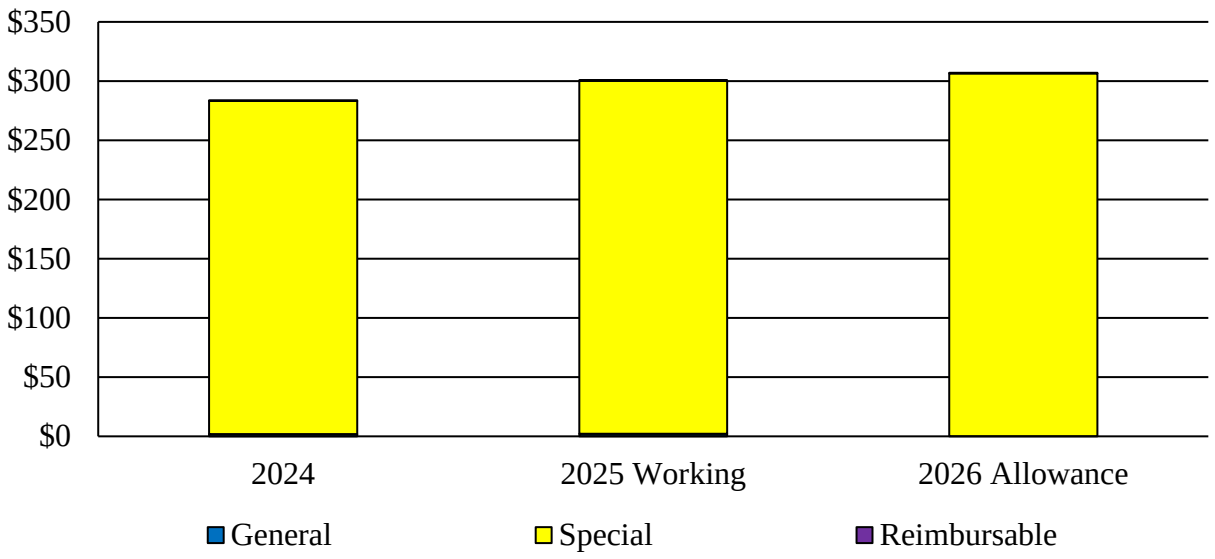
# M00R01
# Health Regulatory Commissions
### Maryland Department of Health

## Program Description

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

## *Operating Budget Summary*

**Fiscal 2026 Budget Increases $6.0 Million, or 2.0%, to $307.0 Million**
**($ in Millions)**




Note: The fiscal 2025 working appropriation accounts for deficiencies. The fiscal 2026 allowance accounts for contingent reductions. The fiscal 2025 impacts of statewide salary adjustments are centrally budgeted in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2026 impacts of the fiscal 2025 statewide salary adjustments appear in this agency's budget. The fiscal 2026 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget.

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## Fiscal 2025

### Implementation of Legislative Priorities

Section 21 of the fiscal 2025 Budget Bill (Chapter 716 of 2024) added a total of $1.5 million in general funds for two initiatives in the Health Regulatory Commissions. However, on July 17, 2024, the Board of Public Works approved two cost containment actions that reduced $375,000 of this funding, leaving $1.1 million remaining for the following one-time uses:

- $750,000 within MHCC to distribute a grant to the Maryland Patient Safety Center for a public awareness campaign related to health care workplace violence. This funding supports a contract to develop the campaign, including a website, digital advertisements across various social media and news platforms, and other advertisements across the State; and

- $375,000 within HSCRC to distribute funding to the Chesapeake Regional Information System for our Patients (CRISP) for services from DrFirst.

**MDH and the Health Regulatory Commissions should provide an update on how much of this funding has been spent and whether the full amount of general funds will be expended in fiscal 2025.**

### Proposed Deficiency

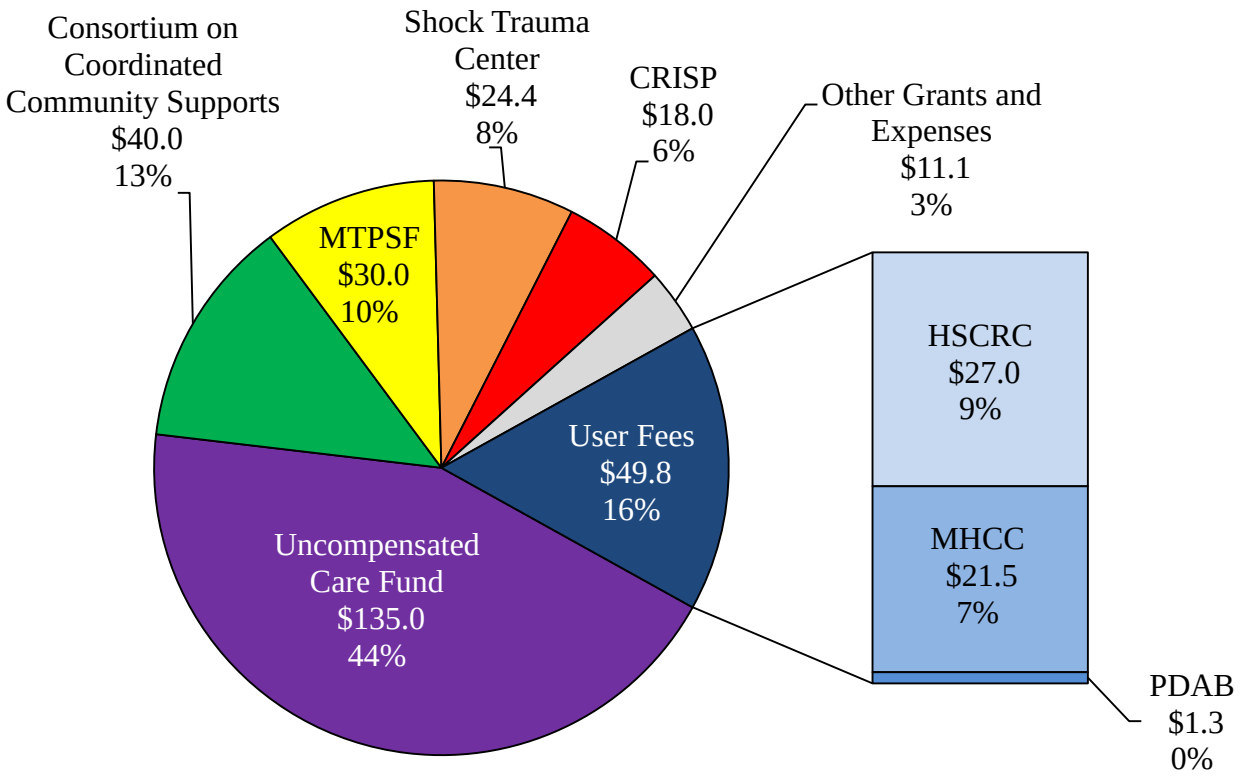
The fiscal 2026 allowance includes two proposed fiscal 2025 deficiencies, adding a net total of $21.5 million within MHCC for the R Adams Cowley Shock Trauma Center (Shock Trauma Center). One deficiency withdraws $3.7 million in special funds from the Maryland Emergency Medical System Operations Fund (MEMSOF) for the Shock Trauma Center operating grant. This is more than offset by the second deficiency, which adds $25.2 million in special funds to distribute revenue to the Shock Trauma Center from the increase in the vehicle registration surcharge, as required in Chapters 717, 718, and 719 of 2024. Further discussion of funding for the Shock Trauma Center and other trauma facilities can be found in Key Observation 3.

