MHCC | MARYLAND HEALTH CARE COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2007

(July 1, 2006 through June 30, 2007)

Martin O'Malley
Governor

Gail R. Wilensky, Ph.D.
Vice Chair

Rex W. Cowdry, M.D.
Executive Director

http://mhcc.maryland.gov/

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Our vision is a state in which informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation.

The Maryland Health Care Commission's 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.

The Commission is composed of fifteen members appointed by the Governor, with the advice and consent of the Senate, for a term of four years. A brief biography of each Commission member follows.

Stephen J. Salamon, is an Independent Health Insurance and Employee Benefit Broker with Heritage Financial Consultants, LLC. He has more than twenty years of experience in the insurance industry. Mr. Salamon also serves on the National Association of Health Underwriters Leadership Team and is past president of the Baltimore Health Underwriters Association. Mr. Salamon chaired the Commission until his resignation on February 15, 2007.

Gail R. Wilensky, Ph.D., Vice Chair, is a Senior Fellow at Project Hope, an international health education foundation where she analyzes health care reform policies and changes in the medical marketplace. From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, which covered health care for both veterans and military retirees. She also served as Assistant for Policy Development to President George Herbert Walker Bush, on health and welfare issues. Prior to that, Dr. Wilensky served as Administrator for the Health Care Financing Administration, overseeing the nation's Medicare and Medicaid programs.

Rev. Robert L. Conway was employed by the Calvert County Public School System for more than thirty years, serving as an elementary school teacher and principal. He is a graduate of Bowie State, George Washington University, and the Howard University School of Divinity. Commissioner Conway, a member of the Board of Directors of Calvert Memorial Hospital for the past nine years, has also served on Maryland's Hospital Bond Project Review Committee for

four years. A resident of Calvert County, Reverend Conway is the pastor of the United Methodist Church.

Garret A. Falcone is the Nursing Home Administrator of Renaissance Gardens, a skilled nursing home facility located in Catonsville. He has over 13 years experience in long term care. Commissioner Falcone is a graduate in Business Management from Fairleigh Dickinson University in New Jersey and earned his Masters Degree in Health Services Administration from Russell Sage College in Albany, New York. He is a member of the Mid-Atlantic Non-Profit Health and Housing Association and served as Chairman from 1996-1998. He was awarded the MANPHA Chairmen's Award in 2001 and the Special Chairmen's Award, AEGIS Inc., in 2001. He resides in Carroll County.

Sharon K. Krumm, R.N., Ph.D. is the Administrator and Director of Nursing at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Hospital. She is jointly appointed is an Assistant Professor at the Johns Hopkins School of Nursing, and the Johns Hopkins School of Medicine. Commissioner Krumm received her Ph.D., as well as two nursing degrees, from the University of Missouri. She resides in the City of Baltimore.

Jeffrey D. Lucht, FSA, MAAA, is the general manager of Key Accounts for the Mid-Atlantic region of Aetna Health, Inc. He joined Aetna is 1985. From 1985 through 1994, he held various actuarial, financial, and underwriting positions in Aetna's Connecticut offices, including those of National Accounts Financial Officer and CHAMPUS Financial Officer. In 1994, Mr. Lucht assumed the role of Director, Sales and Customer Relations for the Maryland market. Since that time, he has served as Senior Network Manager and Head Regional Underwriter for Aetna's Capitol Region. He also served as Chief Operating Officer of Johns Hopkins Health Care in 1998 and 1999. Mr. Lucht is a graduate of Gettysburg College with a B.A. in Mathematics. He is a Fellow of the Society of Actuaries and is a Member of the American Academy of Actuaries.

Robert Moffit, Ph.D. is the Director of the Center for Health Policy Studies at the Heritage Foundation in Washington, D.C. He joined the Heritage Foundation in 1991. Dr. Moffit served in the Reagan Administration, where he was appointed Deputy Assistant Secretary for Legislation for the Department of Health and Human Services. Prior to that, he served as an Assistant Director of the U.S. Office of Personnel Management, with responsibilities for both federal personnel policy and Congressional relations. Dr. Moffit earned his B.A. from LaSalle University in Philadelphia, and his Masters and Doctorate from the University of Arizona, all in political science. He has received public service awards from several organizations, including

the American College of Eye Surgery, the Great Lakes Association of Clinical Medicine, and the National Hispanic Family Against Drug Abuse.

Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc., is the Founder and President of PH RockWood Corporation, which is focused on the prevention, treatment, and control of infectious diseases worldwide. Until his retirement in December 2003, Dr. Moore served with the U.S. Department of Health and Human Services. For the last twelve years of his career, he was the principal person responsible for development support in the Office of the Secretary, Department of Health and Human Services, with primary emphasis on Continental Africa and other less developed countries of the world. Dr. Moore received his undergraduate degree and Doctor of Veterinary Medicine from Tuskegee Institute; his Master of Public Health in Epidemiology from the University of Michigan; and his Ph.D. in Epidemiology from Johns Hopkins University. Dr. Moore was awarded an Honorary Doctor of Science degree in recognition of his distinguished public health career by Tuskegee University. He has served on the Board of Directors and the Executive Committee for Montgomery General Hospital in Olney, Maryland.

Robert E. Nicolay, C.P.A., is a retired executive from the ExxonMobil Corp. After retiring from ExxonMobil, he was president of his own management consulting firm. He later served as Executive Vice President of the American Original Corp., a national seafood company. Commissioner Nicolay has served on several non-profit boards, including the John L. Deaton Medical Center, where he conducted the feasibility study for that hospital's expansion in Baltimore's Inner Harbor.

Andrew N. Pollak, MD, is Associate Professor of Orthopaedics at the University of Maryland School of Medicine. He is also a part-time instructor of Orthopaedic Surgery at the Johns Hopkins University School of Medicine. Dr. Pollak has led major research in orthopaedic trauma surgery and emergency medical services. A Baltimore native, Dr. Pollak earned his M.D. from Northwestern University Medical School.

Debra Herring Risher has been the President and owner of Belair Engineering and Service Co., Inc., in Upper Marlboro since 1990. She is a former board member for the Bowie Therapeutic Nursery. Ms. Risher is a graduate of Washington College. She is a member of the Crofton Kiwanis and the Greater Bowie Chamber of Commerce, having served as that organization's President from 1996-97. She is also a member of the Advisory Board of Directors of BB&T Bank.

Constance Row is a nonprofit association executive, consultant, and university teacher with a special interest in healthy communities. Many volunteer boards and community groups have

created new initiatives to meet community needs under her leadership. Ms. Row is a graduate of Barnard College, Columbia University and has an MPA from the Maxwell School at Syracuse University. Her career includes nearly a decade of experience at the federal level in health policy, legislation, and administration, and a second career in hospital and health care system administration, having served for ten years as a CEO in four community/teaching hospitals and health systems.

Sheri D. Sensabaugh is President and founder of ACT Personnel Temporary. Commissioner Sensabaugh serves on the Board of Directors of the Allegany Arts Council, the Garrett Information Enterprise Center, the Frostburg State University Foundation and serves on the Executive board of the Greater Cumberland Committee. She is a graduate of Arizona State University and has a Bachelor of Fine Arts, Painting, and Art History. She has served as the Co-Chairman of the Small Business Advisory Board, the Board of Directors for Family Services and was the Co-Founder, charter member and past Vice President of the Women's Economic Development Council

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Nevins W. Todd, Jr., M.D. is a retired thoracic surgeon residing in Salisbury, Maryland. A graduate of the University of Maryland Medical School, he is Board Certified in Thoracic Surgery. Prior to his retirement, Dr. Todd practiced medicine for nearly forty years in Salisbury. During that time, he served as Chief of Staff, Chief of Surgery, and Chief of Thoracic Surgery at Peninsula Regional Medical Center. In 1984, Dr. Todd was appointed to the Board of Trustees of the hospital and continues to serve in that capacity today.

Clifton Toulson, Jr. is the Chief Executive Officer and owner of Toulson Enterprises, which provides consultancy services to small business enterprises. He recently retired from the federal government where he served as the Deputy Associate Administrator for Small Business Development with the U.S. Small Business Administration (SBA). The Small Business Development Program is the SBA's largest non-credit program designed to enhance economic development through entrepreneurial assistance.

EXECUTIVE STAFF

Rex W. Cowdry, M.D.
Executive Director

Pamela W. Barclay
Director, Center for Hospital Services

Bruce Kozlowski
Director, Center for Long-term Care and Community-based Services
and
Director, Center for Healthcare Financing and Policy

David Sharp
Director, Center for Health Information Technology

Ben Steffen
Director, Center for Information Services and Analysis

EXECUTIVE SUMMARY

The Maryland Health Care Commission is an independent state agency located within the Department of Health and Mental Hygiene. Our fifteen Commissioners are appointed by the Governor with the advice and consent of the Senate, come from communities across the state, and represent both the state's citizens and a broad range of other stakeholders.

Our mission is simply stated:

> 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.

We pursue this mission through our information gathering and dissemination, our health planning and regulatory powers, and our health policy analyses.

MHCC STAFF AND THE FIVE CENTERS

During FY 2007, the Commission had an appropriation for 62 full time positions and filled one contractual position. The Commission's staff members represent a broad range of backgrounds and skills, including public policy analysis, data management and analysis, health planning, health facilities construction and financing, Medicaid administration, quality assessment, clinical and health services research, and public performance reporting.

In July 2006, the staff was restructured. Previously, the Commission was organized by functions: health planning and certificate of need, health plan benefits, performance measurements of plans and providers, and data analysis. This structure reflected the two commissions that were merged in 2000 to form the MHCC. A six month reassessment concluded that we should be organized around the health care systems we seek to evaluate, regulate, or influence, bringing a wide range of tools (data gathering, public reporting, planning and regulation) to bear and improve quality, address costs, or increase access. Two of the centers - the Center for Hospital Services and the Center for Long-term Care and Community-based Services - are organized around provider organizations, bringing together under one leadership the expertise and tools to address cost, quality, and access in those sectors of our health care system. Two of the centers include both cross-cutting responsibilities and sector specific efforts: The Center for Healthcare Financing and Policy deals with broad policy issues relating to the organization and financing of health care and with narrower issues relating to the regulation of the small group health insurance market. The Center for Information Services and Analysis conducts broad studies using both Maryland databases and national surveys, but also has specific responsibilities relating to physician services. The fifth center, the Center for

Health Information Technology, has responsibilities that cut across sectors to facilitate the adoption of electronic health records and to enable the private and secure transfer of personal health information among sectors.

The organizational chart is attached as Appendix 1. A brief description of each of the Centers follows:

The **Center for Hospital Services** focuses on improving hospital care, bringing together planning, certificate of need, and public reporting of cost and quality under the leadership of Pam Barclay, the Center Director.

- Planning for hospital services and the drafting of the acute care chapter of the State Health Plan are the responsibility of the Center for Hospital Services.
- The entire Certificate of Need program remains within the Center for Hospital Services because hospital certificates of need are the most complex and costly of projects requiring CON action. Maryland hospitals are in the midst of a dramatic rebuilding program, replacing an aging hospital infrastructure through renovation, new construction, and in some cases, consolidation or relocation of facilities.
- The Center oversees specialized inpatient services such as cardiac surgery, obstetrics, pediatrics, and psychiatry, including developing the state health plan chapters, managing certificates of need for these services, and granting appropriate waivers to allow hospitals meeting rigorous criteria to perform emergency angioplasty.
- The Center is committed to providing meaningful information to consumers about the quality and outcomes of care provided in all Maryland acute care hospitals. It publishes the Hospital Guide, containing both general information and specific quality and outcome measures. The Center currently reports on the quality of hospital efforts in surgical infection prevention and is developing strategies to gather and report the rates of key hospital acquired infections. The Center plans to expand public reporting of angioplasty quality and outcomes beyond the current waiver hospitals to include all hospitals performing emergency angioplasty and is examining public reporting of risk-adjusted data on the quality and outcomes of cardiac surgery.
- The Center serves as the lead for a report on emergency department crowding.
- As part of the MHCC's Price Transparency Initiative, the Center, working closely with the Health Services Cost Review Commission, publishes each hospital's charges for the most common Diagnosis Related Groups (DRGs).

The **Center for Long-term Care and Community-based Services** focuses on improving long-term and community-based care, bringing together planning and public reporting efforts under the leadership of Bruce Kozlowski, the Center Director.

