch related Catalyst Grant Program; expand SBIRT into MDPCP programs (311 have implemented as of January 2022)	32 of 32 hospitals participate to implement the Hypertension Safety Bundle from the Alliance for Maternal Health Innovation; Complete Maryland Maternal Health Improvement Task Force Strategic Plan	Check population projections to ensure accurate identification of affected population; development of asthma dashboard; and asthma-related ED visits as a Title V performance measure and shift funding to support asthma interventions
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

Total Population Health	Diabetes	Opioids	Maternal and Child Health	
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

BMI: body mass index
ED: emergency department
SBIRT: Screening, Brief Intervention, and Referral to Treatment
SMM: Severe Maternal Morbidity

Source: Health Services Cost Review Commission

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

Object/Fund	FY 21 Actual	FY 22 Working Appropriation	FY 23 Allowance	FY 22 - FY 23 Amount Change	Percent Change
Positions					
01 Regular	108.90	112.90	117.90	5.00	4.4%
02 Contractual	7.70	9.59	11.28	1.69	17.6%
Total Positions	**116.60**	**122.49**	**129.18**	**6.69**	**5.5%**
Objects					
01 Salaries and Wages	$ 16,134,736	$ 16,966,895	$ 18,234,720	$ 1,267,825	7.5%
02 Technical and Special Fees	729,668	783,545	912,014	128,469	16.4%
03 Communication	93,072	104,645	107,523	2,878	2.8%
04 Travel	16,034	330,912	343,017	12,105	3.7%
06 Fuel and Utilities	0	0	3,196	3,196	N/A
08 Contractual Services	132,498,349	153,083,127	165,271,527	12,188,400	8.0%
09 Supplies and Materials	65,426	89,951	80,009	-9,942	-11.1%
10 Equipment – Replacement	173,902	30,500	25,500	-5,000	-16.4%
11 Equipment – Additional	54,119	925,279	1,048,117	122,838	13.3%
12 Grants, Subsidies, and Contributions	17,096,596	11,063,001	75,414,136	64,351,135	581.7%
13 Fixed Charges	486,781	781,875	795,687	13,812	1.8%
Total Objects	**$ 167,348,683**	**$ 184,159,730**	**$ 262,235,446**	**$ 78,075,716**	**42.4%**
Funds					
01 General Fund	$ 0	$ 0	$ 10,213,545	$ 10,213,545	N/A
03 Special Fund	160,838,452	183,599,009	251,845,040	68,246,031	37.2%
05 Federal Fund	4,975,245	0	0	0	0.0%
09 Reimbursable Fund	1,534,986	560,721	176,861	-383,860	-68.5%
Total Funds	**$ 167,348,683**	**$ 184,159,730**	**$ 262,235,446**	**$ 78,075,716**	**42.4%**

Note: The fiscal 2022 appropriation does not include deficiency appropriations. The fiscal 2022 working appropriation and fiscal 2023 allowance do not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which include cost-of-living adjustments, increments, bonuses, and may include annual salary review adjustments.