## Fiscal 2026 Overview of Agency Spending

The fiscal 2026 allowance for the Health Regulatory Commissions totals $307.0 million, almost entirely in special funds. As shown in **Exhibit 1**, the largest component of the budget is the Uncompensated Care Fund (UCF) at $135 million, accounting for 44% of total expenditures. HSCRC distributes the UCF to acute general hospitals that provide a disproportionate amount of uncompensated care through charity care or financial assistance and bad debt for regulated services that are not anticipated to be paid for out of pocket by the patient. Within MHCC, a combined $54.4 million (18%) supports trauma centers through the Maryland Trauma Physician Services Fund (MTPSF) and funding distributed to the Shock Trauma Center. The next largest share of the

budget (13%) is for the Consortium on Coordinated Community Supports (Consortium) within MCHRC, which receives $40 million in special funds from the Blueprint for Maryland's Future (Blueprint) Fund after accounting for a contingent reduction.

**Exhibit 1**
**Overview of Agency Spending**
**Fiscal 2026 Allowance**
**($ in Millions)**




**Total Expenditures = $307.0 Million**

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

Note: The fiscal 2026 allowance accounts for contingent reductions. The fiscal 2026 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

Source: Department of Budget and Management

Other special fund sources that support the fiscal 2026 allowance mainly consist of user fees assessed on health care payors, hospitals, nursing homes, and prescription drug product manufacturers, among other related health care practitioners and providers. Of the $49.8 million in operating expenses supported with user fees, HSCRC accounts for more than half at $27.0 million. Through June 30, 2025, HSCRC may charge user fees up to a cap based on the greater of (1) 0.1% of budgeted hospital revenue or (2) the largest cap amount determined during the immediately preceding five fiscal years. After June 30, 2025, total user fees assessed by HSCRC annually may not exceed the average of the amounts determined for fiscal 2023 to 2025. HSCRC indicated that this cap would not be sufficient to cover projected fiscal 2026 expenditures. SB 229/HB 54 of 2025 are departmental bills that would repeal the termination of the formula to determine the cap on user fees, which would increase HSCRC user fee revenue by an estimated $1.6 million to address the shortfall in fiscal 2026. **The fiscal 2026 allowance includes this $1.6 million in additional user fees; therefore, it should be noted that failure to pass SB 229/HB 54 would result in a shortfall within the HSCRC budget.**

## Proposed Budget Change

As shown in **Exhibit 2**, the fiscal 2026 allowance increases by $6.0 million compared to the fiscal 2025 working appropriation, after accounting for proposed deficiency appropriations for the Shock Trauma Center and contingent reductions of Consortium grants and the grant for the Maryland Patient Safety Center. Additional spending under the MTPSF drives this overall budget growth due to an increase in the distribution of vehicle registration surcharge revenue to the fund as required in Chapters 717, 718, and 719. Other increases support two HSCRC contracts, specifically $2.0 million for a vendor to assist with full hospital rate reviews and $1.6 million for Mathematica to assist with development of the Advancing All-payer Health Equity Approaches and Development (AHEAD) model (further discussed in Key Observation 2). A decrease of $14.7 million for Health Equity Resource Community grants partially offsets this spending growth.

**Exhibit 2**
**Proposed Budget**
**Maryland Department of Health – Health Regulatory Commissions**
**($ in Thousands)**

| How Much It Grows: | General Fund | Special Fund | Reimb. Fund | Total |
|---|---|---|---|---|
| Fiscal 2024 Actual | $2,000 | $281,106 | $560 | $283,666 |
| Fiscal 2025 Working Appropriation | 2,125 | 298,230 | 560 | 300,915 |
| Fiscal 2026 Allowance | 0 | 306,397 | 560 | 306,957 |
| Fiscal 2025-2026 Amount Change | -$2,125 | $8,167 | $0 | $6,042 |
| Fiscal 2025-2026 Percent Change | -100.0% | 2.7% | | 2.0% |

| **Where It Goes:** | **Change** |
|---|---|
| **Personnel Expenses** | |
| Salary increases and associated fringe benefits, including fiscal 2025 COLA and increments | $1,889 |
| Reclassification expenses for contractual conversions in fiscal 2025 that are realigned to salaries and other fringe benefits in fiscal 2026 | -99 |
| Employee and retiree health insurance | -290 |
| Turnover adjustment (increase from 4.32% to 6.24%) | -404 |
| Other fringe benefit adjustments | -27 |
| **Maryland Health Care Commission** | |
| Additional revenue from the vehicle registration surcharge for the Maryland Trauma Physician Services Fund, in accordance with Chapters 717, 718, and 719 of 2024 | 17,000 |
| Database development costs increase due to $631,444 in special fund spending not yet accounted for in fiscal 2025 | 663 |
| Consulting and project management services for the All-payer Claims Database | 297 |
| Contract for the Primary Care Workgroup required by Chapter 667 of 2022 and to expand data analysis in coordination with the AHEAD model | 250 |
| Development costs for a new Maryland Compare website for healthcare spending in Maryland and other states using the All-payer Claims Database | -100 |
| Maryland Patient Safety Center grant, due to a legislative addition in fiscal 2025 and contingent general fund reduction partially offset by special funds budgeted in fiscal 2026 | -750 |
| Funding for the R Adams Cowley Shock Trauma Center, including deficiencies to remove MEMSOF support and add vehicle registration surcharge revenue in accordance with Chapters 717, 718, and 719 | -800 |
| **Health Services Cost Review Commission** | |
| Contract to assist with financial analyses required as part of full hospital rate review and application determinations and to support development of a framework for identifying latent demand for acute hospital care to address access | 2,000 |
| Contract with Mathematica to assist in developing the AHEAD model and Statewide Health Equity Plan, including support with data analytics and monitoring | 1,557 |
| Maryland Department of Health indirect costs | 404 |
| Contract for value- based design, specifically for Care Transformation Initiatives and quality improvement | 335 |
| One-time legislative addition for DrFirst services distributed through CRISP | -375 |
| Design and implementation contracts related to annual filing revision that completed most work or payments in fiscal 2025 | -695 |

| | |
|---|---|
| **Other Changes** | |
| Health Equity Resource Community grants (annual mandated appropriation ends in fiscal 2025) | -14,703 |
| Other operating expenses | -108 |
| **Total** | **$6,042** |

AHEAD: Advancing All-payer Health Equity Approaches and Development
COLA: cost-of-living adjustments
CRISP: Chesapeake Regional Information System for our Patients
MEMSOF: Maryland Emergency Medical System Operations Fund

Note: Numbers may not sum to total due to rounding. The fiscal 2025 working appropriation accounts for deficiencies. The fiscal 2026 allowance accounts for contingent reductions. The fiscal 2025 impacts of statewide salary adjustments are centrally budgeted in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2026 impacts of the fiscal 2025 statewide salary adjustments appear in this agency's budget. The fiscal 2026 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget.