- The Center is responsible for health planning regarding long-term and community-based care, including the policies guiding the determination of need in the Certificate of Need process for nursing homes, home health agencies, and hospices.
- The Center is responsible for the Commission's study of long-term care vision and needs over the coming 25 years, required by legislation during the 2006 session.
- CON applications for nursing homes, home health agencies, and hospices are managed by the CON staff in the Center for Hospital Services, operating according to policies developed by the Center for Long-term and Community-based Care.
- The Center publishes the Nursing Home Guide for Marylanders, providing an easy way to locate and compare nursing homes on quality and outcomes measures. The Center is also pioneering the public reporting of resident and family satisfaction measures.
- The Center has responsibility for policies and information dissemination related to assisted living programs.

The **Center for Healthcare Financing and Policy** has a specific regulatory responsibility for the small group market for health insurance and a broader responsibility for the analysis of public policy options relating to the organization and financing of health care. Bruce Kozlowski also serves as the Director of this Center.

- This Center is responsible for the small group health insurance market, including regulation of the Comprehensive Standard Health Benefit Plan. Specifically, the Commission is responsible for specifying the benefits and covered services included in the core CSHBP offerings, modifying these when necessary to meet statutory affordability requirements.
- The Center reports on trends in the small group market, including the costs of plans and the degree of concentration in the market, suggesting regulatory changes that will improve affordability, innovation, and value through improved competition.
- The Center's HMO Consumer Guide reports publicly on the performance of and satisfaction with health plans. Traditionally focused on measures of the clinical performance HMOs, the Guide is expanding in two ways. MHCC will now report collaboratively with the Mid-Atlantic Business Group on Health additional measures of health plan quality and value and will soon report on PPOs in addition to HMOs.
- The Center is responsible for the development and analysis of state health policy options affecting the organization and financing of health care. Particular emphasis

has been placed on both incremental and non-incremental strategies for expanding health insurance coverage and on strategies to reduce health care expenditures and increase health care value.

- The Commission's commitment to reporting disparities in health and health care is expressed in the Center's Racial and Ethnic Disparities initiative.

The **Center for Information Services and Analysis** has expertise in the creation, maintenance, and mining of large databases, in the management of information technology and networks, and in the analysis and interpretation of population surveys. Ben Steffen serves as the Director of this Center.

- The Center produces key reports to guide health policy, including reports on health expenditures, health insurance, the uninsured and uncompensated care.
- A special focus of the Center will be physician services, including physician reimbursement and reporting on the cost and quality of physician services. The Commission staff has provided consultation to the General Assembly
- The Center oversees the Maryland Trauma Services Fund and has responsibility for development its procedures and policy options.
- This Center provides analytic and programming services to other divisions of the Commission and is responsible for our intranet and web site. Two individuals serve as liaisons to the Center for Hospital Services and the Center for Long-Term Care and Community-Based Services, participating as appropriate in the discussions of those Centers and assuring that the necessary expertise is brought to bear on the other Centers' data gathering, management, and analysis.

The **Center for Health Information Technology** is responsible for the Commission's initiatives in health information technology. David Sharp serves as the Director of this Center.

- The Center, in conjunction with the HSCRC, manages the joint MHCC/HSCRC initiative to plan and implement state-wide health information exchange.
- The Center staffs the Task Force on the Electronic Health Record, established by the General Assembly.
- The Center is conducting a series of privacy and security studies across health care sectors to understand the potential barriers to widespread adoption of electronic health records and health information exchange.
- The Center conducts HIPAA awareness activities, oversees the state certification of electronic data interchange reporting, and conducts provider education on health information and HIPAA issues.

In addition to the five centers, the Executive Director directly oversees the Executive Direction unit which is responsible for the key functions of budget, user fee assessment, and procurement. The Government Relations and Special Projects unit which manages the legislative activity of the Commission responds to special requests for information by the Maryland legislature, executive departments, and other external groups and serves as an incubator for newly mandated Commission activities. Finally, the Legal Services unit, composed of two Assistant Attorneys General, provides advice to the Executive Director and the Commission.

BUDGET & FINANCES

In FY 2007, the Commission was appropriated $19,611,789 which includes an appropriation of $10 million for the trauma fund. The Commission is funded with special funds through a user fee assessment paid by Nursing Homes, Hospitals, Insurance Companies, and the Health Occupation Boards in order to accomplish its mission and program functions.

Assessment

The Maryland Health Care Commission's budget is 100% special funds and is funded through a user fee assessment on Hospitals, Nursing Homes, Payers, and through the licensing process of the Health Occupational Boards. Each of these entities contributes to the MHCC budget appropriation according to workload and the assessment is currently capped at $12 million. Currently, the Commission assesses: 1) Payers for an amount not to exceed 32% of the total budget; 2) Hospitals for an amount not to exceed 26% of the total budget; 3) The Health Occupational Boards for an amount not to exceed 20.5% of the total budget; and 4) Nursing Homes for an amount not to exceed 21.5% of the total budget. The amount is derived differently for each industry and is set every four years based on Commission work load. House Bill 800 (2007) requires the Commission to study the feasibility of bringing other health care industries into the assessment. This report must be submitted to the General Assembly by December 1, 2008.

Surplus

At the close of FY 2007, the Commission's surplus was $3.2 million. In an effort to reduce the surplus, the Commission reduced its assessment by $1 million over fiscal years 2006 and 2007.

Sunset Review

During FY 2007, the Maryland Health Care Commission was evaluated under the Maryland Program Evaluation Act (the "sunset review" process). We are pleased with the outcome of the review and endorse each of its recommendations, including the recommendation from Department of Legislative Services Staff to increase the cap on assessments of plans and

providers from $10 million to $12 million. We anticipate that this increase will last 5 years and that the actual assessment will increase only gradually. The Sunset Review recommendations are included as Appendix 2.

Legislative Action

In FY 2007, the Commission submitted policy reports to the General Assembly on Emergency Department Crowding and Air Ambulance Services, in addition to the numerous policy reports submitted annually. Commission staff provided six issue briefings for various legislative committees. During the 2007 Session of the General Assembly, the Commission sent letters of information on eight bills, a letter of concern on one bill, opposed six pieces of legislation and supported 22 bills, either as drafted or with amendments.

Departmental Legislation

Departmental legislation was enacted (HB 800) which implements recommendations contained in the program evaluation report (sunset review) conducted in 2006. This legislation (1) changes quorum and voting requirements, (2) increases the cap on user fee assessments, (3) changes certain reporting provisions regarding the Maryland Trauma Physician Services Fund, mandated health insurance benefits, and the Limited Benefit Plan, (4) repeals language requiring a certain study on preventable adverse events because the study has been completed, (5) makes technical changes in language authorizing MHCC to compile certain data from health care practitioners and facilities to be included in the medical care data base, and (6) provides for an evaluation of the Commission and the statutes and regulations that relate to the Commission on or before July 1, 2017.

In addition, the legislation requires the Commission to submit reports regarding:

- alternative insurance options for individuals enrolled in the Limited Health Benefit Plan;
- possible changes in user fee assessments based on the required assessment of the Commission's workload;
- implementation of the recommendations from the 2005 Certificate of Need Task Force and from the comprehensive evaluation of CON conducted in 2000-2001;
- options for reducing the Maryland Trauma Physician Services Fund's surplus;
- the collection of data on facility costs, practitioner costs and insurance product design and how these data could be used to promote quality and affordable health care; and
- implementation of the recommendations contained in the 2006 Evaluation of the Maryland Health Care Commission.

Small Group Market

House Bill 339 as enacted alters the rating bands in the small group market from +/- 40 percent to + 40 percent/-50 percent. The legislation also requires the Commission to adopt proposed

permanent regulations that will now require carriers to report enrollment in the small group market by age and the geographic location of the business. The Commission's original concerns with this bill were addressed through amendments.

House Bill 579 as amended will allow insurers in the small group market to offer exclusive provider organizations (EPOs), administrative discounts for purchasing additional insurance products, and a limited policy designed for part-time, seasonal, and temporary employees. Finally, the bill as amended requires the Commission to study the standard plan and report on options for reforming the plan in a manner to encourage more small employers to enter the market and to report our findings on or before December 1, 2007. The Commission's original concerns with this bill were addressed through amendments.

The Commission opposed another bill (HB 477) which would have eliminated of the eligibility restrictions, the data collection, and the sunset provisions of the Limited Benefit Plan. This legislation received an unfavorable report from the Health and Government Operations Committee.

Certificate of Need

Senate Bill 750 was enacted as emergency legislation that provides for the licensing of a freestanding medical facility in Queen Anne's County. The Commission supported SB 750 with amendments that were adopted to make the proposed Queen Anne's facility a second pilot project; exempting it from certificate of need review but requiring that it meet all state licensure requirements. Status as a pilot project will also assure that it provides data to the Commission as required for the pilot project at the Germantown Emergency Center. This second pilot project, located on the Eastern Shore, will provide information from a different part of the State on the delivery of emergency care in a freestanding facility.

Another piece of legislation (SB 628) would have repealed the entire scope of certificate of need regulation with the exception of home health agencies and hospice programs. While the Commission supports in concept an orderly and incremental reduction in the certificate of need process in Maryland we also voiced concerns about the specific approach taken in Senate Bill 628. This legislation received an unfavorable report from the Senate Finance Committee.

Racial & Ethnic Disparities

The Commission supported the enactment of House Bill 788 because it will enable health plans to collect racial and ethnic data on application for insurance while prohibiting health plans from using this information to deny or otherwise affect a health insurance policy or contract. This bill will also allow the Maryland Health Care Commission to collect and report racial and ethnic data from health plans as required under §19-134 of the Health General Article.

Health Care Access

Senate Bill 107 was enacted to establish a Task Force on Health Care Access and Reimbursement, which will be staffed by the Commission to study physician reimbursement rates and the impact of those rates on access to care in the state of Maryland. A report is due by December 31, 2007. The Commission supported the concept of forming a broad-based task force to study the market for physician services, to identify the underlying issues, and to develop policy options.

The Family Coverage Expansion Act (HB 1057) as enacted requires individual and group health insurance policies and contracts that allow family coverage to provide, at the request of an insured or group policy holder, the same benefits and eligibility guidelines that apply to other covered dependents for a domestic partner or the child dependent of a domestic partner of the insured. The bill also requires insurers, nonprofit health service plans, and HMOs (carriers) to allow a child dependent to remain on an insured's plan until age 25. The bill takes effect June 1, 2007 and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed on or after January 1, 2008. While this bill does not currently apply to the Comprehensive Standard Health Benefit Plan (CSHBP), the Commission will consider such an expansion of coverage eligibility at its annual evaluation of the CSHBP. House Bill 1057 also requires the Commission to submit a report on the high prevalence of uninsurance among young adults and to examine options to insure more young adults. The Commission supported this provision and will submit the report to the General Assembly before the 2008 Session.

A number of bills were considered that would have extended coverage to the state's uninsured populations; however, none of these bills were adopted. As a result, the Commission was asked to evaluate a number of reform options. House Bill 572 requires the Commission to submit a report on personal responsibility proposals and address a specific set of questions. In addition, the Chairs of the Senate Finance and House Health and Government Operations Committees sent a letter to the Commission asking for an analysis of the feasibility and desirability of establishing a health insurance exchange, with answers to a specific series of questions about exchanges. Because these policy options, in addition to the expansion of coverage to young adults are interrelated and part of a larger set of issues relating to escalating health care costs, variable health care quality, and problems with access to health care, the Commission plans to write a single report encompassing all these issues and options for submission to the General Assembly in December 2007. A complete list of legislatively-mandated reports is included as Appendix 3.

Health Policy Analysis

The Maryland General Assembly has increasingly required the Commission to undertake new projects and provide numerous ad hoc studies and reports. Sometimes the analysis arises as a Commission initiative to fulfill its broad statutory responsibilities to improve access, address

costs, and improve quality. The Commission has launched a more aggressive program of health policy analysis to identify the strengths and weaknesses, the costs and savings, and the effects on access for a range of proposals.

At the outset of FY 2007, Commissioners asked that Commission staff analyze a series of policy issues involved in relatively comprehensive reform proposals such as the Massachusetts plan to determine whether a similar plan might be appropriate for consideration in Maryland. During the 2007 Session of the General Assembly, Commission staff presented its analysis of a comprehensive reform proposal encompassing market reform, a health insurance exchange, personal responsibility, and low income premium subsidies. Staff also presented an analysis of two small group market reforms.

Broad Health Reform Options

In an effort to address the problem of the rising number of uninsured, several states have looked at substantive health care reform. In 2006 Massachusetts passed a much-anticipated and heavily observed universal health care law that combines both private and public sector reforms. Many state policymakers, including those in Maryland are looking closely at variations in this law to see if its model would work for them.

