MDH ATTENDEES: Laura Herrera Scott, MD, MPH, Secretary
Marie Grant, JD, MDH Assistant Secretary for Health Policy

CHRC ATTENDEES: Edward J. Kasemeyer, CHRC Chair
Mark Luckner, Executive Director

MHCC ATTENDEES: Ben Steffen, Executive Director

Available For Questions: Richard Proctor, Chief Administrative Officer
Diana Dembeck, Director of Administration
Tracey DeShields, Director, Policy Development and External Affairs

HSCRC ATTENDEES: Jon Kromm, Executive Director

Available For Questions: Deborah Rivkin, Director, Government Affairs
Xavier Colo, Chief Operating Officer

Maryland Department of Health (MDH) Health Regulatory Commissions
Fiscal Year 2025 Operating Budget
Response to Department of Legislative Services Analysis

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Emily Shetty
February 15, 2024

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
February 19, 2024

The Department thanks the Governor, the Department of Budget and Management (DBM), and the Budget Committees for their support. We thank the Department of Legislative Services for its insightful budget analysis and for its recommendations to concur with the Governor's allowance.

MCHRC should clarify:

- **the timing of Consortium on Coordinated Community Supports service grants and hub grant distribution;**
- **whether the first round of service grants spends all Blueprint funding carried over from prior years and the fiscal 2024 appropriation, or if there will be remaining funds; and**
- **the timing and criteria for awarding consortium grants using $110 million allocated in the fiscal 2025 allowance, considering that the first RFP for service grants will be awarded for an 18-month term ending June 30, 2025 (p. 10).**

CHRC Response:

The timing of Consortium on Coordinated Community Supports service grants and hub grant distribution: Earlier this month, CHRC Commissioners voted to award 129 grants totaling $111 million to support the first round of services grants for the Consortium. A list and summary of these grants is attached to this response. The Hub Pilots Call for Proposals (another, second funding opportunity) generated 17 proposals requesting $9 million. These Hub pilot proposals will be discussed at the Consortium's next meeting on February 20 and it is anticipated that the CHRC Commissioners will issue 10 Hub pilot grant awards (approximately $6 million in total funding) at its next meeting in March 2024. The awards for these two RFPs (services and Hub awards) are anticipated to result in approximately $117 million being funded/awarded to support the statutory objectives of the Consortium.

Whether the first round of service grants spends all Blueprint funding carried over from prior years and the fiscal 2024 appropriation, or if there will be remaining funds: The first round of service grants and Hub awards fully expends the Blueprint funding carried over from the prior year (FY 2023) and expends the bulk of the appropriation for FY 2024 (current fiscal year). In addition to the 129 service grants ($111 million) and 10 Hub grants (estimated at $6 million), the Consortium is planning to allocate another $3 million for a technical assistance project to support the Maryland Department of Health's state plan amendment for expanded behavioral health school Medicaid billing. This technical assistance project is a request from MDH leadership and will begin in FY 2024 and will continue through FY 2025. Additional funds will be expended to support the Consortium's contract with the National Center for School Mental Health and training for grantees and school-employed staff in evidence-based programs. Based on these activities, we are estimating approximately $11 million will be unspent at the close of FY 2024. Given that the first RFP for services generated $380 million in requests (more than three times what was awarded in the first services RFP, $111 million), we would request permission to carry over this unspent funding in FY 2024 into FY 2025 for the second round of service provider and Hub grants.

The timing and criteria for awarding consortium grants using $110 million allocated in the fiscal 2025 allowance, considering that the first RFP for service grants will be awarded for an 18-month term ending June 30, 2025 (p. 10): The next round of Consortium grants is anticipated to be released in January/February 2025 with awards made in the spring of 2025. This schedule would allow for the continuation of funding of programs that were awarded in the first RFP, as well as additional programs. Similar criteria for the second RFP are anticipated. As mentioned above, the first RFP for services generated requests of $380 million and the total request/allowance for FY 2025 is $110 million.

The Department of Legislative Services (DLS) recommends adopting committee narrative requesting a report on the timing and use of consortium grants in fiscal 2024 and 2025 year to date (p. 10).

The CHRC is happy to comply with this proposed Committee narrative.

The Health Regulatory Commissions should discuss any plans to implement the preliminary recommendations of the Commission to Study Trauma Center Funding in Maryland and discuss the timeframe for implementation. For preliminary recommendations that would require legislative action, such as changes to MTPSF allocations, MHCC and HSCRC should discuss whether any departmental bills will be introduced in the 2024 session (p. 17).

MHCC Response:

All changes in funding to trauma providers will require legislative action. Certain oversight functions including audits, data system enhancements, and quality reporting requirements could be completed without legislation. Expanded oversight functions could be included as uncodified language in legislation as was done with the provision regarding standby in the original language that established the Maryland Trauma Physician Services Fund. The table below presents the recommendation, flags whether legislation is required, the estimated funding, and possible sources of funds.

Recommendation	Legislation Required	Hospital Costs	Funding Needed	Source of Revenue
A.1-2. Increase On-Call Payments	Y	N	$7,600,000	Currently MVA Surcharges
B.1-2. Add additional flexibility For Trauma Fund Administration (MHCC and HSCRC) to modify program parameters	Y	N	No Budget Impact	No Funding Impact
C. Enable non-physician providers to receive payment from the Trauma Fund	Y	N	$500,000	Currently MVA Surcharges
D.1 Allow all standby costs for the four primary specialties to be fully included in hospital rates	N	Y	$11,000,000	HSCRC rate setting authority
D.2 HSCRC should audit the incremental hospital costs associated with the trauma service	N	Y	$200,000	HSCRC Operating Budget
D.3 HSCRC should consider full accounting for incremental trauma costs as opposed to considering these costs as part of its hospital efficiency methodology.	N	Y	Increase costs to payers and residents due to higher hospital costs and thus higher premiums or higher Medicaid costs	Hospital Rates. Community hospitals reported $82 million and RACSTC $269 million in trauma costs in 2022-23.