## Contingent Reduction of the Maryland Patient Safety Center Grant

Chapters 529 and 530 of 2022 required MHCC to designate a Patient Safety Center for the State by December 31, 2025, established the Patient Safety Center Fund to subsidize a portion of the costs of the center, and established a $1.0 million annual mandated appropriation for the fund beginning in fiscal 2024. MHCC administers the fund and may provide an annual grant from the fund to the designated center. Patient Safety Center activities include:

- developing, coordinating, and implementing patient safety initiatives across the State;
- being a model for patient safety innovation and implementation;
- convening health care providers, patients, and families to improve the quality of care, reduce preventable and avoidable harm, and provide safe and equitable health care for State citizens; and
- sharing information related to best practices among providers and patients in the State.

A provision in the Budget Reconciliation and Financing Act (BRFA) of 2025 would repeal the requirements that the Governor provide $1.0 million annually for the Maryland Patient Safety Center Fund beginning in fiscal 2026. Instead, the provision authorizes the Governor to include at least $1.0 million in the annual budget for the fund. The fiscal 2026 budget as introduced includes a $1.0 million general fund reduction contingent on the enactment of legislation eliminating the mandate. However, the fiscal 2026 budget includes the $1.0 million special fund appropriation from the Maryland Patient Safety Center Fund and would not reduce this funding contingent on enactment of the provision in the BRFA.

## *Personnel Data*

| | FY 24 Actual | FY 25 Working | FY 26 Allowance | FY 25-26 Change |
|---|---|---|---|---|
| Regular Positions | 117.90 | 121.90 | 121.90 | 0.00 |
| Contractual FTEs | 7.53 | 7.76 | 8.28 | 0.52 |
| **Total Personnel** | **125.43** | **129.66** | **130.18** | **0.52** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 7.61 | 6.24% |
| Positions and Percentage Vacant as of 12/31/24 | 12.00 | 9.84% |
| Vacancies Above Turnover | 4.39 | |

- As of December 31, 2024, the Health Regulatory Commissions reported 12 vacancies, including 5 positions in MHCC, 4 positions in MCHRC, and 3 positions in HSCRC. MHCC and MCHRC each reported 1 long-term vacant position that had been unfilled for more than a year, and MCHRC reported 3 vacancies for program manager positions allocated in fiscal 2024 to support the Consortium that have never been filled.

- Within MHCC, the executive director position is vacant, and the director of Health Information Technology and Innovation Care Delivery is filling the role in an acting capacity while the commission conducts a search for a new executive director.

# *Key Observations*

## 1. BRFA Provision Proposes Ongoing Reduction to Consortium Grants

Chapter 36 of 2021 (Blueprint – Implementation) established the Consortium within MCHRC to:

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

The Consortium is also tasked with implementing a grant program for coordinated community supports partnerships and developing a model for expanding available behavioral health services and support to all students through the maximization of public funding through Medicaid, among other financing efforts. Special funds from the Blueprint Fund support the Coordinated Community Supports Partnership Fund. Chapter 36 required the Governor to appropriate increasing minimum funding levels for the Consortium's grant program beginning in fiscal 2022. Due to the timing of the Governor's veto and legislature's veto override for Chapter 36, the fiscal 2022 budget did not provide funding for the Consortium. Chapter 713 of 2022 further increased mandated grant funding each year. As a result, the mandated funding levels are $110 million in fiscal 2025 and $130 million beginning in fiscal 2026. Considering the delayed timing of grant distribution, $70 million was reduced in fiscal 2025, providing a total appropriation of $40 million for the Consortium grants.

A provision in the BRFA of 2025 would reduce the amount that the Governor must provide annually for the Coordinated Community Supports Partnership Fund to $40 million beginning in fiscal 2025. The fiscal 2026 budget as introduced includes a reduction of $90 million in special funds from the Blueprint Fund contingent on the enactment of legislation that level funds the mandate for the Consortium to the fiscal 2025 appropriation. **Exhibit 3** shows annual mandated appropriations for the Consortium under Chapter 36 as enacted, under current law, and under the BRFA proposal. Considering that current projections indicate general funds will be needed to support Blueprint costs beginning in fiscal 2028, the cumulative Blueprint Fund savings from the Consortium grants will result in general fund savings totaling $270 million in fiscal 2026 through 2028 and $90 million annually in fiscal 2029 and subsequent years.

**Exhibit 3**
**Consortium on Coordinated Community Supports Budget**
**Fiscal 2022-2026**
**($ in Millions)**

| | 2022 | 2023 | 2024 | 2025 | 2026 and On |
|---|---|---|---|---|---|
| Chapter 36 of 2021 as Enacted | $25 | $50 | $75 | $100 | $125 |
| Chapter 713 of 2022 (Current Law) | | | 85 | 110 | 130 |
| Proposed BRFA of 2025 | | | | | 40 |
| **Actual Spending/Appropriation** | **$0** | **$50** | **$70** | **$40** | **$40** |

BRFA: Budget Reconciliation and Financing Act

Note: Fiscal 2023 and 2024 actual expenditures include $25 million that was accrued and could be spent in fiscal 2025. The fiscal 2026 allowance includes a contingent special fund reduction of $90 million.

Source: Department of Budget and Management; Department of Legislative Services

## Consortium Funds Used to Reimburse Medicaid

Ongoing allowable uses of the Consortium funding include:

- providing reimbursement to support the work of the Consortium, under a memorandum of understanding, to the National Center for School Mental Health and other technical assistance providers;
- providing grants to coordinated community supports partnerships to deliver services and supports to meet students' holistic behavioral health needs; and
- paying associated administrative costs.

The BRFA of 2024 expands the authorized uses of Blueprint funds for the Consortium in fiscal 2025 to include not only providing grants for school-based behavioral health services but also reimbursing MDH for school-based behavioral health services provided on a fee-for-service (FFS) basis through a Medicaid waiver. Language in the fiscal 2025 Budget Bill specifies that no more than $12 million in special funds budgeted for the Consortium may be used to reimburse MDH for this purpose. By using Consortium funds to reimburse MDH for general funds spent on eligible Medicaid-covered services, this State spending would receive matching federal fund rates of 50% under Medicaid and 65% under the Maryland Children's Health Program (MCHP).

Medicaid reimbursement for school-based services was previously limited to only services required by a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and services provided by community-based providers that directly bill Medicaid. Beginning on January 1, 2025, Medicaid reimbursement expanded to school-based services provided by school psychologists and social workers to students without IEPs and IFSPs who are eligible for Medicaid or MCHP. For six months of expanded school-based services provided in fiscal 2025, MDH estimated that it would spend a total of $17.0 million, including approximately $8 million in State funds that would be supported with Consortium funding. In addition to the $40 million Blueprint Fund appropriation in fiscal 2025, MCHRC reported that $25 million in prior year funding was accrued at fiscal 2024 closeout for future use. As a result, $57 million would be available in fiscal 2025 for Consortium grants and other allowable uses after accounting for the projected $8 million reimbursement for MDH.

## Consortium Grants

In August 2023, the Consortium issued its first request for proposals (RFP) focused on grants to service providers statewide to expand access to high quality behavioral health or wraparound services. The RFP described the grants as being able to support each tier of the multi-tiered system of supports: (1) universal promotion or prevention; (2) early intervention; and (3) treatment. On February 8, 2024, the Consortium announced 129 grant awards totaling $111.1 million with a grant term from March 2024 to June 2025. This amount included prior year special funds that were allocated to MCHRC and accrued to fiscal 2024.