After considering the strategies involved in a Massachusetts-like plan, the Commission thought it would be valuable to model a reform option involving the following principles:

- Personal responsibility – where an individual must have at least catastrophic coverage and no free riders.
- Individual choice – where each employee can choose coverage.
- Public responsibility – where there is premium support for low income Marylanders.
- Employer responsibility – where employers offer employees access to exchange and provide payroll deduction and a Section 125 premium conversion plan. Each employer will choose – but is not required to contribute.
- Merge individual and small group markets, including MHIP, where the Exchange is the only way to obtain fully insured coverage.
- Assure broad participation through serious penalties for remaining uninsured (75% of the cost of a high deductible health plan) and a generous affordability standard that varies the contribution to premium at $0 at incomes below 100% FPL and a sliding scale up to 7.5% of income at incomes from 250 to 300% FPL.
- Rich benefit design equivalent to BC/BS Basic plan offered under the Federal Employee Health Benefit Plan (FEHBP).

MHCC contracted with The Lewin Group to model this reform option which resulted in near universal coverage (98%) of Marylanders but at a high total cost. It is important to note that this model is not the only option and that the costs of reform can be reduced in a number of

ways. Lewin estimated that the cost to Maryland per newly-insured individual is $3,171 before offsets from the existing uncompensated care fund. This figure is similar to Senator John Kerry's 2004 health reform proposal and is half the cost of President Bush's 2007 plan. The analysis found a substantial reduction in household expenditures and a reduction in health expenditures for all businesses under 100 employees. Firms with less than 10 employees experienced the greatest reduction in spending of $1,262 per worker.

Under this analysis, health care spending increases $1.274 billion. While household spending decreases $1.748 billion, state and local spending increases $2.474 billion. However, state and local spending estimates should be reduced by part of uncompensated care fund reprogrammed for premium support (~$400 million), any federal matching achieved through state plan amendment or waiver and savings in public health expenditures over time. Federal spending is estimated to increase by $548 million.

The Commission also mentioned options to reduce the cost of the reform. Strategies include developing a high performance plan design with narrower benefits (rather than basing the plan on the FEHBP) and using a high performance provider network and/or provider incentives for high quality and low cost. Additional strategies include restricting subsidy eligibility to those uninsured for at least 6 months or using less generous affordability criteria to determine the subsidy. These strategies will increase household expenditures and thus decrease the necessary government expenditures. Efforts to increase employer expenditures thereby reducing those experienced by the government include requiring employer contributions (although there are issues with ERISA) and/or redesigning the subsidy eligibility in an effort to reducing employer crowd out.

As a result of the 2007 Session, the Commission will be building upon this initial modeling and presenting an analysis to members of the General Assembly prior to the 2008 Session.

Specific Small Group Market Options

In recent years much attention has focused on the small group market which is comprised of businesses with 2 to 50 employees. As discussed previously, a large percentage of Maryland's uninsured are employed in small businesses. As the cost of health care has continued to escalate we have seen a concomitant decline in both the number of participating employers and the number of individuals with insurance coverage in this market. Prices for health insurance in the small group market continue to rise faster than inflation and somewhat faster than other markets, posing a challenge to small businesses and their employees. By law, the average premium cost for the standard benefit plan may not exceed 10 percent of the State's average wage. To stay under the 10 percent cap the Commission has increased deductibles, copayments, and coinsurance and reduced pharmacy benefits. While these actions have produced results, the Commission continues to evaluate policies that may address the cost of coverage in this market. Two such options that were discussed in the 2006 Session include the

introduction of health as a rating factor by implementing NAIC's 1993 model legislation as well as the option of expanding the small group market to those employers with up to 75 or 100 employees.

NAIC 1993 Rating Standards

The Commission contracted with The Lewin Group to study the cost and coverage impacts of adopting model legislation for the small group market developed by the National Association of Insurance Commissioners (NAIC) in 1993. Modified Community rating in Maryland's small group market currently permits premiums for a given product to vary only by the age of the group, family status and geography. Premiums do not vary by health status or claims experience as they do in the individual market.

The NAIC 1993 model rating standard adds health status, gender, industry and firm size to the rating structure. Overall, the rating model would result in substantial changes in health insurance premiums. Adoption would result in increased premiums for older and sicker groups and reduced premiums for younger and healthier groups. Our consultant reported that 32% of individual employers in the small group market would see premiums increase by 10% or more while 42% of individual employers would see premiums drop by over 10%. A substantial number of small firms with a disproportionate number of older and sicker individuals would drop coverage due to increased premiums. A smaller number of firms with younger and healthier people would start to offer coverage due to a reduction in premiums. The net effect would be a reduction in employer sponsored coverage of 22,770 individuals.

The legislation also has implications for coverage in the non-group market. For example, some of the workers who have coverage in the non-group market who become covered in a newly insuring group would typically drop their non-group coverage. Similarly, some of those in groups that discontinue coverage would obtain coverage in the non-group market. These shifts in coverage would result in a change in premiums in the non-group market even though rating in that market is not directly affected under the NAIC legislation.

These changes would also impact Medicaid enrollment and costs. For example, reductions in private coverage for higher cost people are likely to lead to increased Medicaid enrollment through the medically needy class of eligibility. Lewin estimates that there would be a net increase in state Medicaid spending of about $400,000, reflecting that the new enrollees are generally older and are likely to use more health services than the younger people who leave the program to take up employer-sponsored coverage. Overall, the number of uninsured in Maryland would increase by 22,200 individuals, resulting in an increase in uncompensated care spending and a subsequent increase in hospital rates.

Expansion of Small Group Market

The Commission contracted with Mercer to examine the feasibility of expanding the definition of Maryland's small group market and its corresponding rating rules beyond the current group size limits of 50 eligible employees to either 75 or 100 eligible employees. According to Mercer, requiring the same rating restrictions that currently exist in the 2 to 50 small group market to this larger market would encourage many of the larger groups (especially those with lower than average premiums) to self-insure since they no longer could benefit from experience rating and they would be forced to subsidize other groups. Moreover, requiring the same minimum benefit levels also would be unpopular, since groups in the 51+ market currently enjoy more flexible benefit design options. Depending on how competitive the 51 to 75/100 market is currently, this expansion may result in carriers exiting that market if the small group market rating rules were extended to their larger book of business. Also, it is doubtful that this expansion will result in new carriers entering the small group market but instead would benefit the two carriers that currently dominate that market in Maryland.

Mercer also notes that the impact this expansion could have on the overall cost of the CSHBP is difficult to estimate. Mercer predicts that blending the 51 to 75/100 market into the 2 to 50 market would cause an immediate increase in premiums in the 51 to 75/100 market, thus creating an incentive, particularly for healthy groups, to self-insure and maintain any unique benefit designs they currently may enjoy. In addition, the expanded small group market could experience significant adverse selection by high risk groups currently in the 51 to 75/100 market that would obtain lower premiums in the newly expanded small group market, putting upward pressure on premiums in the small group market. Plus, if healthy larger groups exit the market because of the more restrictive rating rules or groups of any size exit because of the initial increase in premiums, the reduced size of the pool made up of less healthy groups will cause subsequent premiums to rise even more. This again may result in more groups exiting the pool, again causing premiums to increase. This is referred to as an assessment spiral. If the existing 51 to 75/100 market is highly competitive, the overall increase in premiums may be smaller initially, as carriers strive to retain that market share; however, as noted earlier, premiums would be subject to further increases in subsequent years.

Overall, Mercer estimates that the initial premium rates in the new, expanded small group market would be 2% to 5% higher than what the analogous premium rates would be for the existing small group market, in addition to any premium increase incurred in the existing small group pool due to historical trend.

As a result of the 2007 Session and the passage of House Bill 579, the Commission will evaluate several additional reform options for the small group market and present an analysis to members of the General Assembly prior to the 2008 Session.

OVERVIEW OF FY 2007 ACCOMPLISHMENTS

July 2006

The Commission approved a Certificate of Need (CON) – Modification to Howard County General Hospital

The Commission approved a CON for Franklin Square Hospital for new construction and Expansion.

The Commission approved an Electronic Health Network (EHN) accreditation for PayerPath and Eyefinity.

The Commission approved staff recommendations regarding the affordability cap for the Comprehensive Standard Health Benefit Plan.

August 2006

The Commission did not meet.

September 2006

The Commission approved a CON for Fairland Adventist Nursing and Rehabilitation Center for expansion and renovation.

The Commission approved a CON for Sheppard Pratt for closure of Sheppard Pratt-Ellicott City RTC Program and Partial Relocation of RTC Bends to Sheppard Pratt – Towson Campus.

The Commission approved a CON for the University of Maryland Medical System for construction of an Ambulatory Care Center.

The Commission held an Exceptions Hearing for Baltimore Washington Medical Center – Re-examination and Clarification of Findings Regarding COMAR 10.24.12.04(13) Pursuant to an Order of the Circuit Court for Baltimore city (Civil Action No. 24-C-05-011540AA)

The Commission approved a CON modification for Western Maryland Health System to increase approved Capital Cost.

The Commission approved a CON modification for Stella Maris to increase approved Capital Cost.

The Commission approved a CON modification for Baltimore Washington Medical Center to add two floors of shell space and make related changes.

The Commission held an Exceptions Hearing for Fort Washington Medical Center regarding granting a CON for expansion and renovation
The Commission Granted a Modification of Waiver to Anne Arundel Medical Center for Primary Percutaneous Coronary Intervention.

The Commission approved final action to COMAR 10.24.18 – State Health Plan for Facilities and Services – Neonatal Intensive Care Services – Update Levels of Care Consistent with Most Recent Maryland Perinatal System Standards and Related Changes.

The Commission approved final action to COMAR 10.24.06-Data Reporting by Freestanding Medical Facilities – Implement Data Reporting Requirements for the Freestanding Medical Facility Pilot Project at the Shady Grove Adventist Emergency Center.

The Commission approved final action to COMAR 10.24.01 – Certificate of Need for Health Care Facilities – Implement Changes to the CON Program Enacted by the General Assembly under House Bill 1015/Senate Bill 832.

The Commission approved final action to COMAR 10.25.10 – Maryland Trauma Physician Services fund – Implement Changes to the Fund Enacted by the General Assembly under House Bill 1164.

The Commission approved final action to COMAR 10.25.01 – Conduct of a Public Meeting – Repeal.

October 2006

The Commission approved a CON for Doctors Community Hospital and Massachusetts Avenue Ambulatory Surgery.

The Commission approved a CON-Modification for Clifton T. Perkins.

The Commission approved EHN Certifications to GE Healthcare, HealthFusion, Mutual of Omaha, and Per Se Technologies

Staff presented to the Commission the “Annual Report on the Status of the Maryland Trauma Physicians Services Fund.”

November 2006

The Commission approved proposed action to COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Homes, Home Health Agencies, and Hospice Services.

The Commission approved final action to COMAR 10.25.13 – Health Information Technology Funding Application.

December 2006

The Commission approved a CON – Modification for the Surgery Center of Potomac and Ruxton SurgiCenter.

The Commission approved the report "Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding – Required under the Joint Chairmen's Report – 2006 General Assembly

The Commission approved the "Air Ambulance Study" required under Senate Bill 770.

Staff presented to the Commission the report on "2005 Prescription Drug Use and Expenditures."

January 2007

The Commission approved a CON for Dimensions Healthcare System for Gladys Spellman Specialty Hospital and Nursing Center.

The Commission approved EHN Recertification for Kodak Dental Systems and Proctologic Corporation.

The Commission approved EHN Certification for Tesia-PCI Corporation and NaviMedix, Inc.

Staff presented the report on "Insurance Coverage in Maryland through 2005."

Staff presented the report on "Prescription Drug Use and Expenditures: Trends among Privately Insured Patients through 2005."

February 2007

The Commission approved a CON for Frederick Memorial Hospital for a Level IIIa Perinatal Program to Include Level IIIa Neonatal Intensive Care Unit.

The Commission approved a final action to COMAR 10.24.08 – State Health Plan for Facilities and Services: Nursing Homes, Home Health Agencies, and Hospice Services.

Staff presented the report on State Health Expenditures for 2005.

March 2007

The Commission approved several temporary extensions of Waivers to provide Primary Percutaneous Coronary Intervention (PCI) Services.

The Commission approved two requests for Waiver to Provide Primary PCI without Cardiac Surgery On-site for Frederick memorial Hospital and Washington County Hospital.

The Commission approved CON's for Southern Maryland Hospital Center for expansion and renovation and Peninsula Regional Medical Center for the establishment of Level IIIa neonatal Intensive Care Unit.

The Commission approved final action to COMAR 10.24.01 – Certificate of Need for Health Care Facilities

The Commission approved final action to COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan

April 2007

The Commission approved a request for a Research Waiver by the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) to Study Non-Primary PCI Performed in Maryland Hospitals without On-Site Cardiac Surgery.

May 2007

The Commission approved a Request for Waiver to Provide Primary PCI without Cardiac Surgery On-Site to Upper Chesapeake Medical Center.