E. Conduct biennial audits to confirm that managed care organizations (MCOs) are reimbursing all trauma providers at the Medicare rate	N	N	$250,000	Possibly funded by the Trauma Fund or by Medicaid's operating budget.
F.1 Award National Children's Hospital an increase in their NTE stipend consistent with the increase in on-call payments	Y	N	$310,000	Currently, Children's receives a stipend of up to $590,000 from the Trauma Fund based on documented costs.
F.2 Increase on-call payments to the Specialty Pediatric, Hand, Eye, and Burn trauma centers consistent with the increases for Level II and III trauma centers	Y	N	n/a	Cost already reflected in recommendation A.1
G.1 Align the Trauma Data Systems with MHCC and HSCRC Data Systems to enable more complete analysis of trauma care and costs	N	N	$100,000	Annual cost, but possibly smaller once established. Possibly funded by the Trauma Fund or agencies
G.2 MHCC shall convene a workgroup to examine establishing quality measures for trauma care	N	N	$100,000	One-time Expense. Funded from MHCC budget

HSCRC Response:

HSCRC supports additional funding for the Maryland Trauma Physicians Fund. The lack of increase in income for the Trauma Fund is a risk to the sustainability of our trauma system, crucial in providing high quality care to patients. Some trauma costs are funded through hospital rates. HSCRC does not have legal authority to set hospital rates for physician costs, which are a substantial component of trauma costs (Health General §19-201, §19-211, Total Cost of Care Model Contract §9(c)). The Trauma Physicians Fund provides funding for costs that are not funded through hospital rates. HSCRC cautions against a major expansion of hospital rates to fund trauma. HSCRC is obligated to control the growth in Medicare and all-payer costs under the Total Cost of Care Model. Adding physician costs to hospital rates would constrain HSCRC's ability to control this cost growth and meet Maryland's obligations to the federal government under the Model. Maintaining Maryland's performance under the Total Cost of Care Model is particularly important as Maryland is in the process of applying to the federal government for a new Model contract. This risk does not apply to other proposed funding sources for the Maryland Trauma Physicians Fund.

MHCC should also comment on any new revenue sources or changes to existing revenue sources for trauma centers that were considered by the Commission to Study Trauma Center Funding, such as changes to the Maryland vehicle registration surcharge (p. 17).

MHCC Response:

Currently, the Maryland Trauma Physicians Services Fund (MTPSF) is financed through a $5 surcharge on biennial automobile registrations and registration renewals. The revenue derived from the surcharge has been quite stable since the fund was established in 2003. If the nine recommendations that impact the MTPSF are adopted, $9 million in additional revenue would be needed for the Maryland Trauma Physicians Services Fund. Other funding sources aside from increasing the surcharge on motor vehicle registrations and renewals discussed were creating an excise tax on firearms and ammunition and a surcharge on moving motor vehicle violations. At a minimum for trauma centers to be expanded the automobile registration surcharge will have to increase. The table below provides estimates of the potential additional revenue raised if the surcharge was raised by $2, $4, or $6 per biennial renewal.

Funding Source	Annualized Surcharge in Statute	What Consumers See in their Biennial Vehicle Registration	% Increase from $2.50 Base	Projected Revenue
Current Law	**$2.50**	**$5.00**	**0.0%**	**$12,349,547**
Increase $1.00 in annualized Surcharge	**$3.50**	**$7.00**	**40.0%**	**$17,289,366**
Increase $2.00 in annualized Surcharge	**$4.50**	**$9.00**	**80.0%**	**$22,229,185**
Increase $3.00 in annualized Surcharge	**$5.50**	**$11.00**	**100.0%**	**$24,699,094**

Most other trauma center costs are regulated by HSCRC. These costs or a portion of these costs are included (at the discretion of HSCRC) in the hospital rates approved by the HSCRC. The Commission to Study Trauma Center Funding has recommended that the HSCRC consider increases in trauma center standby and incremental costs associated with operations of a trauma center. These suggested increases would parallel the increases in the MVA surcharge.

DLS determined the letter to be in compliance with the language and recommends the release of $100,000 in special funds restricted in fiscal 2024 pending the submission of a letter regarding regulations for restrictions of protected health data required by Chapters 248 and 249. DLS will process a letter to this effect if no objections are raised by the subcommittees (p. 18).

MHCC Response:

The MHCC wishes to thank the Committee for releasing the funds. We are also providing an update on the implementation of the protected health information legislation (HB 812. SB 786). Much of this information was contained in the MHCC last quarterly update to the Committees on implementation of HB812/S786.

Introduction:

The Maryland Health Care Commission (MHCC or Commission) was directed under Chapters 249/248 (House Bill 812/Senate Bill 786) *Health – Reproductive Health Services – Protected Information and Insurance Requirements* (2023) to adopt emergency regulations regarding the disclosure of legally protected health care by health information exchange (HIE) and electronic health network (EHN) entities operating in the State.[1]' [2] The law (Md. Code Ann., Health – General Article §4–302.5) requires MHCC to report quarterly to the Senate Finance Committee and the House Health and Government Operations Committee on the status of the implementation. This letter provides information on progress in implementing the law.