In response to committee narrative in the 2024 *Joint Chairmen's Report* (JCR) requesting a report on Consortium grants, MCHRC submitted a report on January 11, 2025. The commission indicated in the report that a grant award of $845,000 for a program in Prince George's County was on hold, and another grant award of $920,000 for a program in Worcester County was not moving forward. Of the $109.3 million in active awards, MCHRC had distributed $44 million through July 2024 for the first payment and expected to distribute a total of $89 million through February 2025. As shown in **Exhibit 4**, at least one grantee in all 24 local jurisdictions received a Consortium service grant, and the awards are expected to serve 143,900 students. **MCHRC should provide an update on the amount of grant funding distributed, including an estimate for any remaining funds that would be carried over at fiscal 2025 closeout for future use. MCHRC should also comment on whether the estimated students served are children who would not otherwise have received services or would have simply been served through a different funding mechanism.**

**The Department of Legislative Services (DLS) questions the efficiency of the Consortium grant process, as there are vast differences in the cost per student served across jurisdictions (excluding the hub pilot funding), with providers in Allegany County spending $144 per student served compared to $428 in Baltimore City, $1,271 in Anne Arundel County and $2,637 in Worcester County.**

**Exhibit 4**
## Community Supports Service and Hub Grants by Jurisdiction
**Grant Term of March 2024 to June 2025**
**($ in Thousands)**

| | Total Services Grants | Total Services Funding | Estimated Students Served | Total Hub Pilot Funding | Total Consortium Funding |
|---|---|---|---|---|---|
| Allegany County | 1 | $825 | 5,727 | $410 | $1,235 |
| Anne Arundel County | 8 | $11,115 | 8,744 | $520 | $11,635 |
| Baltimore City | 11 | $12,010 | 28,046 | $480 | $12,490 |
| Baltimore County | 8 | $8,870 | 6,305 | $585 | $9,455 |
| Calvert County | 7 | $2,900 | 2,518 | | $2,900 |
| Caroline County | 2 | $655 | 4,712 | | $655 |
| Carroll County | 2 | $1,630 | 813 | | $1,630 |
| Cecil County | 5 | $2,470 | 7,850 | | $2,470 |
| Charles County | 4 | $3,965 | 5,108 | | $3,965 |
| Dorchester County | 5 | $1,465 | 2,073 | $410 | $1,875 |
| Frederick County | 12 | $7,640 | 6,566 | | $7,640 |
| Garrett County | 2 | $1,305 | 700 | * | $1,305 |
| Harford County | 7 | $4,535 | 5,611 | $410 | $4,945 |
| Howard County | 5 | $4,960 | 3,420 | $550 | $5,510 |
| Kent County | 2 | $975 | 1,873 | * | $975 |
| Montgomery County | 8 | $8,395 | 3,255 | $505 | $8,900 |
| Prince George's County | 18 | $24,070 | 39,020 | | $24,070 |
| Queen Anne's County | 4 | $1,405 | 5,267 | * | $1,405 |
| Somerset County | 2 | $945 | 1,799 | * | $945 |
| St. Mary's County | 2 | $2,020 | 680 | $300 | $2,320 |
| Talbot County | 1 | $790 | 250 | * | $790 |
| Washington County | 6 | $4,105 | 2,420 | | $4,105 |
| Wicomico County | 2 | $965 | 650 | | $965 |
| Worcester County | 3 | $1,300 | 493 | $575 | $1,875 |
| **Total** | **127** | **$109,315** | **143,900** | **$4,745** | **$114,060** |

*Denotes local jurisdictions served by hub pilot grantees that operate in multiple counties. The awards for these grants are shown in Allegany, Dorchester, and Worcester counties.

Note: One grant of $845,000 for a program in Prince George's County is currently on hold and not included in this exhibit.

Source: Maryland Community Health Resources Commission

In October 2023, the Consortium released a second RFP for grants to hub pilot programs that would coordinate service providers and schools. Eventually the Consortium's goal is to establish community supports partnerships with statewide hubs that (1) coordinate service providers; (2) act as a fiduciary by managing MCHRC grants and awarding grants to service providers as subgrantees; and (3) collect and report data. The RFP listed local behavioral health authorities and local management boards as the only two types of organizations eligible to apply for this funding and outlined allowable uses as mainly operating expenses. On March 19, 2024, the Consortium awarded 10 hub pilot grants totaling $4.7 million, with a grant term of April 2024 to June 2025.

The Consortium published an RFP in December 2024 for a second round of grants, with applications due by February 4, 2025. The RFP described three funding tracks to support (1) community supports partnerships; (2) future partnership hub capacity; and (3) grants to service providers. Additionally, grant funding would be available to applicants that received Consortium funding through the first round and new applicants. Award decisions are expected in April or May 2025, and the grant period would be July 1, 2025, through June 30, 2026.

## 2. HSCRC Prepares to Launch AHEAD Model in Calendar 2026

On November 1, 2024, Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) signed an agreement for the AHEAD model, which will take effect on January 1, 2026, and continue through calendar 2034. The AHEAD model builds on the current Total Cost of Care (TCOC) model, which began in January 2019, and the prior All-payer Model contract that was in effect from calendar 2014 through 2018. The AHEAD model is designed to (1) continue the State's all-payer hospital rate setting system; (2) control growth in healthcare costs; (3) improve population health; and (4) improve health equity by reducing disparities in care outcomes across all payers. As part of the agreement, Maryland will aim to meet negotiated targets for Medicare and all-payer total cost growth and primary care investments.

Under the TCOC model, Maryland committed to reaching an annual Medicare expenditure savings target of $300 million through the end of calendar 2023 (program year five) in Medicare Part A (*e.g.*, hospital services) and Part B (*e.g.*, doctor office visits, preventive services, and other nonhospital services). The State met or exceeded each of the goals evaluated by CMMI for TCOC in calendar 2023. **Appendix 2** shows the State's performance on each of the goals in calendar 2021 through 2023.

### Maryland Primary Care Program

A component of the TCOC model that continues under the AHEAD model is the Maryland Primary Care Program (MDPCP), a voluntary program that offers incentives for primary care providers to deliver advanced primary care services with the goal of improving individual and population health outcomes prioritized under the model. MDPCP incentives are fully supported with federal funds and are provided through care management fees offering additional per Medicare beneficiary per month payment for care management and team-based care,

performance-based incentive payments, and comprehensive primary care payments for certain eligible providers that transition to a more stable funding stream. Payments made through the MDPCP count toward TCOC Medicare spending. Beginning in calendar 2022, CMMI added Health Equity Advancement Resource and Transformation Payment as a new component to care management fees to address beneficiaries' social needs using existing fees. Under the AHEAD model, the MDPCP is extended through at least calendar 2028, when the program will be evaluated to determine if it will continue through calendar 2034.

As of January 2024, 511 primary care practices located across all 24 Maryland jurisdictions participated in the MDPCP. Among participating practices, the program attributes Medicare beneficiaries to practices that provide a plurality of the beneficiaries' health services. Practices assigned to a panel of beneficiaries are tasked with providing advanced primary care, which uses a model similar to a patient-centered medical home. At the start of calendar 2024, approximately 50% of eligible Medicare beneficiaries in Maryland (362,000) were attributed to a provider under the MDPCP.