The Commission approved a CON to Homewood at Williamsport for a Replacement Nursing Home Facility and to Johns Hopkins for the relocation of Operating Rooms.

Staff Presented to the Commission "small Group Market: summary of Carrier Experience for year ending December 331, 2006.

Staff Presented to the Commission "Practitioner Utilization Report 2004-2005, Trends within Privately Insured Patients."

June 2007

The Commission approved proposed regulations for COMAR 10.25.05 – Small Group Market Data Collection.

The Commission approved proposed regulations for COMAR 10.24.05 – Research Waiver Applications for Participation in the Atlantic C-PORT Study of Non-Primary PCI Performed in Maryland hospitals without On-Site Cardiac Surgery

The Commission approved CON's for Mercy Medical Center's – New Tower Project, Montgomery General Hospital's – New Construction and Renovation Project, and St. Agnes Hospital's request for Closure of Surgery Center.

The Commission approved a CON-Modification for Howard County Hospital.

The Commission approved several renewal applications for Metropolitan Baltimore Primary PCI Waiver.

The Center for Information Services and Analysis

Cost and Quality Analysis Division

Overview

The Cost and Quality Analysis staff's primary responsibilities are preparation of the annual state health care expenditure and practitioner services utilization reports that are mandated by Commission statute. The staff also conducts more narrowly focused studies of health care spending and service use, such as examining changes in spending for insured prescription drugs, and changes in private insurance premiums. The division's staff members examine broader health care issues as well, including the measurement and analysis of insurance coverage in the state. The Commission's Medical Care Data Base is a key data source for several publications.

Accomplishments

During FY 2007, the Cost and Quality Analysis division released five publications, including four reports and one issue brief, which are discussed in the paragraphs that follow. Two of the reports created by the division, *State Health Care Expenditures: Experience from 2005* and *Practitioner Utilization: Trends within Privately Insured Patients, 2004-2005,* are annual reports mandated in the legislation that created the Commission.

State Health Care Expenditures: Experience from 2005 forms an essential component of monitoring the performance of the state's health care system by reporting the level and growth rate of health care spending. Released in February, the report estimates that total spending for health care received by state residents increased 7% in 2005 to $30.2 billion. Mirroring the national trend in spending, Maryland's per capita rate of increase was 6% in 2005, slightly below the longer-term trend of 7% per year since 2001. Although this marks the third consecutive year of slowed growth, the increase in health care spending continues to exceed gains in wages and personal income. Analysis of expenditures by service type indicates that spending on hospital care (inpatient and outpatient) and prescription drugs grew faster than

total spending in 2005, with hospital care accounting for 41% of the $2.1 billion increase in state health care spending. Payer administrative expenses and the net cost of insurance also increased significantly. Analysis by payer-type shows that public payers (Medicare, Medicaid, and other government) accounted for 43% of total health care spending in 2005, compared with 40% paid by private insurance arrangements (including commercial insurance, health maintenance organizations, and self-insured employer plans) and 17% paid directly by consumers for both covered and uninsured services.

Practitioner Utilization: Trends within Privately Insured Patients, 2004-2005, a mandated report based on analyses of the MCDB, was released in May. The purpose of this annual analysis is to provide an understanding of the factors underlying increases in expenditures for insured practitioner services. The report examines how the volume of care for privately insured Maryland residents under age 65, and the associated payments to physicians and other health care professionals, changed from 2004 to 2005, including a comparison to 2005 Medicare reimbursement rates. Across all users, the average expenditure in 2005 was $904, up 3% from $880 in 2004. The increase was driven by a 2.6% increase in prices paid to practitioners and a modest increase in total resources per user. Geographically, per-user spending remains highest in the National Capital Area (NCA) at $969. Per-user spending in NCA was stable from 2004 to 2005, but grew about 5% in the Baltimore metropolitan area and 2% elsewhere in the state. Consumer-directed health plans (CDHPs) accounted for three times as many users in 2005 as they did in 2004, but still cover less than 1% of privately insured service users. Mean spending per CDHP user was $863, with 48% paid out-of-pocket, compared to an average 18% paid out-of-pocket by non-CDHP users. Per user expenditures differ by type of private coverage, duration of enrollment, and user health care needs. Due to improvements in enrollment data provided by Maryland insurers, this report includes information on utilization and spending among those enrolled for the entire year. A second innovation in this report is the introduction of a risk score, based on each full-year user's diagnoses, to indicate a user's expenditure risk. Full-year users covered by public employers have higher expenditure risk, use more services, and, consequently, average higher annual spending than users in large private employer plans ($1,027 versus $996). Payers with large market share (consisting of CareFirst and United Healthcare) have higher per-user spending for full-year enrollees ($1,026) than other payers ($987), due mainly to higher service volume per user.

Prescription Drug Use and Expenditures: Trends among Privately Insured Patients, 2005 was released in February. It is a study of prescription drug utilization among nonelderly Maryland residents with private drug coverage, with the MCDB as the key data source. Prescription drug spending for the typical (median) user was $229 in 2005—$144 (63%) paid by the insurer and $85 paid by the consumer—up from $163 in 2001. The growth in per-user spending over this period was driven about equally by price increases and changes in drug utilization. The portion of total per-user spending reimbursed by insurers fell from 69% in 2001, indicating that consumers paid an increasing share of drug expenditures out-of-pocket. Like many health care

services, drug spending is characterized by a relatively small number of users with high expenditures and a large number of users with small expenditures. In 2005, the highest 25% of users accounted for 81% of prescription drug expenditures; the bottom half of users accounted for only 5 percent of expenditures. The typical (median) user obtained 5 prescriptions costing $229, while those at the 25th percentile obtained two prescriptions totaling $65, and those at the 75th percentile obtained 12 prescriptions costing $767. Branded drugs accounted for 51 percent of the prescriptions, 82 percent of total prescription spending, and 73% of out-of-pocket payments. There was a relative increase in use of generic drugs from 2003 (43% of all prescriptions) to 2005 (47%). Generic drugs remain a better deal for the consumer, since they account for about half of consumer prescriptions but only one-fourth of out-of-pocket payments. The Maryland prescription drug market continues to be dominated by retail sales: in 2005 prescriptions dispensed by a mail order pharmacy accounted for only 9 percent of Maryland prescription drug spending and a similar proportion of prescriptions, unchanged from 2004. Nationally, use of mail order is considerably higher. Maryland's lower mail-order share is likely due to two subsections of the Maryland Insurance Article that 1) prohibit insurance carriers from mandating use of mail order or offering enrollees reduced co-payments as an incentive to use mail order, and 2) require carriers to allow enrollees to obtain a 90-day supply of a maintenance drug after the initial prescription.

The division staff conducted extensive analyses of health insurance coverage in Maryland using Maryland data from the national Current Population Survey and released a report in January, *Health Insurance Coverage in Maryland Through 2005.* This report is designed to meet the varied needs of the Maryland Department of Health and Mental Hygiene (DHMH), legislators, and stakeholders by providing information on the broad patterns and trends in insurance coverage in the state, as well as more detailed information on selected sub-populations, including children. The state's nonelderly uninsured rate in 2004-2005 was 15.8%, with an average of 780,000 nonelderly uninsured residents per year. These statistics likely reflect persons who were uninsured for four or more months of the year, and, since the typical uninsured spell lasts 5.6 months, include most of those who were uninsured during the year. The state rate was below the comparable uninsured rate for the U.S. in 2004-2005, 17.7%. During the period from 2000-2001 through 2004-2005, Maryland experienced a significant increase in its two-year-average nonelderly uninsured rate—from 12.8% in 2000-2001 to 15.3% in 2002-2003—but the rate was statistically stable from 2002-2003 to 2004-2005. From 2000-2001 to 2004-2005, the employment-based coverage rate declined from 77% to 69%, but remains higher than the national average. Conversely, the state's Medicaid rate rose during this period from 6% to 9%. In Maryland as nationwide, some demographic groups are more likely to obtain health insurance than others. Excluding children, whose uninsured rate (9%) is much better than the state's nonelderly average, residents with less income and education are more likely to be uninsured. Younger adults are more likely to be uninsured than older adults, even at the same income levels. Regardless of income, Hispanics especially, and Blacks to a lesser degree, are more likely to be uninsured than Whites, and non-citizens are more likely to be uninsured than U.S. citizens. Maryland differs somewhat from the national average in the

composition of its uninsured who, like Maryland as a whole, tend to be more affluent than the national average. Most of Maryland's uninsured live in families with at least one working adult (80%) and have family incomes at 300% of the federal poverty level or below (63%). Most (82%) are adults, especially adults without dependent children (61%).

A *Spotlight on Maryland* issue brief, *Asthma Could Be More Effectively Managed for Many Privately Insured Children in Maryland*, was released in September. The purpose of the study is to provide information on the quality of asthma care received by privately insured children in Maryland by assessing adherence to National Asthma Education and Prevention Program (NAEPP) medication guidelines. Lack of asthma control and evidence of nonadherence to the NAEPP guidelines in the treatment of asthma are widely acknowledged. Data for the study of children ages 5-17 with a diagnosis of asthma and private insurance coverage for both physician care and prescription drugs came from MHCC's Medical Care Data Base of private insurance claims. Children who obtained three or more prescriptions for rescue medications during the year were classified as having uncontrolled asthma. The results indicated that asthma was uncontrolled in more than one-fourth of all the privately insured children with asthma, amounting to 37% of the children classified as having persistent asthma. NAEPP guidelines advocate daily use of anti-inflammatory medications (controller medications) as maintenance drugs for control of persistent asthma, with inhaled corticosteroids as the preferred first-line anti-inflammatory. However, more than one-third of the children with uncontrolled asthma received no inhaled corticosteroids medications for symptom management, with 13% not receiving controller medications of any type. The results of this study provide a baseline to measure efforts by Maryland's physician, insurer, and public health communities to improve the treatment of asthma. We intend to reproduce this study in the future.

Maryland Trauma Physician Services Fund

The Maryland Trauma Physician Services Fund ("Trauma Fund" or "Fund") covers the costs of medical care provided by trauma physicians at Maryland's designated trauma centers for uncompensated care patients, Medicaid enrolled patients, and trauma related on-call expenses. The Fund is financed through a $5 surcharge on motor vehicle registrations and renewals. A balance of about $20 million developed in the Trauma Fund as collections exceeded spending in the first four years of operation. House Bill 1164 (Trauma Reimbursement and Grants) passed during the 2006 session of the Maryland General Assembly realigned spending with collections by increasing the physicians specialties eligible for uncompensated and Medicaid under-compensated care and raised the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers became eligible for uncompensated care reimbursement and elevated Medicaid payments. The General Assembly directed the MHCC to award trauma equipment grants totaling $3 million from the balance in the Trauma Fund at the end of FY 2006.

During FY 2007, the Maryland Motor Vehicle Administration ("MVA") collected $12.9 million from the $5 surcharge on motor vehicle renewals. Disbursements from the Trauma Fund significantly increased in FY 2007 as a result of the passage of House Bill 1164. The Trauma Fund paid trauma physicians and trauma centers $13.1 million for uncompensated care, Medicaid under-compensated services, trauma on-call expenses, and trauma grants. The Fund also held $3.0 million in claims for uncompensated care, on-call, and standby expenses that were incurred, but not paid during the fiscal year. The balance in the Trauma Fund remained at approximately $20 million at the end of FY 2007, or $17.5 million if incurred but not paid obligations were netted against the Fund.

The MHCC estimates MVA collections through the $5 fee should increase by about 2 percent per year in 2008 and 2009. Projected spending under current law in 2008 will be about $12.7 million or 7 percent below collections from the MVA. The Fund balance is projected to increase by about $1.5 million over the next several years. MHCC recommends that the General Assembly grant MHCC flexibility to disburse Trauma Fund balances on trauma equipment grants and for adjusting physician fees to ensure broad participation in the Trauma System. The $275,000 cap on reimbursement to emergency medicine should be removed as no other specialty operates under with a limitation on uncompensated care. These changes require modification to the statute. MHCC recommends a limited expansion in the eligibility of on-call payments. That modification will apply to Level I trauma centers and referral centers and can be accomplished through a regulatory change.

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for managing data collection efforts and health care provider surveys mandated by law. The Commission has authority to collect and manage information on health care professionals, hospitals, nursing homes, assisted living facilities, and adult day care centers. This division also acquires and manages external analytic databases used by the Commission, including the Maryland and District of Columbia hospital inpatient and emergency department data, state and private psychiatric hospital data, outpatient ambulatory surgery data, Medicare and private payer outpatient claims data, large private payer pharmacy data, and several CMS data collections including the Minimum Data Set, Oscar file of nursing home deficiency data, and the Nursing Home resident file. The division has primary responsibility for development of administrative software systems, analysis support systems used by research staff, and Internet applications for survey data collection and dissemination of health care consumer information.