Approach:

Throughout the legislative recess, MHCC worked with technology vendors (EHNs and HIEs) to identify challenges in supporting the law. The MHCC solicited input from stakeholders to inform the development of emergency and proposed regulations. EHNs facilitate the exchange of electronic health care administrative transactions (transactions) between payers and providers, such as verifying the accuracy of claims data submitted, reporting on errors identified, and formatting transactions to align with national standards established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIEs allow authorized users to securely access and share electronic patient information for clinical, quality improvement, and public health purposes. A total of 29 EHNs that accept transactions from payers operating in Maryland are certified by MHCC.[3] A total of 16 HIEs operating in Maryland have registered with MHCC.[4]

COMAR 10.25.18, *Health Information Exchanges: Privacy and Security of Protected Health Information* and COMAR 10.25.07, *Certification of Electronic Health Networks and Medical Care Electronic Claims Clearinghouses* (collectively regulations), are the existing regulatory frameworks to support implementation of the law. The proposed permanent regulations were published in Volume 51, Issue 1 of the Maryland Register on January 12, 2024 and emergency regulations were published in Volume 51 Issue 3 of the Maryland Register on February 9, 2024.

The MHCC worked collaboratively with HIEs and EHNs to draft amendments to the regulations. On September 22, 2023, MHCC released draft amendments to the regulations for a 30-day informal comment period. Public comments were considered and emergency and proposed permanent regulations were approved by the Commission November 16, 2023. The MHCC notified around 160 stakeholders about the informal release of draft amendments to the regulations; approximately 133 comments from 17 organizations were received. The MHCC made various changes to the draft regulations to address stakeholder concerns.

The amendments to the regulations align with the Maryland Department of Health's (MDH) regulations, COMAR 10.11.08, *Abortion Care Disclosure,* which require HIEs and EHN entities operating in Maryland to restrict the disclosure of select medical diagnosis codes, current procedural terminology codes, and medication codes related to protected reproductive health care services (legally protected health information). A draft of MDH's *Abortion Care Diagnosis, Procedure, and Medication Code Technical Guidance Document* was shared with HIEs and EHNs on October 4, 2023; a more condensed list of medical diagnosis, procedural, and medication codes was released by MDH on November 21, 2023. The law requires MDH to establish a Protected Health Care Commission (PHCC) to make recommendations to the Secretary regarding the sensitive health services that should be determined by the Secretary to be legally protected health care. The PHCC has convened twice since the fall of 2023, MHCC participates on the PHCC.

The MHCC convened two HIEs and EHN Town Hall events in December 2023 to review the regulations and address stakeholder questions.[5], [6] Questions raised by stakeholders informed development of HIE and EHN implementation guidance to support compliance with the regulations. Among other things, the regulations require HIEs and EHNs to submit an affirmation that the entity possesses the technological capability to filter and restrict from disclosure legally protected health information, or submit an implementation plan describing steps the entity is taking to comply with the regulations and timeline to implement the requirements by June 1, 2024. The submissions are currently under review by MHCC and will be released to the public in March. The next update from HIEs and EHNs will occur in April of 2024. At that point, MHCC will have a clearer report on the industry's progress in complying with the statute and the supporting regulations.

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[1] *House Bill 812/Chapter 249, Health - Reproductive Health Services - Protected Information and Insurance Requirements Implementation Guidance: Health Information Exchanges* available at: mhcc.maryland.gov/mhcc/pages/hit/hit_hie/documents/HIE_Guidance_012624.pdf

[2] *House Bill 812/Chapter 249, Health - Reproductive Health Services - Protected Information and Insurance Requirements Implementation Guidance: Electronic Health Networks* available at: mhcc.maryland.gov/mhcc/pages/hit/hit_ehn/documents/ehn_guidance.pdf

[3] A listing of certified EHNs is available here: mhcc.maryland.gov/mhcc/Pages/hit/hit_ehn/hit_ehn_certified.aspx.

[4] A listing of registered HIEs is available here: mhcc.maryland.gov/mhcc/Pages/hit/hit_hie/hit_hie_registration.aspx.

[5] A listing of HIE Town Hall participants is available at: mhcc.maryland.gov/mhcc/pages/hit/hit_hie/documents/hie_town_hall_participant_list_121823.pdf.

[6] A listing of EHN Town Hall participants is available at: mhcc.maryland.gov/mhcc/pages/hit/hit_ehn/documents/ehn_town_hall_participant_list_122023.pdf.

HSCRC should comment on potential changes to the MDPCP to make it cost effective. Considering the net increase in TCOC model costs, DLS recommends adopting committee narrative requesting a report evaluating the MDPCP from HSCRC, in consultation with the MDPCP Project Management Office within MDH (p. 20).

HSCRC Response: HSCRC concurs on a report evaluating cost and utilization under the MDPCP program, similar to the reports completed in each of the past four years. MDPCP program is an investment in care transformation to develop coordinated, advanced primary care for Marylanders. HSCRC encourages the Committee to consider the cost of the program in the context of improved outcomes for patients. MDPCP has reduced hospital utilization by 2.66% or $114 million over the four years of the program compared to practices that are not participating in MDPCP. This has a significant benefit to patients who are not spending time in the hospital because of improved primary care. The savings resulting from the reduced hospital utilization does not fully offset the costs of additional payments to participating practices and Care Transformation Organizations. The program has resulted in a some amount of additional cost over the past four years of program evaluation. There has been substantial volatility in the year-to-year savings rate, especially given abnormal health care utilization patterns resulting from the COVID-19 pandemic. As practices continue to mature in their adoption of advanced primary care and assume greater risk under the program, cost and utilization data may change.