Given the role of the MDPCP in TCOC, the budget committees have annually requested program evaluations, with particular focus on whether the cost of incentive payments have been offset by savings elsewhere in the State's health care system. In response to committee narrative in the 2023 JCR, HSCRC found that incentive payments under the program caused a net increase in costs every year from calendar 2019 through 2022. Despite the MDPCP consistently reporting some savings by reducing inpatient utilization, the increase in care management fees outpaced the dollar impact of any savings resulting from the program.

The Hilltop Institute at the University of Maryland Baltimore County conducted the MDPCP cost effectiveness evaluation requested in the 2024 JCR and used a different methodology. Specifically, the Hilltop Institute used a difference-in-differences approach for FFS Medicare beneficiaries attributed to MDPCP participating practices compared to FFS Medicare beneficiaries in Maryland. From this study, Hilltop found that MDPCP attributed beneficiaries experienced an average reduction in total Medicare FFS spending of $119.60 per person per quarter prior to accounting for program costs. **Exhibit 5** shows the scaled-up impact estimates to assess cost effectiveness of health care savings for all MDPCP participants compared to total program costs. The Hilltop Institute found that the aggregate impact from calendar 2019 to 2022 was budget neutral or suggested cost savings of $161.9 million that could rise to $342.2 million for the lower bound of the 95% confidence interval, though the upper bound would still result in slight net cost of $18.3 million.

**Exhibit 5**
**MDPCP Cost Effectiveness, Relative to Calendar 2018**
**Calendar 2019-2022**
**($ in Millions)**

| | Aggregate Effect | 95% Confidence Interval Lower Bound | Upper Bound |
|---|---|---|---|
| Health Care Expenditures | -$672.4 | -$852.7 | -$492.2 |
| MDPCP Fees and Overall Program Cost | 510.5 | 510.5 | 510.5 |
| **Net Impact on Costs** | **-$161.9** | **-$342.2** | **$18.3** |

MDPCP: Maryland Primary Care Program

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

## New Primary Care Initiatives under the AHEAD Model

MDH reported that the MDPCP program management office will be renamed the Office of Advanced Primary Care and will coordinate three initiatives under the AHEAD model: (1) the existing MDPCP; (2) the new Medicaid Advanced Primary Care Program; and (3) a new national Medicare program operated in partnership with the Centers for Medicare and Medicaid Services (CMS) to work with primary care practices not participating in MDPCP. Administrative costs for the MDPCP Program Management Office are budgeted in MDH, but HSCRC and MHCC each annually fund MDPCP personnel costs with $600,000 in special funds supported with user fees. The fiscal 2026 budget plan realigns the MDPCP Program Management Office from the Office of the Secretary to the Medical Care Programs Administration (MCPA). MDH has transferred the MDPCP Program Management Office multiple times between the Office of the Secretary and MCPA.

The new Medicaid Advanced Primary Care program will begin implementation on July 1, 2025, and will be supported by a new Medicaid Primary Care Program Fund established through the proposed BRFA of 2025. The new special fund will be supported with $30 million from hospital rates assessed by HSCRC that will be transferred to MCPA, with $16 million planned in fiscal 2026 and the remaining $14 million to be transferred in fiscal 2027. The Advanced Primary Care program will operate similarly to the MDPCP. Through the new program, MDH will provide care management fees of $2 per member per month for Medicaid managed care program participants assigned to eligible primary care practices. The department will also administer a quality incentive program for the calendar 2026 performance year. Aside from these initiatives, MDH budgeted a rate enhancement for physician evaluation and management fees in fiscal 2026 to increase the rates from 98% to over 100% of Medicare rates in coordination with efforts under the AHEAD model to increase funding for primary care services under Medicaid.

**MDH should comment on whether managed care organizations will retain all savings resulting from advanced primary care or if savings will be shared with the State.**

**DLS recommends requesting that MDH and HSCRC submit an evaluation of the MDPCP and a status update related to the new Medicaid Advanced Primary Care Program and other primary care initiatives. Considering the realignment of the MDPCP Program Management Office to MCPA, this recommendation appears in the analysis for M00Q01 – MCPA.**

## New Statewide Health Equity and Population Health Initiatives

A key component of the AHEAD model is that participating states must develop a statewide health equity plan. CMS provided a template for the plan in which states must set five core domains within their plan, including at least one behavioral health-specific equity goal. States must also select one optional domain from the following choices: maternal health outcomes; prevention measures; or social drivers of health. The health equity plan must include strategies to increase safety net provider recruitment and use social risk adjustment of provider payments to address the needs of vulnerable populations. The plan should seek to promote health-related social needs screenings among hospitals and primary care providers so that patients can be connected to necessary community resources. Participating hospitals will also need to develop their own health equity plans in alignment with the state's health equity priorities. By July 2025, HSCRC and MDH must provide the state health equity plan to CMS. The Maryland Commission on Health Equity will develop and monitor the plan as required by Chapter 787 of 2024.

The AHEAD model also continues and establishes various efforts to improve population health in Maryland. HB 1104 of 2025 would establish the Population Health Improvement Fund as a special fund to invest in efforts to support statewide population health targets. In December 2024, HSCRC approved a one-time broad-based uniform hospital assessment that will yield approximately $25 million in revenue for the fund. This amount will be collected through hospital rates in fiscal 2026, contingent on enactment of HB 1104. The fiscal 2026 allowance as introduced does not account for any special fund expenditures from this fund.

## Federal Funding for AHEAD Model Implementation

In preparation for the AHEAD model, CMS awarded $4.4 million in federal funds through a cooperative agreement with MDH. The fiscal 2026 budget plan does not reflect this funding in fiscal 2025 or 2026, but the department plans to account for the federal funds in the Office of the Secretary by realigning funding throughout the department, processing a budget amendment, or including the funds in a supplemental budget. MDH outlined the following uses of the funds:

- $1.4 million for a partnership with the State's health information exchange (CRISP);
- $1.3 million for regional population health hub grants;

- $1.2 million for personnel and other operating costs;
- $320,000 for stakeholder engagement;
- $170,000 for health-related social needs strategic plan development; and
- $110,000 for learning collaboratives.

## 3. Recent Legislative Changes to Trauma Center Funding

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

Chapters 341 and 342 of 2023 established the Commission to Study Trauma Center Funding in Maryland to assess the adequacy of trauma center funding across the State for operating, capital, and workforce costs and identify opportunities to improve funding mechanisms. Chapters 717, 718, and 719 implemented some of the commission's recommendations and adjusted State funding for trauma centers by:

- increasing the annual vehicle registration surcharge and requiring an increase in the distribution to the MTPSF by $4 to $6.50 and to the Shock Trauma Center by $23 to $40;
- increasing the maximum fines for specified drunk and drugged driving offenses, with at least 20% of the fines collected going to the MTPSF;
- requiring MHCC to award an annual grant from the MTPSF of up to $1.8 million to Level I pediatric trauma centers ($900,000 to Children's National Medical Center and $900,000 to Johns Hopkins Children's Center);
- altering MTPSF reimbursement methodology and parameters; and

- increasing flexibility in administration of the MTPSF by allowing MHCC to change:
    - in consultation with HSCRC, the percentage of the reasonable compensation equivalent paid to trauma hospitals under specified circumstances and with certain notice;
    - in consultation with HSCRC, the number of allowable hours of trauma on-call each year with specified notice; and
    - the percentage paid of the reasonable compensation equivalent for on-call hours no more than once each year.