Accomplishments

Data Processing
Data Staff compiled a comprehensive application development requirements document which is now used in all contracts requiring application development. Application Staff assisted with development of the health disparities site. Staff developed an intranet based data request application which allows MHCC staff to create a new data request, copy an existing data request, print a data request, and browse existing data requests based on a key word search. Staff produced and published to the web public use data files for Adult Day Care, Assisted Living, Comprehensive Care, and Chronic Facilities.

Bed Need Inventory
For the nursing home facility occupancy database project, bed data was produced by scanning in the paper based files and then converting them into XML format. During this process staff reconciled the worksheet counts that OHCQ sends to MHCC versus the record count from the conversion. Staff developed processes for handling Multiple Facility bed transfers and for keeping an audit trail for each type of transaction.

Helicopter Study
Data Staff extracted private payer and Medicare payment data for the SB 770 (Helicopter Study). Methodologies were constructed to sum various payments associated with patient claims data for air ambulance services. Average totals were computed for helicopter transport used in inter-hospital and scene transport of patients. Staff generated a map of the distribution of helipads for the air ambulance report.

Home Health
The Home Health agency methodology was rewritten to allow the use of Maryland's Minimum Data Set for identifying home health agency candidates from Maryland nursing homes to help predict future need for home health agency services. Data Staff also assisted in preparing analyses for western Maryland and the eastern shore to determine which agencies could help in serving jurisdictions that are underserved. Data Staff assisted Home Health Staff in updating the State Health Plan for home health agencies. Staff began development of the Home Health Agency web-based survey.

Hospital Services/Certificate of Need
Staff completed 42 projects during the fiscal year. Projects included the Dimensions Hospital restructuring effort, the St. Agnes Campus revitalization project and a Review of Primary PCI Application for adult (18+) patients undergoing diagnostic cardiac catheterization at Upper Chesapeake Medical Center. Patient discharges, patient days and average length of stay by various diagnosis codes, charges, county of jurisdiction, planner-defined service or payment methods was calculated for numerous projects. Planning Services Study of out-migration Maryland residents to hospitals in D.C. was conducted.

Geographical analysis was utilized to illustrate various drive times to specific hospitals for different planner defined services. Staff assessed the hospitals affected and the level of impact potentially associated with closure of Laurel Regional Hospital.

The MHCC Daily Census Program was utilized when analyzing CON applications. An electronic CON Application for Hospitals to utilize was developed by staff. Staff completed conversion of the Excel Hospital Bed Projection application into SAS and the acute care methodology to SAS. The Calendar Conversion Program for the Discharge Abstract was updated to be able to process fiscal year 2006 data received from HSCRC which has a different format from previous years.

Staff assessed those hospitals affected and the level of impact potentially associated with closure of Laurel Regional Hospital. Staff worked on: the St. Agnes Expansion Project, the Frederick Memorial Hospital Neonates Discharges Project, the Peninsula Regional Medical Center Project, the Prince George's Hospital and Laurel Regional Hospital Project, a Review of the Primary PCI Application, the Planning Services Study of out-migration of Maryland residents to Hospitals in D.C., and the Dimensions restructuring effort.

Institutional Review Board

The IRB limited Data set of the DC inpatient data was approved for eight research projects. The data sets requested ranged from CY 2000-2006. Approved projects included: DP Services to Support Data Analysis (St. Paul Computer Center, Inc); Inpatient origin and market share analysis (Soo Suh, Senior Associate, Kaufman Hall & Associates); Hospital Discharge Forecasting Model (Tim Garton, President, Health Forecasts); Outmigration of residents from Maryland Eastern Shore (Mary Lanham, Director, Marketing and Public Relations, Baltimore Washington Medical Center); Utilization of District of Columbia Hospitals by Maryland (Richard Coughlan, Cohen, Rutherford & Knight); Planning Services Study of outmigration Maryland residents (Andrea Tolbert, Senior Market Analyst, Holy Cross Hospital); Planning Services Study of outmigration Maryland residents to Hospitals in DC (Soo Suh, Senior Associate, Kaufman Hall & Associates); and Investigation of MD Teen Births & Infant Mortality, maternal Complications of Pregnancy, Childhood (Marsha Smith, MD, MPH, Medical Director Perinatal, Center for Maternal & Child Health, DHMH).

Long Term Care

Data Staff completed a series of demographic tables describing Maryland nursing home residents and home health patients. These tables were used to update the State Health Plan for Long Term Care Services. Data Staff performed quarterly updates to the nursing home website for deficiencies, resident demographics, quality measures and quality indicators. Data Staff completed the Long Term Care Bed Trends reports for Comprehensive Care and Assisted Living facilities.

Maryland Assessment Tool for Community Health (MATCH)
The purpose of the MATCH project is to design, develop, test and implement a web-based data-mart analysis portal that will allow the public to easily perform statistical queries of select Department datasets and obtain immediate hypercube data results. The vision is to build a maintainable, scalable website within the Department where internet users can build, run and download aggregate data queries from the Department's health agencies. MHCC participated in the development of this project and contributed the private payer portion of the Medical Care Data Base, the Maryland Inpatient Discharge Abstract, and the Maryland Ambulatory Care (Emergency Department) data set.

Medical Care Data Base
Data Staff assisted the cost and quality staff with Current Population Survey processing and made modifications to the asthma report. Data Staff analyzed private payer and Medicare data for telemedicine procedures and summarized physician payments for the physician pricing application.

OfficeTrak
Data Staff developed and deployed the OfficeTrak administrative tracking database which allows staff to communicate all budget, requisition, bid board and proposal requests through the database application which tracks fulfillment of these requests.

Physician Database
Staff worked with the Board of Physician Quality to determine the format and content of the Physician Database public use file. Data Staff standardized the fields across years, added new variables and constructed a flag indicating records which are in the MHCC subset of active practice physicians. Data staff processed the manually entered license database and cleaned and merged the data with the electronically submitted licenses. Staff worked on a Physician by Specialty Report which compares Maryland doctors to national statistics by specialty.
The Maryland General Assembly's Office of Policy Analysis requested a report detailing the racial makeup of Maryland's doctors.

Trauma Fund/Emergency Room
Data Staff conducted analysis of trauma patients who were admitted to acute care hospitals and of all patients treated at the University of Maryland Shock Trauma Center. A report detailing the number of patients treated and the number of self-pay patients for calendar year 2006 was produced. Data Staff updated a Project Hope study on use of Maryland's emergency rooms to determine the type of medical problem, whether the emergency care was actually needed and who paid for the medical treatment. Data Staff developed reports of billing data by tax-ID and physician suffix and data grouped by suffix for each tax-ID.

Graphic Work
Data Staff developed bookmarks, logos, report covers and reports and provided technical support for print and press issues for all divisions of the Commission. Data Staff trained administrative staff in the use of graphic software in order to distribute the load of graphic work.

Web Application Development

Internal Development

Assessment Database
Major changes were made to the Assessment application to allow for the adjusted calculation of hospital assessments based on a prior year adjustment of assessments fees. This resulted in debits or credits given to hospitals on this year's assessment. Supporting reports were also modified to show these adjustments.

Long Term Care and Assisted Living Profile
The Data Staff incorporated Medicaid cost report data into the annual electronic survey to save facilities from having to retype the information. The 2005 survey was developed and released and surveys were monitored for accuracy and technical support to the facilities was provided. Data Staff assisted with updating the State Health Plan for nursing homes and home health agencies, and conducted post survey processing of the completed 2005 survey. Staff worked together to make program coding changes for the Long Term Care Survey and changed the method of matching provider numbers which have varied over the years. Data from assisted living facilities were uploaded to the WEB to produce a profile of these facilities for the public.

Nursing Home Report Card
Staff overhauled MDS processing because of format changes starting with the 1st quarter 2006 MDS assessment file. In addition, the facility page was rewritten in order to accommodate frequent additions of new fields requested by the Long Term Care Staff.

MHCC Website
The MHCC website was overhauled to direct users into 4 core user types in order to better direct them to needed information. The overhaul incorporated newer search engine optimization techniques. New areas of the website were developed for health disparities, PCI Waiver, Long Term Care Study, and RPRC (cardiovascular). Data Staff evaluated and installed a web analytics system so that staff can track and manage their project web traffic.

External Development

Dental Online licensing ended on June 30, 2006 as planned. There were 3,262 applicants (75%) renewals online of which 2,936 (91%) paid by credit card collecting $1,036,806. The Dental

Radiation Tech Online Renewal application was developed and went live January 1, 2007. The Physical Therapy Online Renewal application was developed and went live on March 1, 2007. A new credit card interface was developed to work with Mac users for the Physician Licensing Renewal application as well as a new navigational system. The final statistics for the Physicians Renewal were: renewals 10,670 (77% of database on file); fees collected $5,501,651 ($4,662,348 by credit card).

Network and Operating Systems Division

Overview

The division's staff developed and maintains the Commission's local area network (LAN). This function encompasses a wide variety of hardware and software products. The MHCC hardware includes database, file, print, mail, Intranet and Internet servers, PCs, and peripherals such as tape and disk subsystems, switches, and other infrastructure equipment. The staff configures and maintains all network servers and workstations and installs and maintains all server and workstation software.

Division staff implement and enforce security conventions to guard against external threats and maintain the data access conventions adopted by the Commission that control staff's access to sensitive information. The division is responsible for network disaster recovery and business continuity planning.

Staff also provide technical assessment, configuration management, and capacity planning functions for the organization and is responsible for assessing new technologies and recommending and implementing changes to keep the Commission's information systems fully responsive to the Commission's needs.

Accomplishments

During FY 2007, the Commission's LAN was available to staff more than 99% of the time.

The Commission's LAN has been safeguarded by the vigilant application of software patches and an upgrade of anti-virus software. Security is enhanced because it is a private network behind an MHCC firewall, which isolates the MHCC LAN from the DHMH wide area network, which is behind its own firewall.

The Center for Long Term Care and Community Based Services

and

The Center for Health Care Financing and Health Policy

THE CENTER FOR HEALTH CARE FINANCING AND HEALTH POLICY

Small Group Market

Overview

The initial charge to the Health Care Access and Cost Commission (HCACC —one of the predecessors of the MHCC) was to develop a benefit plan for small employers which includes benefits that are at least equivalent to those benefits required to be offered by a federally qualified HMO with an average premium cap for the basic plan that does not exceed twelve percent of Maryland's average annual wage in any year. Working with this statutory floor and ceiling, the legislation also directed the Commission to adopt regulations specifying a comprehensive standard health benefit plan (CSHBP) to apply under Maryland insurance law (*Annotated Code of Maryland,* Health-General Article 19-103(c)(6)). The Maryland Insurance Article ***(****Annotated Code of Maryland,* Insurance Article, Title 15***)*** initially defined the small group market as employers with two to fifty employees. In 1996, the small group market was expanded to include the self-employed. Regulations require the Commission to review the CSHBP annually to assess the adequacy and affordability of coverage (COMAR 31.11.06.12). In 2003, the cap was set not to exceed ten percent of the state's average annual wage (Chapter 93 of the Laws of Maryland, effective July 1, 2003.) The General Assembly passed SB 1014 (during the 2005 legislative session) that no longer allows the self-employed to enroll in the CSHBP.

As of July 1, 1994, carriers participating in the small employer market can only offer a policy incorporating the CSHBP on a guaranteed issue, guaranteed renewal basis. Medical underwriting was phased out as of January 1, 1995. Riders can be issued to improve the

benefits, but not to diminish them. The insurance reform required community rating adjusted only for age and geography. Rating bands were established and are currently set at +/- forty percent. Since its inception, this health insurance reform initiative has provided small businesses in Maryland with access to a comprehensive health insurance benefits package on a guaranteed issue, guaranteed renewal basis, without rating based on health status.

During the 2004 legislative session, the General Assembly passed SB 570 that required the MHCC to develop a Limited Benefit Plan (LBP) that was available to certain small employers beginning July 1, 2005. In specifying the LBP, the MHCC must ensure that the actuarial value of the LBP does not exceed seventy percent of the actuarial value of the Comprehensive Standard Health Benefit Plan as of January 1, 2004. SB 570 requires that the LBP be offered to a small employer who: (1) has not provided the Standard Plan during the twelve-month period preceding the date of application or, if the small employer has existed for less than twelve months, from the date the small employer commenced its business; and (2) has employees in the employer's group with an average annual wage that does not exceed seventy-five percent of the average annual wage in the state.