It is important to note that Maryland has succeeded in meeting the annual Medicare Total Cost of Care cost saving targets under each year of the Total Cost of Care Model while also making substantial investments in improving primary care through the MDPCP program. The new AHEAD Model, which Maryland is applying to participate in, requires Maryland to set primary care investment targets. The MDPCP program is an important first step in demonstrating Maryland's commitment to investing in primary care as we apply to the AHEAD Model.

In considering the appropriate entity to make recommendations about changes to the MDPCP program, it is important to consider the program's governance structure. The MDPCP is jointly run by the federal Centers for Medicare and Medicaid Services (CMS) and MDH. Any changes to the program would likely require CMS approval, which is a time consuming process. At the state-level, MDPCP has a robust governance structure level, with a project management office in MDH and an active advisory council which is staffed by the Maryland Health Care Commission.

HSCRC should comment on the fiscal impact of delayed proposal submission and approval of the two remaining outcome-based credits (p. 23).

HSCRC Response: Maryland's performance on the outcome-based credits serves to increase savings under the Total Cost of Care Model. HSCRC staff will request that the remaining outcome credit methodologies be applied retrospectively from the beginning of the TCOC model. For example, if CMS approves the opioid use disorder credit in calendar year 2024, and Maryland earned savings under the new credit for performance between the start of the Model and 2024, those savings would all be applied to the TCOC savings calculation for either 2024 or 2025, depending on timing. As long as CMS approves that request, the time of submission will not prevent Maryland from earning savings on Medicare Total Cost of Care based on the State's performance on the outcome-based credit measures of population health. Over the term of the Total Cost of Care Model, which began in 2019, Maryland has succeeded in meeting the annual Medicare Total Cost of Care cost saving target under each year of the Total Cost of Care Model, maintaining hospital funding in line with health care inflation, and keeping all-payer per capita in-state hospital revenue well below the model target of 3.58% growth and actual State GSP. Maryland does not need these savings at present, as we are on track to meet our savings targets under the Model. Thus, we do not anticipate there to be any fiscal impact from the delayed submission

HSCRC should discuss the federal review process and timeline for implementing a new Maryland Model and comment on the initial goals and components of a new model that have been discussed with stakeholders (p. 23).

MDH/HSCRC Response: The Centers for Medicare & Medicaid Services (CMS) released a Notice of Funding Opportunity (NOFO) for the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model in fall 2023. The AHEAD Model is an 11 year, voluntary, state total cost of care model that seeks to drive state and regional health care transformation and multi-payer alignment to accelerate transformation across the entire health system. The AHEAD Model is designed to curb health care cost growth, improve population health, and advance health equity by reducing disparities in health outcomes across all payers including Medicare, Medicaid, and private coverage. AHEAD is the pathway to continue Maryland's all-payer rate setting authority and offers tools for primary care transformation,

healthcare cost containment, and population health improvement. AHEAD builds on the Maryland TCOC Model, advancing the vision of equity and excellence in Maryland's healthcare delivery system to improve the health of all.

Maryland submitted a non-binding Letter of Intent to CMS to participate in Cohort 1 of AHEAD which would run from CY 2026 through CY 2034. The application deadline for Cohort 1 is March 18, 2024. Awards are expected to be announced in May 2024. An 18-month pre-implementation period (June 2024-December 2025) will follow the award wherein the State and CMS would negotiate a State Agreement outlining the terms of Maryland's participation in AHEAD, including the development of Medicare and all-payer total cost growth targets and Medicare and all-payer primary care investment targets. Maryland's Medicaid program will be part of the all-payer total cost growth targets as well as the all-payer primary care investment target. The pre implementation period is followed by a 9 year implementation period (1/1/2026 – 12/31/2034). Up to $12 million in federal funds is available to each State in the AHEAD Model to support implementation over a 5.5 year period (ending in 2029).

MDH and HSCRC have convened three committees to advise the State on the future of Maryland's agreement with CMS. These committees are advising the State in the development of the AHEAD NOFO response.

The Population Health Transformation Advisory Committee (P-TAC) provides advice to MDH and HSCRC to transform the state's approach to equity-centered population health improvement.

The Healthcare Transformation Advisory Committee (H-TAC) provides advice on all-payer cost savings targets, hospital quality improvement, and continued transformation of Maryland's healthcare delivery system.

The Primary Care Program Transformation Advisory Committee (PCP-TAC) provides advice on primary care spending targets and the future of a multi-payer aligned primary care program.

MHCC's Budget Presentation
House Appropriations Committee

Fiscal Year 2025

M00R0101

February 15, 2024

The Maryland Health Care Commission

A 15-member independent regulatory agency. The Maryland Health Care Commission is organized around the health care systems we seek to evaluate, regulate, or influence, utilizing a wide range of tools (data gathering, public reporting, planning and regulation) in order to improve quality, address costs, or increase access.

Mission:

Is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

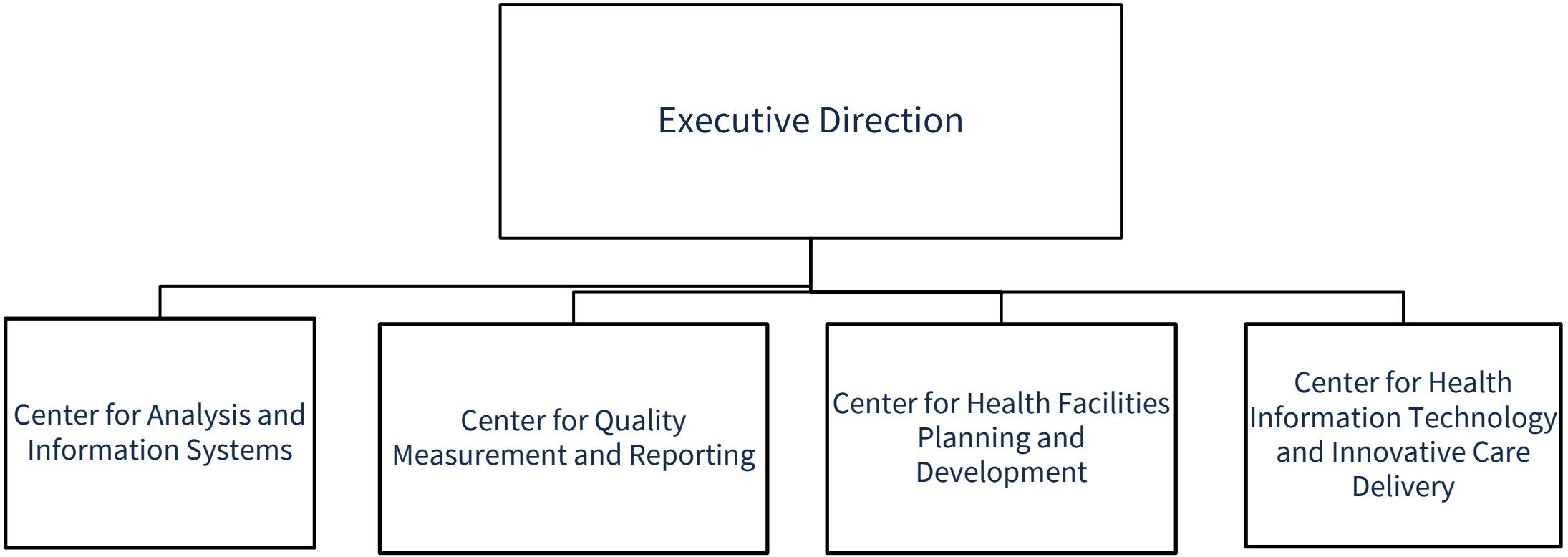
Strategic Intent: Reduce health care disparities while improving health care access, quality, outcomes, and cost in Maryland by…

- Aligning health care payers around State strategic goals, including primary and behavioral health care access, chronic disease prevention and management and other emerging priorities;
- Increasing the use of actionable cost and quality data to drive improvements in care; and
- Using MHCC authorities to increase geographic, racial, and ethnic health care equity.

Our Roles

- Plan for health facility development;
- Measure and aggregate cost and quality data;
- Enable information technology innovation;
- Convene and engage stakeholders; and
- Assess health policy options

Organizational Structure



MHCC Fiscal Year 2025 Budget Allowance

FY 2025 Allowance - $38,410,861

1. Operating Budget - $20,110,861 ($19,550,861 SF, $560,000 RF)

- Industries Assessed – Payers, Hospitals, Nursing Homes, and Health Occupation Boards
- FY 2023 Closing Revenue Balance - $5,932,127
- Total Permanent Staff : 55.9
- Total Contractual Staff: 1.0 Part-Time

2. Managing Critical Funds – Trauma and Maryland Patient Safety Center

- Maryland Trauma Physicians Services Fund - $12,000,000
- Maryland Trauma Grants - $1M
- Shock Trauma Grant - $3,700,000
- Maryland Patient Safety Center - $1,000,000 – General Funds

3. Serving where we can help in FY 2025

- Sustaining the MDPCP - $600,000

MHCC Strategic Priorities

2023-2026

1. Increase the intentionality of a health equity focus in MHCC programs and services.
2. Use MHCC's health care facility regulatory authority to enhance equity in health care delivery by improving access to services, and the quality and outcomes of care.
3. Facilitate the adoption of new technologies and health care data innovations and assess their impact on access and quality of health care.
4. Increase the use of data among policymakers, payers, providers, purchasers, and patients to improve the quality, affordability and outcomes of health care delivered in the State.
5. Promote new models of care to address barriers to reducing the Total Cost of Care in Maryland and use new authorities under Health Insurance: Two-Sided Incentive Arrangements and Capitated Payments – Authorization (Chapter 297 laws of Maryland)

Policy and Legislative Reports Released in Nov 2023 – January 2024

- **Insurance Mandates:**
  SB0075, 2023 - Insurance and Maryland Medical Assistance Program – Treatment of Alopecia Areata – Coverage Requirements - Mandated Health Insurance Services Evaluation Report

  SB0108, 2023 -Health Insurance-Annual Behavioral Health Wellness Visits-Coverage and Reimbursement-Mandated Health Insurance Services Evaluation Report

  SB0184/CH298, HB0376/Ch. 299 (2), 2023 - Health Insurance - Diagnostic and Supplemental Examinations for Breast Cancer - Cost-Sharing – Mandate Evaluation Report (MSAR #14660

  HB0937, 2022 - Abortion Care Access Act - (Labor and Delivery) Mandated Health Insurance Services Evaluation Report

- Forthcoming in March 2024

  A Comprehensive Analysis of Maryland's Mandated Health Insurance Services Required Under Insurance Article § 15-1502

Policy and Legislative Reports Released in Nov 2023 – January 2024

- **Nursing Home, Assisted Living, and Palliative Care**

  SB0509/CH289, HB0702/Ch. 288 (2), 2023 - Health Insurance – Health Care Facilities – Nursing Homes – Acquisitions and Licensure - Nursing Home Acquisitions Report (MSAR #14920)

  SB 531/ HB 636 2022 Small Assisted Living Programs Study Recommendations Report

  HB0378/CH0301, 2022 - Maryland Health Care Commission – Palliative Care Services – Workgroup – Final Report (MSAR #14046)