As a result of the increase in revenues distributed to the MTPSF, the MTPSF special fund appropriation increases from $13 million in the fiscal 2025 working appropriation to $30 million in the fiscal 2026 allowance. The MHCC budget also includes funding distributed to the Shock Trauma Center, and a proposed deficiency appropriation recognizes the additional revenue from the vehicle registration surcharge by adding $25.2 million in special funds in fiscal 2025. Another fiscal 2025 deficiency withdraws the $3.7 million MEMSOF appropriation for the center. MEMSOF support for the center is discontinued in fiscal 2026 as well as the allowance provides only $24.4 million in surcharge revenue for the Shock Trauma Center. There has been conflicting information provided on the estimated revenue to be distributed to the Shock Trauma Center as the Highlights volume of the Governor's Fiscal 2026 Budget Books lists $38.6 million in fiscal 2025 and $39.7 million in fiscal 2026. MDH reported that the Department of Budget and Management (DBM) and the Shock Trauma Center are working to reconcile the amount of revenue to be distributed. **DBM and MHCC should clarify the correct amount of vehicle registration surcharge revenues that should be distributed to the Shock Trauma Center in fiscal 2025 and 2026 and explain how the funding will be added to the budget.**

In response to the language requiring a report evaluating the findings and recommendations from the Commission to Study Trauma Center Funding in Maryland, HSCRC and MHCC submitted a report to the budget committees on December 16, 2024. The report provided responses and updates on the following four information requests related to commission recommendations.

- ***The Difference in Incremental Trauma Expenses and Standby Payments Incorporated in Regulated Rates versus Actual Costs Subject to HSCRC Rate Regulation:*** HSCRC analyzed its approach for accounting for trauma costs when setting GBRs and reported significant variation of trauma cost growth across hospitals from fiscal 2014 to 2023. According to HSCRC, this could be due to different rates of increase for trauma expenses or data errors. Additionally, actual trauma costs in fiscal 2023 were $44 million higher than what was been included in HSCRC rates (0.75% of regulated revenue at the hospitals), driven by costs reported at three hospitals. Without those hospitals, actual costs are higher by $6.7 million (0.29% of regulated revenue).

- ***Efforts to Ensure All Regulated Costs for the Four Primary Specialties Are Accounted for in Regulated Hospital Rates and Plans to Consider Covering Additional Incremental Costs:*** HSCRC reported that total regulated margins across all trauma centers were positive before the implementation of GBRs and increased from fiscal 2014 to 2023 with the implementation of GBRs. As a result, HSCRC indicated that trauma centers were not underfunded during this time and that hospitals can submit a full rate review request to HSCRC to assess rate adequacy. HSCRC also found that the gap between actual trauma center spending and regulated rates without the outlier hospitals was small enough that it believes current rates still account for costs at these hospitals overall.

- ***Plans to Audit Annual Supplemental Schedules of Regulated Trauma Costs Provided to HSCRC by Trauma Hospitals:*** Considering the findings of this report, specifically the high-cost growth at the three hospitals, HSCRC indicated that its audit and integrity team will conduct two audits that will focus on trauma costs overall and reported by those hospitals in addition to annual audits.

- ***Status of Aligning Data Systems with MHCC and MIEMSS:*** HSCRC and MHCC use encryption resources from CRISP for patient data to be able to link all-payer claims data with HSCRC's hospital discharge/case-mix data. The Trauma Registry administered by MIEMSS is not currently linked to the other two systems, and CRISP found that its encrypted patient identifier data would not be able to match individuals in MIEMSS's registry.

**MHCC and HSCRC should provide a timeline for conducting the two audits of trauma center costs and linking the MIEMSS trauma registry, the HSCRC hospital data set, and the MHCC All-payer Claims Database.**

**DLS determined the report to be in compliance with the budget bill language and recommends the release of $125,000 in special funds for HSCRC and will process a letter to this effect if no objections are raised during the budget hearings.**

## 4. PDAB Cost Review Process and Upper Payment Limit Policies

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

- by or on behalf of a unit of State or local government;

- through a health benefit plan on behalf of a unit of State or local government; or

- by the Medicaid program.

PDAB must report to the General Assembly by December 1, 2026, on (1) the legality, obstacles, and benefits of setting UPLs on all purchases and payor reimbursements of prescription drugs in the State and (2) recommendations on whether the General Assembly should expand the authority of the board to set UPLs to all purchases and payor reimbursements of prescription drugs in the State. Should the General Assembly wish to extend PDAB's authority to set UPLs for all prescription drugs, additional statutory authority is needed.

Under the cost review study process, PDAB can identify prescription drugs to refer to the prescription drug affordability stakeholder council for cost review. Eligible prescription drugs for review must be selected at an open meeting and meet the following regulatory requirements:

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

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

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

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

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

After identifying such drugs, PDAB must determine whether to conduct a cost review by seeking Stakeholder Council input and considering the average cost share of the drug. If PDAB conducts a cost review, it must determine whether use of a prescription drug has led or will lead to affordability challenges for the State health care system or high out-of-pocket costs for patients by considering specified factors.

In March 2024, PDAB identified eight prescription drugs to consider for cost review and referred them to the Stakeholder Council. PDAB narrowed the list to six drugs for immediate cost review in May 2024 (Dupixent, Farxiga, Jardiance, Ozempic, Skyrizi, and Trulicity) and chose not to study two (Biktarvy and Vyvanse). PDAB has begun the process of collecting data for the cost reviews. Based on this data, PDAB may make a preliminary determination as to whether a prescription drug may lead to affordability challenges to the State health care system or high out-of-pocket costs for patients. PDAB completed a supply chain report in September 2024, which in part found that setting UPLs is in the best interest of the State.

On September 12, 2024, PDAB submitted an *Upper Payment Limit Action Plan* to LPC for approval. The plan establishes criteria and a policy review process that PDAB must apply when determining whether to set a UPL and the amount of the UPL. On October 22, 2024, LPC approved the plan. In the 2024 annual report, PDAB reported that it is still in the process of updating regulations to match the policies and procedures in the action plan.

As outlined in the *Upper Payment Limit Action Plan*, the policy review process includes an information gathering phase, a preliminary determination of whether to establish a UPL or a non-UPL policy, and a final policy action on (1) the cost review, by making a definitive determination as to whether or not a prescription drug has or will create an affordability challenge and (2) the policy review, by adopting a resolution for a non-UPL policy, adopting a proposed regulation establishing a UPL (which includes the UPL amount, the government entities to which the UPL applies, and a prospective effective date), or both. If PDAB sets a UPL, the plan identifies methodologies that may be used to determine the value. The plan also provides opportunities for public input, requires PDAB to work with eligible government entities to develop the best method for implementing a UPL for the entity, and requires PDAB to monitor the availability of a prescription drug for which it set a UPL and suspend or modify it if a shortage is identified.