Accomplishments

Comprehensive Standard Health Benefit Plan

Throughout FY 2006, the Commission accomplished several goals relating to the CSHBP. As the result of data reported in May 2005 survey of carriers participating in the small group market, the Commission began an extensive and thorough review of benefits and out of pocket costs in the CSHBP, since the survey indicated that CSHBP premiums were estimated to have exceeded the affordability cap by about 2%. In September 2005, the Commission developed both short-term and long-term strategies to ensure the viability of the CSHBP and the small group market. A major part of this initiative involved a series of town meetings held throughout the State to receive as much feedback as possible from all parties directly impacted by small group reform. These interested parties included Maryland residents, small business owners, their employees and families, as well as insurance companies, brokers, agents, advocacy groups, and various other stakeholders. The town meetings resulted in an enormous amount of valuable information that the Commission used to modify its initial strategies and ultimately craft new regulations for the CSHBP. The new regulations, which allow carriers to offer more flexibility in benefit design and pricing, include a high deductible prescription drug benefit and an HSA-compatible HMO product. The new regulations become effective on July 1, 2006 in an effort to bring the overall cost of the CSHBP below the statutory cap.

Limited Benefit Plan

As the result of public meetings, the Commission developed the Limited Health Benefit Plan (LBP), which participating carriers began offering to certain small employers on July 1, 2005. Along with conducting meetings with interested parties and holding a public hearing, staff worked with Mercer Human Resource Consulting (Mercer), its consulting actuary, as well as

CareFirst BlueCross BlueShield (CareFirst) and United HealthCare, to develop alternative proposals that meet the statutory requirement of pricing the LBP at 70% of the cost of the CSHBP as of January 1, 2004. The process resulted in the development of two proposed options: a credit fund plan and a capped benefit plan. In March 2005, the Commission approved the final regulations for both options to be implemented effective July 1, 2005. CareFirst and United, the two carriers required to participate in the LBP, began offering the capped benefit plan on July 1, 2005. The Commission is required to submit a report to the General Assembly by January 1, 2008.

Health Plan Quality and Performance Division

Overview

The Annotated Code of Maryland, Section 19-135C, *et seq.* directs the Commission to establish and implement a system to evaluate and compare, on an objective basis, the performance and quality of care provided by commercial health maintenance organizations (HMOs). The Commission is required to publish the findings of the evaluation system and disseminates reports to Marylanders, HMOs, and interested parties annually. The statute also permits the Commission to solicit opinions on HMO performance from enrollees. Regulations require an HMO to file data collected using the standardized tool Health Plan Employer Data and Information Set (HEDIS; renamed *Healthcare Effectiveness Data and Information Set* summer 2007) with the Commission if it holds a certificate of authority in Maryland and has a premium volume in Maryland exceeding $1 million. HMOs having more than 65 percent of their enrollees covered through the Medicare and Medicaid programs are not required to submit HEDIS reports to the Commission.

Accomplishments

2006 Report Series

The Division of Health Plan Quality and Performance is charged with collecting, and making available to the public, comparative information on the performance of commercial HMOs operating in Maryland. The comparative information supports consumers, purchasers, academics, and policymakers in assessing the relative quality of services provided by this segment of managed care plans.

Division staff worked in partnership with contractor staff having special expertise in health quality measurement to develop the tenth series of annual HMO reports. The four report series had separate release dates during the fiscal period to coincide with audiences' timeframes for use. Beginning in autumn 2006, two publications—*Measuring the Quality of Maryland HMOs and POS Plans: 2006/2007 Consumer Guide* and *2006 Comprehensive Performance Report: Commercial HMOs & their POS Plans in Maryland*— were completed and released.

The *Comprehensive Report* targets audiences, such as health benefit plan managers, who seek detailed content. This report assembled the collective results reported by plans to form a statistical compendium of HEDIS (clinical) and CAHPS (survey) data. Results for the seven plans required to submit their performance data were benchmarked against the state average. The state average reflects the simple average of the combined plan performances for each clinical and survey measure. Measurement areas span from frequency of selected medical procedures and utilization of medical facilities to rates of recommended preventive and chronic care services.

The *2006 Consumer Guide*, a consumer-oriented comparative report, was derived from the collective data displayed in the *Comprehensive Report* and presented as a sub-set of the measures of interest to a general audience. This report was designed for individuals who are deciding which health plan to join and for employers who are choosing which HMO or HMO-linked point-of-service plan (POS) to offer their employees**.** HMOs and POS plans are compared on members' satisfaction with their plan and the health care that they receive as well as on the degree to which recommended health care services are provided to members.

In February 2007, the third publication, *Maryland Commercial HMOs and POS Plans: Report to Policy Makers* was released. The release of the publication is timed to coincide with the regular session of the general assembly, the primary audience for the report.

The *Policy Makers Report* extended the analysis of the results by providing a snapshot of how Maryland commercial HMOs and their affiliated point of service products compared to the average performance of their counterparts in the Mid-Atlantic region and the nation. In addition, the report showed how the overall performance of Maryland commercial HMOs changed over time. Analysis of the three-year results (2004—2006) showed no statistically significant changes in measure results, indicating that Maryland's performance on these clinical and satisfaction measures has been consistent over this period. Although not statistically significant, several measures showed increases of five percentage points and higher, with the highest increase at 12 percentage points. The most marked improvements were in Chlamydia Screening, Colorectal Cancer Screening, Childhood Immunizations, Adolescent Immunizations, Controlling High Blood Pressure, Monitoring for Diabetic Nephropathy (kidney disease), and Initiation of Alcohol and Other Drug Treatment. These upward rates shifts represent increased services among the span of age groups and health statuses.

Completing the 2006 HMO report series, the forth and final report, *Measuring the Quality of Maryland HMOs and POS Plans: 2007/2008 State Employee Guide,* was created for Maryland's 50,000 active and retired state employees during spring 2007. This report mirrored the *Consumer Guide* but limited the plan results to only those plans available to state employees. Procedural information specific to state employees was also presented to assist in their understanding of how to obtain authorizations for behavioral health care and to learn of the additional resources developed by other state agencies.

Upon their release, the reports were sent to businesses, HMOs, libraries, policy makers, and academic health care programs, with distribution continuing, when possible, throughout the fiscal year. During this fiscal period, transition to a paperless distribution system began with the *State Employee Guide.* In lieu of producing and distributing 50,000 paper copies, Maryland employees and retirees received a specially designed bookmark in their benefit materials to notify them how to locate and use the comparative report. Declining outreach activities resulted from fewer staff dedicated to this project. Staff fulfilled requests from employers, associations, colleges, universities, and public libraries for printed copies. The *Maryland Commercial HMOs and POS Plans: Report to Policy Makers* was distributed to all Maryland legislators, HMO contacts and CEOs, and other interested parties. All Maryland libraries received the full set of printed reports for their reference section, as well as repositories received them for their state publication archives.

To reach the broadest audience, readers could obtain the reports in paper and electronic formats. All reports in the HMO performance report series were posted on the Commission's website in a PDF format.

2007 Report Series

Administration of the 2007 survey of HMO and POS members was completed in the spring 2007 using the CAHPS 4.0H survey tool making this the ninth year this instrument has been used to collect member opinions. The data collected for this report series followed the most recent survey protocol that required a sample composed of 1,100 adult members from each of the seven HMOs submitting performance data during calendar year 2007. Because six plans have relatively large point of service memberships, the sample of members surveyed for those plans included both HMO and POS members. This allowed plans to more accurately assess how delivery occurs within their health systems.

Over the course of the first half of 2007, the seven HMOs reporting in this calendar year underwent an audit of their HEDIS data collection processes, information systems, and rates submitted to the Commission in June. Division staff directed activities conducted by HealthcareDat.com, LLC, an NCQA-certified (National Committee for Quality Assurance) auditing firm. In addition, Division staff participated in all document reviews, onsite interviews, and communications with NCQA's policy body regarding various matters that affected the data collection process.

Expansion of Health Plan Quality Reporting: Background and Voluntary Activities in 2007

To test the administrative feasibility of performance reporting by preferred provider organizations (PPOs), the Maryland Health Care Commission hosted a series of conference calls throughout 2006 with quality improvement directors from insurers currently collecting HEDIS data for their HMO product line: Aetna, CareFirst, CIGNA, Coventry, Kaiser, and United Healthcare. The objectives of these discussions were to:

- Identify limitations and barriers to PPO plan data collection,
- Report progress and solicit feedback and ideas from all participants,
- Discuss other quality measures outside of HEDIS for possible inclusion in the test measurement set, and
- Obtain a commitment for voluntary participation in data collection, submission, and reporting.

Several plans provided significant input based on efforts they had underway in 2006 to assess their capacity to collect data and validate results of PPO quality measurement. Others reported they had begun preparations for federally required, first-year submissions in 2007.

Two insurers agreed to undergo a simultaneous quality evaluation and audit of their PPO and HMO products in 2007. The evaluation was based on a limited measurement set using a single prescribed data collection method.

General Results and Observations of the PPO Feasibility Study:

- Generally, HEDIS auditors found implementation of the process to be similar to that for HMO/POS plans.
- Unique coding and product specific transaction systems require further attention to organization of the audit process and keen review of details, some complications do exist where a plan relies on unique transaction systems.
- Several technical considerations were identified through this examination. Though limited in the number of observations, the process revealed challenges in collecting data for measures that require medical record review and those with sensitivity for provider type.
- Establishing uniform guidelines for the member population development: risk vs non-risk, benefit structure, enrollment metrics

Future Expanded Public Reporting: PPO performance reporting is feasible using the HEDIS audit tool and protocol. Some limitations exist on the breadth of measures for which data can be reliably collected without excessive resource burdens to the health plans. Principally, the limitations center on measures that require pursuit of medical records to confirm compliance with the measure specifications. Therefore, for the near-term, voluntary participation by PPO plans will exclude medical record reviews to collect data. As this is relatively unchartered performance assessment territory, it is too soon to assess the influence PPO health plans can exert on clinical quality improvement.

2008 Report Series

Upon completion of the feasibility study for expanded performance reporting, a new public-private partnership between the Commission and four major health care providers in the state emerged that will facilitate voluntary collection and reporting of PPO comparative data in 2008. The providers are Aetna, CareFirst BlueCross BlueShield, CIGNA, and United Healthcare.

As it currently stands, Maryland will become the first in the nation to provide consumers with audited, comparative analysis of clinical and member satisfaction measures, giving consumers an opportunity to make distinctions about their health plan choices on factors beyond price.

Mandated Health Insurance Services Evaluation

Overview

In 1998, the Maryland General Assembly expanded the Commission's duties requiring the Commission to conduct an initial evaluation of the cost of existing health insurance services, and requiring the Commission to assess the financial, medical, and social impact of any legislatively proposed health insurance service, (Annotated Code of Maryland, Insurance Article, Title 15, Subtitle 15). The Annual Mandated Health Insurance Services Evaluation report is due to the legislature each December 31. The mandates do not affect Medicare, Medicaid, or self-insured products. It should be noted that the annual mandate evaluation applies only to health services and not to issues of eligibility, continuation of benefits, or reimbursement to certain providers of services, which are also sometimes considered "mandated benefits."

In 1999, the legislature expanded these requirements to request annual reporting on whether the fiscal impact of existing mandates exceeded a statutory income affordability cap of 2.2 percent of Maryland's average annual wage. If the 2.2 percent affordability cap was exceeded, an analysis of the financial, medical, and social impacts of all current mandates was required. That study was eliminated during the 2003 legislative session and replaced with a new study (now called the "Comparative Study") which was required to be submitted to the General Assembly by January 1, 2004, and every four years thereafter. The Comparative Study must include: (1) an assessment of the full cost of each existing mandated benefit as a percentage of the state's average annual wage and of premiums for the individual and group health insurance market; (2) an assessment of the degree to which existing mandated benefits are covered in self-funded plans; and (3) a comparison of mandated benefits provided by the state with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.

Accomplishments

In FY 2006, Mercer prepared its eighth study of the impact of mandated services. Commission staff submitted this report, along with a transmittal letter summarizing the key findings in the report and outlining the issues posed by each proposed mandate, to the General Assembly in January 2006. A complete copy of the mandated services report entitled, *Annual Mandated Health Insurance Services Evaluation, January 19, 2006,* is available on the Commission's website. The first part of the report contains actuarial estimates of the annual cost impact of Maryland's existing required health insurance services for four types of contracts: group insurance plans; individual insurance plans; the CSHBP for small groups; and the Maryland state employee benefit plan. The second part of the report, in preparation for the 2006 legislative

session, includes an evaluation of the financial, medical, and social impact of three mandates, at the request of three legislators. The next comparative study is due January 1, 2008.