Policy and Legislative Reports Released in Nov 2023 – January 2024 (continued)

- **Nursing Home, Assisted Living, and Palliative Care**

  SB0509/CH289, HB0702/Ch. 288 (2), 2023 - Health Insurance – Health Care Facilities – Nursing Homes – Acquisitions and Licensure - Nursing Home Acquisitions Report (MSAR #14920)

  SB 531/ HB 636 2022 Small Assisted Living Programs Study Recommendations Report

  HB0378/CH0301, 2022 - Maryland Health Care Commission – Palliative Care Services – Workgroup – Final Report (MSAR #14046)

- **Value-Based Care, Primary Care Transformation, and Technology Adoption**

  SB0834/Ch. 298, HB 1148/Ch. 297(2), 2022 - Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization - Evaluation Report (MSAR #14245)

  HB1127/CH0296, 2022 - Public Health - State Designated Exchange - Health Data Utility - Report (MSAR #14244)

  SB0734/CH0667 (2), 2022 - Maryland Health Care Commission - Primary Care Report and Workgroup (MSAR #14326)

  HB0670, 2022 -Maryland Health Care Commission - Study on Expansion of Interstate Telehealth - Report (MSAR #14050)

  HB0924/CH0445 (3), 2023 - State Board of Physicians – Registered Cardiovascular Invasive Specialists – Study Report (MSAR #12127)

Policy and Legislative Reports Released in Nov 2023 – January 2024 (continued)

- **Public Health**
  SB0786/CH0248, HB 812/CH0249 (4), 2023 – Health - Reproductive Health Services - Protected Information and Insurance Requirements Quarterly Report (MASAR #14912)

- SB0154/CH0297 (2), 2023 - Public Health – Mental Health Advance Directives – Awareness and Statewide Database – Final Report (MASAR #14660)

- Trauma
  The Maryland Trauma Physicians Services Fund Annual Report (2022-2023) (MASAR 7094)

- Trauma Report: SB0493/Chapter0342, HB0675/Chapter 341 - Commission to Study Trauma Center Funding in Maryland (forthcoming)

Notable Accomplishments

- November 2023 – MHCC approved a CON to establish an Obstetrics Program and build a Clinical Tower at Luminis Doctors Community Hospital -- $299 million
- January 2024 – MHCC approved a CON to relocate and replace UM Shore Regional Health at Easton -- $539 million
- December 1, 2023 – COMAR 10.24.01 Procedural Regulations became final – changes streamline the operations of the Health Planning and CON functions
- MHCC Workgroup recommended major reform of Maryland's approach to Nursing Home Acquisitions
- MHCC worked collaborative with Legislators, MDH, Maryland health systems, and technology vendors in implementing Health - Reproductive Health Services - Protected Information and Insurance Requirements (HB 812/SB 786)

Analyst's Questions on the MHCC's Budget Analysis

- Status of the Recommendations from the Commission on Trauma Funding
- Status on the Distribution of $9.5 Million to Trauma Centers under Stress
- Implementation of Reproductive Health Data Regulations as required under HB 812/SB 786

maryland
health services
cost review commission

HSCRC Overview & the AHEAD Model

Jon Kromm, Executive Director, HSCRC

HSCRC - Who We Are

The Maryland Health Services Cost Review Commission (HSCRC) is an independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high value healthcare.

HSCRC's vision is to enhance the quality of health care and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders.

The HSCRC establishes rates for all hospital services and helps develop the State's innovative efforts to transform the delivery system and achieve goals under the Maryland Health Model.

Structure of the HSCRC

Commission Structure

Maryland Statute mandates that the HSCRC have **7 Commissioners**, including a **Chair** and **Vice Chair**

- 4 Commissioners cannot have any connection with the management or policy of a hospital facility
- Commissioners have held positions as physicians, executives of long-term care facilities, policy scholars, and hospital executives

Staff Structure

- **HSCRC staff** develop policy ideas, engage with stakeholders, and make recommendations during monthly public Commission meetings
- In addition to its full-time staff, the HSCRC receives **analytic support from contractors and CRISP**, Maryland's Health Information Exchange (HIE)

Budget

The Commission's **appropriated budget** is $22.9 million in FY24; 100% of that is from hospital assessments

HSCRC Layout: Staff Organization

Operations
Xavier Colo

Executive Office
Jon Kromm

Engages state and federal stakeholders on Total Cost of Care (TCOC) Model goals

Counsel
Stan Lustman
Ari Elbaum

Medical Economics and Data Analytics

PDD: William Henderson

- Designs health care delivery and payment reform initiatives
- Leads work on care transformation efforts, CTIs, and Regional Partnerships
- Supports activities of other Centers with data analytics

Hospital Rate Revenue and Regulations

PDD: Jerry Schmith

- Approves and distributes GBR rate orders
- Monitors regulatory requirements and announcements to the hospital industry
- Maintains core responsibility of HSCRC to set rates for hospital-based services

Quality and Population-based Methodologies

PDD: Allan Pack

- Develops and monitors hospital quality improvement programs
- Creates innovative population health and health equity strategies
- Develops financial methodologies that further total cost of care accountability