# *Operating Budget Recommended Actions*

1. Concur with Governor's allowance.

# *Updates*

## 1. Maryland Trauma Physician Services Fund

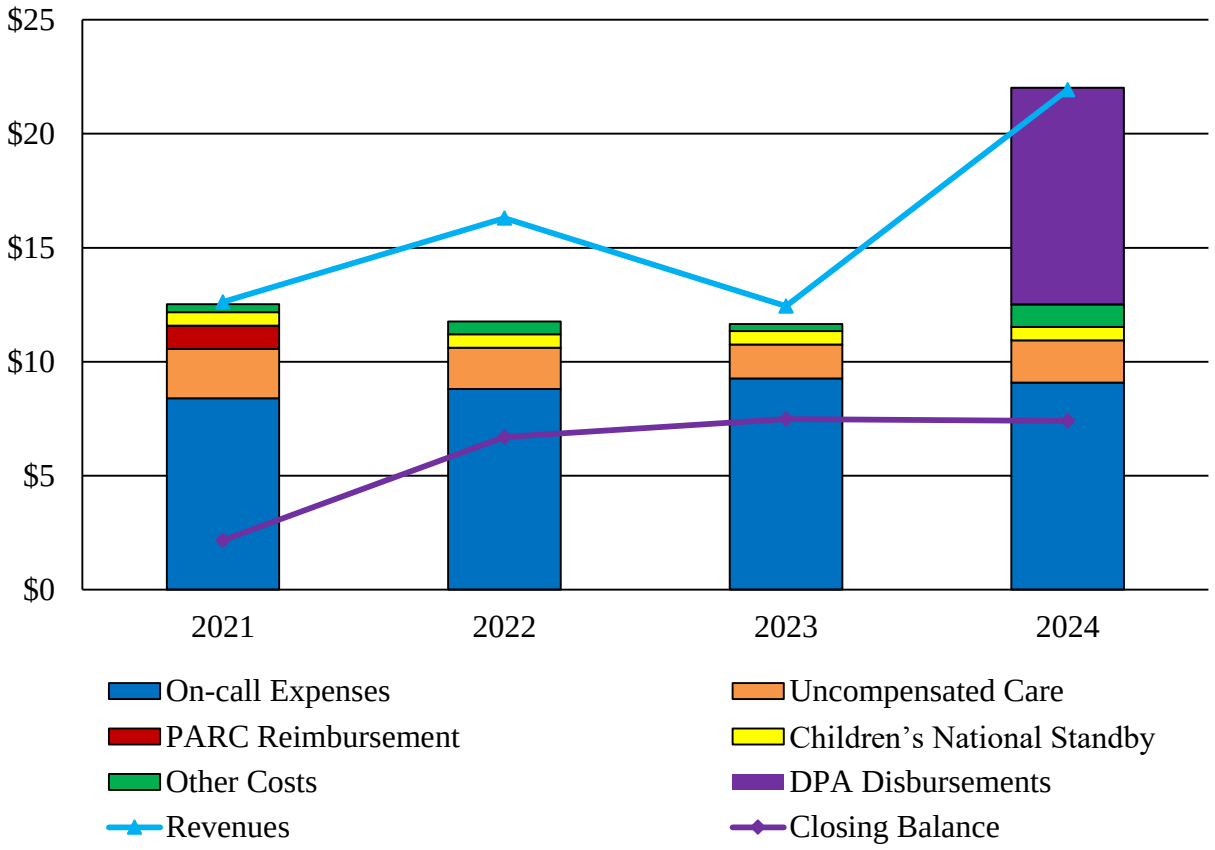
MHCC and HSCRC jointly administer the MTPSF to subsidize the following documented costs:

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

The MTPSF is financed by a surcharge on all Maryland vehicle registrations and, beginning in fiscal 2025, a share of fees from specified drunk and drugged driving offenses. Disbursements from the fund must be made in accordance with a methodology established jointly by MHCC and HSCRC to calculate costs incurred by trauma physicians and centers that are eligible to receive reimbursement. The established methodology must meet requirements outlined in statute. Those requirements specifically outline the parameters to determine the amount of reimbursement made to trauma physicians and trauma centers for Levels I, II, and III trauma centers; a pediatric trauma center; and the specialty referral centers.

As shown in **Exhibit 6**, MTPSF revenues, including a $4.0 million general fund appropriation in fiscal 2022 and $9.5 million in general funds distributed through the Dedicated Purpose Account (DPA) in fiscal 2024, have outpaced recent expenditures. Primarily due to the fiscal 2022 general fund appropriation, the closing MTPSF balance grew from $2.2 million in fiscal 2021 to $7.5 million in fiscal 2023. The closing balance in fiscal 2024 decreased slightly to $7.4 million, as the entire $9.5 million DPA allocation was spent in the same year that it was transferred to the MTPSF, $642,361 in trauma equipment grants were distributed, and uncompensated care payments increased.

**Exhibit 6**
**Maryland Trauma Physician Services Fund Revenues and Expenditures**
**Fiscal 2021-2024**
**($ in Millions)**




Children's National: Children's National Medical Center
DPA: Dedicated Purpose Account
PARC: Primary Adult Resource Center

Note: Fiscal 2022 revenues include $4.0 million in general funds provided for the Maryland Trauma Physicians Fund. Fiscal 2024 revenues and expenditures include $9.5 million in general funds deposited in the DPA for trauma facilities.

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

Section 19 of the fiscal 2024 Budget Bill added $9.5 million in general funds to the DPA to provide assistance to trauma facilities in the State experiencing financial challenges. **Appendix 3** provides the grant distribution by trauma center. MHCC outlined the following methodology that uses three factors to distribute funds:

- 50% of funds are allocated equally, with each of the 10 trauma centers receiving $475,000;

- 25% of funds are allocated based on trauma center designation, with lower-level trauma centers receiving more funding to cover readiness costs that are less likely to be covered through trauma reimbursements; and

- 25% of funds are allocated based on patient acuity, measured as the injury severity score.

## Appendix 1
## 2024 *Joint Chairmen's Report* Responses from Agency

The 2024 JCR requested that the Health Regulatory Commissions prepare five reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Private Payer Coverage of Ambulatory Surgical Facilities:*** On January 13, 2025, MHCC submitted the requested interim report to the budget committees regarding a study on the policies and procedures for including ambulatory surgical facilities in private payer plans. The interim report detailed that Maryland has the fifth highest number of ambulatory surgical facilities, but the centers tend to be small due to the Certificate of Need threshold for a full and comprehensive review being centers with more than two operating rooms. MHCC also reported on commercial health insurance network adequacy regulations established by the Maryland Insurance Administration, generally finding that there are no mandates in Maryland laws or regulations requiring insurance carriers to cover services provided by ambulatory surgical facilities. The final report with findings and recommendations resulting from the study is due on June 1, 2025.

- ***Trauma Center Funding Recommendations:*** Language in the fiscal 2025 Budget Bill restricted $125,000 in special funds within HSCRC pending the submission of a report from HSCRC and MHCC evaluating the findings and recommendations from the Commission to Study Trauma Center Funding in Maryland. The report was submitted to the budget committees on December 16, 2024. Further discussion can be found in Key Observation 3.

- ***Evaluation of the MDPCP and Update on Outcome-based Credits:*** The committees requested that HSCRC and MDH provide information on the cost effectiveness of the MDPCP, comparing cost savings from reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives. Using a new methodology, the Hilltop Institute reported that the MDPCP was budget neutral and may have provided net savings for the State. The report also provided an update on the State's selection of health conditions for outcome-based credits that are applied to the calculation of TCOC savings. When the report was submitted on October 2, 2024, a diabetes measure was still the only federally approved credit. Further discussion of the MDPCP can be found in Key Observation 2.