THE CENTER FOR LONG-TERM CARE AND COMMUNITY-BASED SERVICES

Long Term Care Initiative

Overview

The Long Term Care Quality Initiative, a division within the Center for Long-term Care and Community-based Services, focuses on improving long-term and community-based care through public reporting of the performance and quality of long term care facilities. The division is responsible for developing and maintaining the interactive web-based consumer Guides that present general information on Long Term Care (LTC) topics and the specific performance of nursing homes and assisted living facilities in Maryland. The division provides oversight for administration of an annual survey that measures the experience and satisfaction of family members and other designated responsible parties of residents in Maryland's long-term care facilities. Staff of the division also provide support to the LTC Advisory Committee, a group convened to provide advice on LTC policy, planning, and public reporting issues. In 2007, a significant proportion of staff time was committed devoted to activities in support of the Long Term Care Study mandated by House Bill 1342.

Long Term Care Planning Act

In the 2006 legislative session, House Bill 1342, The Long Term Care Planning Act of 2006, was enacted. This legislation directed the MHCC to conduct a study to:

a. Determine the types of services and programs that people aged 65 and older and individuals with disabilities will need in 2010, 2020, 2030; and,
b. Identify how the State should begin planning for needed services and programs.

Accomplishments

Consumer Guides

Currently two performance guides are produced: the Maryland Nursing Home Guide and the Maryland Guide to Assisted Living Facilities. The purpose of the guides is to assist consumers in making informed choices and to stimulate quality improvement within facilities.

The *Maryland Nursing Home Guide* offers information about more than 224 comprehensive care nursing facilities and continuing care retirement communities. Users can review information on facility characteristics such as ownership information, the number of beds, and clinical services; resident characteristics including gender, age, and functional status; 14 quality measures derived from the CMS Nursing Home Compare data; eleven quality indicators; and the results of inspection surveys. The Guide also provides information about patient rights, how to pay for nursing home care, a checklist to use when choosing a nursing home; and links to additional resources. An interactive search feature allows the user to access nursing home

information by facility name or geographical area (county or zip code). The Maryland Nursing Home Guide received over 1,500 visits each month during the year.

The *Maryland Guide to Assisted Living Facilities* contains an inventory of over 350 assisted living homes with 10 or more beds. Information on facility characteristics, levels of care, facility services, rates, and utilization can be reviewed for individual facilities or compared for multiple facilities. The Assisted Living Guide received over 1,300 visits monthly during FY 2007.

The Commission continually updates each Guide when data are available.

Using focus group feedback obtained in FY 2006, the following enhancements were made to the Nursing Home guide in January 2007.

- A "new look" and feel with brighter colors, font size that can be enlarged by the user, simplified design, font type and colors selected based on suitability for people who have diminished visual acuity
- Enhanced navigation includes buttons that highlight key features
- Simplification of technical terms, updated text, and links to resources
- A major new feature is the ability to compare nursing homes side by side on facility, resident characteristics and quality measures.
- Addition of a user survey to identify the reasons for visiting, who visits the site, and preferences for additional content.

Announcement of new web site features was done in April 2007; press coverage generated considerable interest of Marylanders in guide content with upsurge of requests for searches and content by people without internet access. Staff processed all requests. The nursing home guide now receives nearly 1,500 visits per month.

Commission staff also began planning for the next generation of changes for implementation in the 2008 fiscal year. Planning includes addition of: pictures of facilities, quality measures associated with healthcare associated infection (HAI), report of experience and satisfaction with care for individual facilities, simplification of the ratings to enhance transparency, and expanded information about facility room configuration and proximity of toileting facilities to resident rooms.

Family Survey

During the 2006 fiscal year, the Commission piloted a family survey to determine the feasibility of measuring satisfaction with the quality of care received in Maryland nursing homes. Statewide results of the pilot were released in FY 2006. During 2007, Commission staff released a request for proposals to select a contractor to conduct a Nursing Home Family Satisfaction Survey using a revised questionnaire developed with the input of Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS) and the two

nursing home associations in Maryland. The survey will be completed during FY 2008; results for each participating nursing home will be added to the Maryland Nursing Home Guide.

Long Term Care Study

Throughout the year LTC Quality Initiative staff and staff of the LTC policy and planning divisions provided oversight for conduct of the LTC study. The University of Maryland, Baltimore County, Center for Health Program Development and Management (UMBC) was engaged to provide project management, acquire data/reports to produce specified analyses; draw conclusions from analyses; generate recommendations for consideration; and assist in producing the final report for the approval of the Commission. A second procurement was completed that resulted in identification of a consultant to provide a futurist perspective to the long range planning aspects of the study, articulate the components and configuration of future LTC services and supports, and estimate affordability and cost to the state. A Memorandum of Agreement was executed between the Commission and George Mason University for the services of a faculty member, Dr. William McAuley. Dr. McAuley's expertise in long term care strengthened long range planning aspects of the study, particularly for the distant years of 2015-2030.

Long-term Care and Community-based Services (LTC) Advisory Committee

The LTC Advisory Committee, convened as a resource to the Commission to address various policy and public reporting issues, first met in August 2006. The advisory committee has broad consumer and advocacy representation consisting of twenty individuals representing long-term and community-based service agencies, advocacy groups, state agencies providing or funding LTC services, and consumers.

Monthly advisory meetings were held during FY 2007. Meeting content included presentations by national experts in LTC on topics to enhance members' knowledge of latest advancements in LTC and trends. As the LTC study neared completion, there were presentations of draft sections of the study during meetings. Presentations were followed by the opportunity for members to submit feedback, a step that was helpful in assuring the study scope was inclusive of LTC stakeholders expertise and requirements. The advisory presentations were also posted on the MHCC web site for public use.

Other activities

Staff attended meetings convened by the Office of Health Care Quality (OHCQ) to participate in development of a standard assisted living program services disclosure. OHCQ was required by HB 826 to develop the disclosure form and policy in consultation with the Maryland Health Care Commission and other stakeholders. The form was finalized in November 2006.

At the invitation of Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (CMS), staff participated in a Technical Expert Panel (TEP) held in September 2006 to provide advice on development of consumer tools for assisted living, home health, and community services.

Long Term Care Policy and Planning

Overview

This was a period of Commission structural reorganization and staff transition for this function. Staff moved from the Planning Unit within the Division of Long Term Care and Mental Health Services to the Division of Long Term Care Policy and Planning in the new Center for Long Term Care and Community-Based Services. The former unit was responsible for health planning functions related to community-based and institutional long term care services. This included monitoring changes in demographics, medical technology, financing and reimbursement, and their impact on current and projected utilization of long term care services in Maryland; assessing the current health care delivery system in Maryland; determining where there may be gaps in the continuum of care; and promoting the development of needed services in response to identified needs, assuring access to a full continuum of long-term care services. The new unit incorporates the former planning functions, but also includes data collection, special studies, and quality assessment. The Commission coordinates its long term care policy development and planning efforts with other appropriate state agencies, and provides leadership and direction to technical advisory committees and workgroups conducting analyses of a wide range of issues.

Accomplishments

Reports:

State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services

During this time period, the State Health Plan was developed and finalized. The draft *State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services* was posted on the Commission's website on September 12, 2006 for a 30-day informal public comment period. This was extended for further comments on the hospice component to October 26, 2006. After review and necessary revisions based on the comments received, the State Health Plan was presented to the Commission on November 16, 2006. At that time, the Commission took action to adopt the State Health Plan as proposed permanent regulations with a formal comment period from December 22, 2006 through January 22, 2007. The Commission adopted the State Health Plan as final regulations at its February 15, 2007 meeting with an effective date of March 12, 2007. The State Health Plan and three supplements were posted on the Commission's website in April of 2007. These supplements include: Supplement 1: Statistical Data Tables (providing supporting information and trend data on nursing homes, home health agencies, and hospice programs); Supplement 2: Projected Need for Nursing Home Beds (2011) and Projected Need for Home Health Agencies (2010); and Supplement 3: Required Maryland Medical Assistance Participation Rates for Nursing Homes.

Long Term Services and Supports in Maryland: Planning for 2010, 2020, 2030
During this time period, work was begun on this study that was required under HB 1342, Long Term Care Planning Act of 2006. A Memorandum of Understanding with the University of Maryland Baltimore County, Center for Health Program Development and Management, was in effect from October 5, 2006 through April 30, 2008. Two major tasks were completed during this time period: Population Projections for the 65+ Population and Individuals with Disabilities; and Service Inventory by Category and Geographic Region. In addition, a second Memorandum of Understanding (MOU) was signed with George Mason University for the time period March 15, 2007 through April 30, 2008. The purpose of this MOU was to provide a futurist perspective and to assist in the development of the Long Term Care Study. Weekly conference calls were held with the consultants in the development of this study. They also made monthly presentations to the Long Term and Community Based Services Advisory Committee.

Chronic Hospital Occupancy Update
As required under COMAR 10.24.08, a notice was published in the December 22, 2006 *Maryland Register* to update Chronic Hospital Occupancy for FY 2005. This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital (formerly Deaton); and Gladys Spellman Specialty Hospital and Nursing Center. The state operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center.

Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland Fiscal Year 2004
The Commission's *2004 Nursing Home Occupancy Rates and Utilization by Payment Source* is based on data that were obtained from the 2004 Maryland Long Term Care Survey, 2004 Medicaid Cost Reports, and the Commission's nursing home bed inventory. This report and its accompanying technical notes were updated in June 2007 and later posted on the Commission's website.

Medicaid Patient Days and Nursing Home Occupancy Update
As required under COMAR 10.24.08, a notice was published in the August 31, 2007 *Maryland Register* to update the Percent of Total Patient Days Paid by Maryland Medical Assistance Program by Jurisdiction and Region for fiscal year 2004. In the same issue of the *Maryland Register*, the Commission also published an updated notice for nursing home operating occupancy for FY 2004.

Home Health Agency Data
Staff continued to analyze home health agency utilization data based on information submitted to the Commission in its Home Health Annual Report (survey). During this time period, data

was collected from all licensed home health agencies in Maryland for the FY 2006 reporting period. In addition, there was a contract with Social and Scientific Systems (SSS) for the creation of statistical profile tables for FY 2004, 2005 and 2006.

Guidelines for Establishing a Home Health Agency
In response to questions received by staff for establishing licensed home health agencies, staff developed a one-page information sheet entitled *Guidelines for Establishing a Home Health Agency.* This is designed to assist interested persons in navigating our website, as well as that of the Office of Health Care Quality, and the Centers for Medicare and Medicaid Services, on regulations pertaining to home health agency services. This was posted on the Commission's website in May of 2007.

CAHPS Home Health Survey
Staff was invited to participate on the Technical Expert Panel for the development of a nationwide consumer-based home health agency survey. Referred to as the CAHPS (Consumer Assessment of Health Plans and Providers) Home Health Survey, the Technical Expert Panel met on February 8, 2007 and were asked to provide technical assistance in the development of the survey.

Study of Health Care Services for Children with Life-Threatening Medical Conditions
HB 797 (2007) directed the Commission to work jointly with the Attorney General's Office on a Study of Health Care Services for Children with Life-Threatening Medical Conditions. On June 6, 2007 staff met with Jack Schwartz of the Attorney General's Office to discuss the approach to the bill and the development of the report due December 2007.

Meetings/Collaboration:

Assisted Living Forum
This group was convened by the Office of Health Care Quality (OHCQ) to receive input from providers and regulators on the impact of the licensing regulations on different types of assisted living providers. The division's staff is working closely with OHCQ staff in the area of assisted living. OHCQ is in the process of assessing the current regulations and determining whether they need to be changed to accommodate the various types and models of assisted living care. They are also working on common disclosure forms.

Nursing Home Liaison Committee
This group is chaired by staff of the Medicaid program of the Department of Health and Mental Hygiene (DHMH) and includes representatives of the individual nursing homes, nursing home associations, and accounting firms and consultants. Division staff track changes in Medicaid regulations and receive input from representatives of the long term care industry as members of this liaison committee.

In-Home Health Services Forum
This group was convened by OHCQ in order to review the regulations governing the various in-home services including, but not limited to: home health agencies; residential services agencies; nurse staffing agencies; and nursing referral service agencies. This group met during 2006. Division staff participated in this Forum as well as with the Regulations and Structural Requirements Workgroup.

OHCQ Advisory Group on Hospice
Staff participated with the OHCQ on this group. The purpose of these meetings was to share ideas with the hospice community on more effective ways to measure compliance with OHCQ survey standards. In addition, discussion included more effective corrective measures that providers can take when deficiencies are found.

Presentations:

Staff of the Long Term Care Division made presentations to associations representing those components of long term care for which the Commission plans, i.e., home health agencies, hospice, and nursing homes. Staff made a presentation to the Maryland National Capital Homecare Association on September 11, 2006 as part of its Annual Fall Convention.

In January 2007, staff prepared background materials for a presentation done by the Executive Director for Maryland Hospice Day in Annapolis. Staff presented information on the 2005 public use data set, the hospice section of the State Health Plan and changes made for the 2006 Maryland Hospice Survey.