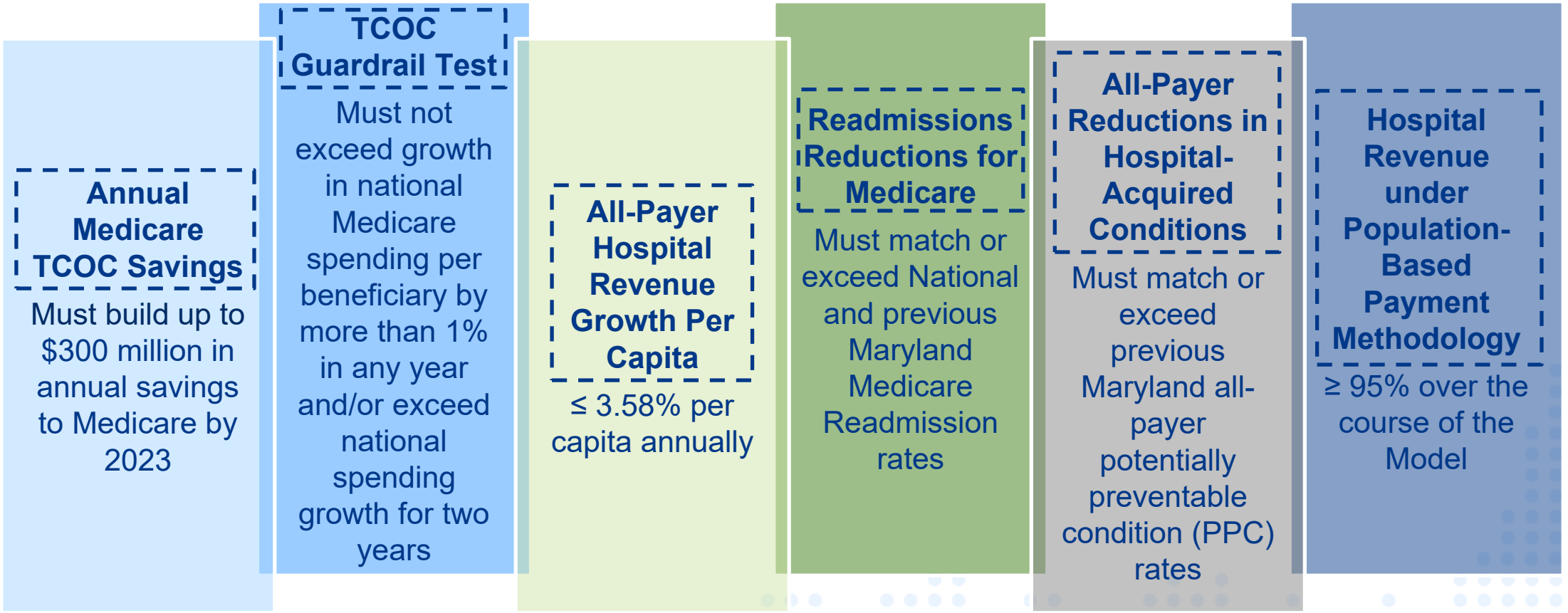
Data Management and Integrity

PDD: Claudine Williams

- Leads activities related to health data management and compliance
- Develops and implements audits of hospital compliance
- Provides expertise related to data privacy and compliance with state and federal laws and regulations