- ***Consortium Grants:*** MCHRC submitted a report on January 11, 2025, that provided detailed grant allocations by grantee and by local jurisdiction under the Consortium's grant program for coordinated community supports partnerships. Further discussion of the grants can be found in Key Observation 1.

## Appendix 2
# TCOC Performance Results

| | Calendar 2021/Program Year 3 | | Calendar 2022/Program Year 4 | | Calendar 2023/Program Year 5 | |
|---|---|---|---|---|---|---|
| | **Goal** | **Performance** | **Goal** | **Performance** | **Goal** | **Performance** |
| Annual Medicare Savings* | $222 million | $378 million | $267 million | $269 million | $300 million | $509 million |
| TCOC Guardrail | Not to exceed national Medicare growth in TCOC by more than 1% and/or exceed 0% for two years | 0.6% above national Medicare growth | **Not to exceed national Medicare growth in TCOC by more than 1% and/or exceed 0% for two years** | **0.9% above national Medicare growth (second consecutive year above)** | Not to exceed national Medicare growth in TCOC by more than 1% and/or exceed 0% for two years | 1.9% below national Medicare growth |
| All-payer Revenue Limit | Average growth ≤ 3.58% per capita annually | 2.37% | Average growth ≤ 3.58% per capita annually | 2.72% | Average growth ≤ 3.58% per capita annually | 2.68% |
| 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 | 0.2% average reduction below calendar 2018 | Not to exceed calendar 2018 rates for potentially preventable conditions | 0.36% average reduction below calendar 2018 |
| Reduction in Readmissions | **≤ National rate for FFS Medicare beneficiaries (15.37% for calendar 2021)** | **15.64%** | **≤ National rate for FFS Medicare beneficiaries (15.40% for calendar 2022)** | **15.56%** | ≤ Risk-adjusted national rate for FFS Medicare beneficiaries (15.45% for calendar 2023)** | 14.94% |

| | Calendar 2021/Program Year 3 | | Calendar 2022/Program Year 4 | | Calendar 2023/Program Year 5 | |
|---|---|---|---|---|---|---|
| | **Goal** | **Performance** | **Goal** | **Performance** | **Goal** | **Performance** |
| Hospital Revenue Population Based Payment | At least 95% of regulated revenue paid according to population-based methodology | 98% | At least 95% of regulated revenue paid according to population-based methodology | 98% | At least 95% of regulated revenue paid according to population-based methodology | 98% |

FFS: fee-for-service
TCOC: Total Cost of Care

*The State's overperformance in annual Medicare savings produces savings in the following model year, as outlined under the contract with the Center for Medicare and Medicaid Innovation.
**In calendar 2023 and beyond, a risk-adjusted measure will be used for the annual Medicare readmissions reduction test.

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

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

## Appendix 3
## DPA Funding Allocation for Maryland Trauma Centers
### Fiscal 2024

| Trauma Center Designation | Trauma Center | Share of Allocation | Amount |
|---|---|---|---|
| PARC | R Adams Cowley Shock Trauma Center | 12.9% | $1,221,910 |
| I | Johns Hopkins Adult | 9.1% | 864,086 |
| | ***PARC and Level I Total*** | ***22.0%*** | ***$2,085,996*** |
| II | Johns Hopkins Bayview | 9.8% | $932,303 |
| | University of Maryland Capital Region Health | 10.7% | 1,011,764 |
| | LifeBridge Sinai Hospital | 9.7% | 923,728 |
| | Johns Hopkins Suburban | 10.0% | 953,772 |
| | ***Level II Total*** | ***40.2%*** | ***$3,821,566*** |
| III | Meritus Health | 10.8% | $1,030,432 |
| | Tidal Health Peninsula Regional | 10.2% | 971,981 |
| | UPMC Western Maryland | 9.1% | 866,600 |
| | ***Level III Total*** | ***30.2%*** | ***$2,869,013*** |
| Pediatric | Johns Hopkins Pediatrics | 7.6% | $723,425 |
| | **Total** | | **$9,500,000** |

DPA: Dedicated Purpose Account
PARC: Primary Adult Resource Center
UPMC: University of Pittsburgh Medical Center

*The Maryland Institute for Emergency Medical Services Systems determines trauma center designations based on specified regulatory standards, with PARC and Level I trauma centers meeting the highest standards.

Source: Maryland Health Care Commission

**Appendix 4**
**Object/Fund Difference Report**
**Maryland Department of Health – Health Regulatory Commissions**

| Object/Fund | FY 24 Actual | FY 25 Working Appropriation | FY 26 Allowance | FY 25 - FY 26 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 117.90 | 121.90 | 121.90 | 0.00 | 0% |
| 02 Contractual | 7.53 | 7.76 | 8.28 | 0.52 | 6.7% |
| **Total Positions** | **125.43** | **129.66** | **130.18** | **0.52** | **0.4%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 20,674,691 | $ 21,304,111 | $ 22,372,414 | $ 1,068,303 | 5.0% |
| 02 Technical and Special Fees | 829,719 | 629,822 | 690,810 | 60,988 | 9.7% |
| 03 Communication | 134,019 | 119,937 | 115,457 | -4,480 | -3.7% |
| 04 Travel | 175,505 | 344,737 | 343,168 | -1,569 | -0.5% |
| 06 Fuel and Utilities | 2,166 | 3,607 | 3,607 | 0 | 0% |
| 07 Motor Vehicles | 0 | 0 | 2,340 | 2,340 | N/A |
| 08 Contractual Services | 164,453,966 | 194,375,202 | 207,227,860 | 12,852,658 | 6.6% |
| 09 Supplies and Materials | 71,386 | 63,826 | 75,973 | 12,147 | 19.0% |
| 10 Equipment – Replacement | 159,763 | 64,500 | 55,500 | -9,000 | -14.0% |
| 11 Equipment – Additional | 12,304 | 1,286,725 | 955,475 | -331,250 | -25.7% |
| 12 Grants, Subsidies, and Contributions | 96,574,889 | 60,372,415 | 165,240,463 | 104,868,048 | 173.7% |
| 13 Fixed Charges | 577,443 | 850,584 | 874,326 | 23,742 | 2.8% |
| **Total Objects** | **$ 283,665,851** | **$ 279,415,466** | **$ 397,957,393** | **$ 118,541,927** | **42.4%** |
| **Funds** | | | | | |
| 01 General Fund | $ 2,000,000 | $ 2,125,000 | $ 1,000,000 | -$ 1,125,000 | -52.9% |
| 03 Special Fund | 281,105,851 | 276,730,466 | 396,397,393 | 119,666,927 | 43.2% |
| 09 Reimbursable Fund | 560,000 | 560,000 | 560,000 | 0 | 0% |
| **Total Funds** | **$ 283,665,851** | **$ 279,415,466** | **$ 397,957,393** | **$ 118,541,927** | **42.4%** |

Note: The fiscal 2025 appropriation does not include deficiencies. The fiscal 2026 allowance does not include contingent reductions or statewide salary adjustments budgeted within the Department of Budget and Management.