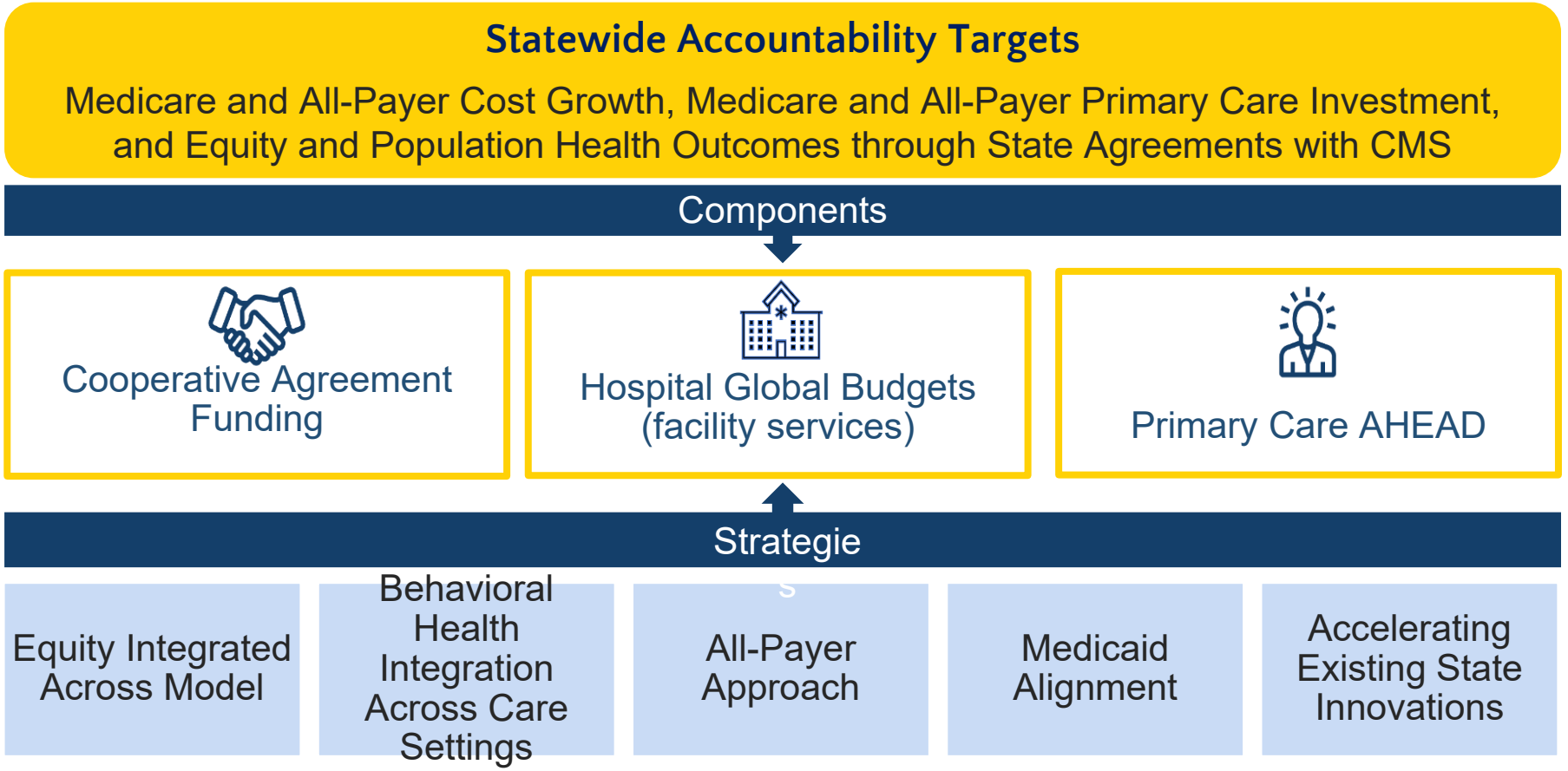
Total Cost of Care (TCOC) Model Targets

The TCOC Model requires the State of Maryland to meet the following targets:



AHEAD Overview

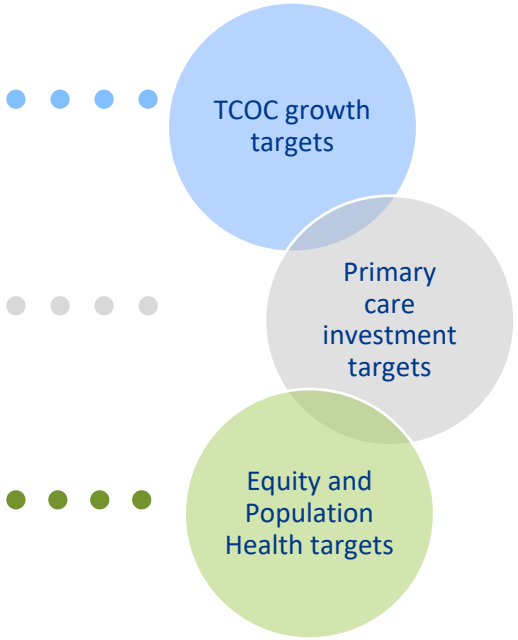
States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model



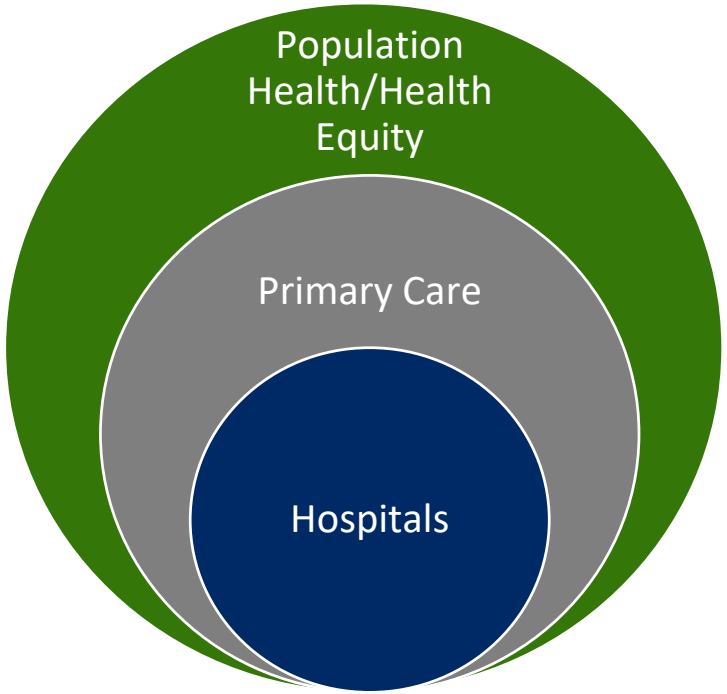
AHEAD Builds on the TCOC Model

The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is a state total cost of care (TCOC) model designed to:

- curb growth in healthcare cost spending;
- improve population health; and
- advance health equity by reducing disparities in health outcomes.



Similar to the Maryland Total Cost of Care (TCOC) Model, AHEAD focuses on three overlapping domains to achieve its goals.



The Maryland Health Model is important to our State

The Maryland Health Model improves the quality of life of Marylanders by:

- Controlling hospital cost growth while enhancing quality (care is provided in the right setting at the right time).
- Guaranteeing equitable funding of uncompensated care
- Stabilizing hospitals in order to ensure access to care in all parts of the state (ex. COVID-19)
- Equalizing hospital charges for all payers (including the uninsured), benefiting consumers, and employers
- Supporting population health and health equity initiatives

Losing the Model would deprive **Maryland communities of these benefits**.

Looking AHEAD

Maryland's NOFO response will seek to **leverage new federal resources** to plan for the future of the Maryland Health Model.

Applying in Cohort 1 will secure **Maryland's role as a leader** in competing for federal funding while providing it **time to negotiate** new model terms prior to 2026 implementation.

The State envisions that **policy development and decision-making** will begin in July 2024 (the beginning of the Pre-Implementation Period) and continue through the July 2025 execution of the State Agreement. There will be **opportunity for community input** throughout this time frame.

Thank you!

- Jon Kromm, Executive Director, HSCRC
  - Jon.Kromm@Maryland.gov

Legislative Liaison

- Deb Rivkin, Director of Government Affairs, HSCRC
  - Deborah.Rivkin@maryland.gov