In February 2007, staff attended the Maryland National Capital Homecare Association's Annual Legislative Conference in Annapolis. A presentation was made, updating the status of the State Health Plan, the annual home health agency survey, and an analysis of relevant trend data.

Data Collection:

Hospice Data Collection
The Commission was charged with collection of its own hospice data without relying on other sources, as a result of SB 732 (2003). In order to complete this task, staff conducted site visits of several hospice programs. A draft survey was developed and reviewed with representatives of the Hospice Network of Maryland. The Commission procured a contract with Perforum (now OCS), which has developed data collection tools for the National Hospice and Palliative Care Organization, to develop an online hospice survey. Weekly conference calls were held with OCS to monitor the data collection and data cleaning process. The fiscal year 2005 hospice data was collected during this time period. A public use data set was posted on the Commission's website in September, 2006.

Surveys:

Long Term Care Survey

The Commission continued to collect data on long term care facilities including comprehensive care**,** extended care, subacute care, chronic care, assisted living and adult day care facilities through the automated web-based survey application. Data elements such as the Medicaid Cost Report data and prior year ending year data were pre-populated into the current year's survey increasing efficiency and reducing errors. The 696 facilities, representing 98% of the surveyed facilities completed the 2005 long term care survey. Survey data was provided to the public via reports such as the Public Use Data Set posted on the Commission's Web Site, responses to the Nursing Home Guide and the Guide to Assisted Living Facilities. Staff released the 2006 long term care survey in July 2007 to 712 facilities across Maryland.

Home Health Agency Survey

The data collection process was transitioned to this center with new staff and a vision for enhancing the data collection process from the previous manual form to an automated web-based application with the goal to increase efficiency, and to obtain quality data in a more timely manner. Staff began writing the specifications to automate the FY 2007 Home Health Agency Survey, to include pre-populated data elements that facility would verify rather then key in, validation checks to allow agency staff to perform error resolutions, and increase efficiency and the ability to submit the data electronically via the Commission's Web Site.

Guide to Assisted Living

The Commission surveys assisted living facilities with ten or more beds during the annual long term care survey collection process. For the 2005 survey year, 332 assisted living facilities completed the survey and were included in the Guide to Assisted Living Facilities. All data for this Guide is derived from the Long Term Care Survey. These assisted living facilities were given the opportunity to update their profile on the Commission's Web Site with current rates, services and administrative information. Of the total, 25% updated their profile during that period. These facilities are also encouraged to include a photograph of their facility on their individual profile; 54% provided a current photograph of the facility.

The Center for Hospital Services

Hospital Planning & Policy

Overview

This program leads development of policies and standards contained in those components of the State Health Plan for Facilities and Services ("State Health Plan" or "SHP") which address acute care general hospitals and other providers of acute and ambulatory care services. Based on the scope of Maryland's Certificate of Need ("CON") program, policies and standards relating to the need for medical surgical inpatient services, pediatric inpatient services, obstetric inpatient services, and ambulatory surgical services, both hospital-based and freestanding, are the priority areas for this program. This program is also the lead program for development of any mandated studies, analyses, or reports addressing these types of health care facilities and services. Personnel involved in these program activities are also involved in analyzing and preparing reports and recommendations on proposed acute and ambulatory care facility and service projects seeking CON approval.

Accomplishments

State Health Plan
Development of a comprehensive revision of COMAR 10.24.10, the Acute Inpatient Services Chapter of the State Health Plan, was initiated during FY 2007. An Acute Care Planning Work Group composed of general hospital representatives, Department of Health and Mental Hygiene representatives (Office of Health Care Quality and Medicaid), and a representative of third-party payors. This effort was concluded in FY 2008 and it is anticipated that a new State Health Plan chapter will be promulgated by the Commission in FY 2009.

Following completion of this effort, work will begin on amending COMAR 10.24.11, the State Health Plan Chapter for Ambulatory Surgical Services.

Annual Acute General Hospital Bed Licensure

Each year, the Commission participates in the annual process of updating the licensed acute care bed capacity for Maryland's acute general hospitals. Acute average daily census for the twelve-month period ending in March of each year is calculated from data collected by the Health Services Cost Review Commission. MHCC then reports the total acute care bed capacity for the upcoming fiscal year, equal to 140% of this average daily census. Each hospital then responds with the service mix designation they wish to assign for this licensed bed total, allocating the beds to up to four defined service categories, so long as they have approval for those services. The categories are medical/surgical/gynecological/addictions, obstetric, pediatric and acute psychiatric.

For FY 2007, the number of licensed acute inpatient beds increased from 10,323 to 10,426. The Commission also asked hospitals to report their physical acute care bed capacity for FY 2007, i.e. the maximum number of acute care beds they could "physically" set up and staff, on short notice. They reported a total of 11,527 beds, 1,101 beds above the total acute care beds licensed for FY 2007.

On May 30, 2007, the application forms with the new bed licensure numbers for FY 2007 were sent to all hospitals. Along with the allocation of their licensed capacity, hospitals are asked to provide information to the Commission on changes in the capacity of other hospital inpatient services. This annual survey, performed in conjunction with the licensure update process, collected information on the inventory of emergency department treatment space, obstetric service facilities, and surgical service capacity.

In contrast to FY 2006, in which there was no substantive change in bed capacity, in FY 2007, the acute care hospital bed licensure update produced results, in terms of an increase in bed capacity, more in line with the experience of recent years. The total inventory of licensed acute care beds in Maryland increased approximately one percent.

Ambulatory Surgery Provider Directory

The ninth edition of the Commission's *Ambulatory Surgery Provider Directory, CY 2005* was posted on the Commission's website in January, 2007. The *Directory* provides CY 2005 information on freestanding and hospital-based ambulatory surgery providers in Maryland, such as inventory and utilization data, surgical specialties, and contact information.

The Commission's survey of ambulatory surgery providers (the source of the Directory's information) is updated annually with input and feedback, as necessary, from representatives of the Maryland Ambulatory Surgery Association.

Policy Coordination with the Health Services Cost Review Commission
Hospital planning and policy staff meet periodically with the HSCRC staff to discuss issues of interest to both agencies, such as data coordination, hospital capital projects, policy and data reports, the status of updates to the State Health Plan for Facilities and Services, the status of CON reviews, rate setting policies and rate reviews.

Other
Under Health-General Article §19-3A-07(c), the freestanding medical facility pilot project, the pilot facility, a freestanding emergency services facility in Germantown (Montgomery County) developed and operated by Shady Grove Adventist Hospital, is required to provide to the Maryland Health Care Commission information, as specified by the Commission, on the configuration, location, operating, and utilization, including patient-level utilization, of the pilot project. In addition, Health General Article §19-131 requires other facilities that may be approved as freestanding medical facilities to provide information to the Commission. To implement the data reporting requirements of the law, the Commission adopted proposed regulations (*COMAR 10.24.06 Data Reporting by Freestanding Medical Facilities)* in FY 2006. The proposed regulation, consistent with the law, identified two major categories of data to be reported to the Commission: facility-level or aggregate data; and, patient-level data. Within each category, the general types of information to be reported are described. The regulation also provides that the Commission will provide notice of the form, format, and schedule for data reporting by freestanding medical facilities. Also in FY 2006, a Data Work Group, composed of representatives from Shady Grove Adventist Hospital, Office of Health Care Quality, MIEMSS, and HSCRC, was established to provide assistance in development of the proposed patient-level data set for the pilot project freestanding medical facility.

In FY 2007, a second pilot freestanding medical facility was authorized by the General Assembly for development in Queen Annes' County. Work was also initiated on the development of a report for the General Assembly examining how the pilot projects function operationally and financially. A preliminary report on the early operational and financial experience of the Germantown facility, which opened in late Summer 2006, was issued in FY 2008.

In September, 2006, hospital planning and policy staff participated in a Maryland Institute for Emergency Medical Services, (MIEMSS) Leadership Summit on hospital emergency department overcrowding as a prelude to the December, 2006 release of an MHCC report entitled *Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding*. This report on the issues of hospital ED overcrowding was mandated by the General Assembly, and examines the causes and potential solutions for this growing problem. In January, 2007, the Commission's Executive Director briefed the House Government Operations Committee of the General Assembly concerning the finding of this report.

In March and April 2007, hospital planning and policy staff were involved in assisting the Secretary of Health in contingency planning related to the potential closure of Dimensions

Health System hospitals and other facilities in Prince George's County. Stop-gap measures for continuing to financially support this system were ultimately developed by the Maryland General Assembly at the end of its 2007 Session, avoiding the need for closure while work on long-term solutions continued.

Hospital Quality Initiatives

Overview

Chapter 657 (HB 705) of the Acts of 1999 required the Commission to develop a performance evaluation system for hospitals. In order to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Maryland Hospital Performance Evaluation Guide (Guide), and (2) design and execute a Marylander-oriented website for the Guide, the Commission contracted with the Delmarva Foundation, in partnership with ABT Associates. The Commission released its initial version of the Hospital Performance Evaluation Guide on January 31, 2002.

The Guide, which may be accessed on the Commission's website (www.mhcc.maryland.gov), enables Marylanders to review information on various hospital facility characteristics. These characteristics include the location of the hospital, number of beds, and accreditation status. Thirty-three high volume diagnosis-related groups (DRGs) are also featured. Marylanders are able to compare the volume, risk adjusted length-of-stay, and risk adjusted readmission rate for each DRG. The Guide continues to provide general information including patients' rights, how hospitals are regulated in Maryland, guidance on what to expect in a hospital setting, and a checklist to help consumers select a hospital.

On March 1, 2007, updated performance data for seventeen core measures reflecting experience during the first two quarters of 2006 were added to the Maryland Hospital Performance Evaluation Guide. The update also included the addition of Quarter 1 and Quarter 2 data for 2006 to the Performance Over Time graphs related to the core measures. The combined Third Quarter and Fourth Quarter 2006 rates for Heart Failure, AMI, and Pneumonia measures were posted to the Commission's website in June 2007.

Hospital Performance Evaluation Guide Advisory Committee

As part of the enabling legislation, MHCC was tasked to work on the design and development of the performance evaluation system in consultation with the Maryland Hospital Association, the Maryland Ambulatory Surgical Association, and interested parties including consumers, payors, and employers. The Hospital Performance Evaluation Guide Advisory Committee has provided expert advice to the Commission on performance measures and quality improvement strategies since inception of the Guide. This 10-member multidisciplinary committee includes members representing health care consumers, hospitals, nursing, medical research, and organizations involved in quality and patient safety initiatives.

Healthcare-Associated Infections

In January 2005, the MHCC adopted a plan for publicly reporting healthcare-associated infections data on the Hospital Performance Evaluation Guide. Healthcare-associated infections (HAI) are infections that patients acquire during the course of receiving medical treatment for other conditions. This initial plan adopted by the Commission required all Maryland hospitals to begin collecting and reporting a set of three process measures designed to prevent infections for patients undergoing hip, knee, and colon surgery: (1) proportion of patients receiving antimicrobial prophylaxis within one hour prior to incision (SCIP-INF-1); (2) proportion of patients receiving the appropriate antimicrobial agent based on current guidelines (SCIP-INF-2); and, (3) proportion of patients whose antimicrobial prophylaxis is discontinued with 24-hours following surgery (SCIP-INF-3). These measures, referred to as Surgical Care Improvement Project (SCIP) measures, have been endorsed by the National Quality Forum (NQF) and adopted by the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, and Hospital Quality Alliance (HQA).

Following a pilot period, the Commission began publicly reporting information concerning the first generation of process improvement measures on healthcare-associated infections in June 2006. The initial data publicly reported on the Hospital Guide measured compliance with the administration of antibiotics prior to surgery and the discontinuance of antibiotics following surgery. In September 2007, the Commission expanded the SCIP process measure set to report on the proportion of hip, knee, and colon surgery patients receiving the appropriate antibiotic (SCIP-INF-2).

In response to the significant impact HAIs have had on both patients and the health care system, a large number of States have already passed or are considering legislation with regards to mandatory public reporting of HAIs. In the State of Maryland, Senate Bill 135, *Hospitals-Comparable Evaluation System-Health Care-Associated Infection Information,* became law on July 1, 2006 as Chapter 42 of Maryland Law. This law required that the Hospital Performance Evaluation Guide be expanded to include healthcare-associated infection information from hospitals.

To assist in developing a plan for expanding the HAI data on the Hospital Performance Evaluation Guide, the MHCC appointed an HAI Technical Advisory Committee (TAC). The HAI-TAC, chaired by Pamela W. Barclay, the Commission's Director of the Center for Hospital Services, was composed of 10-members representing infection prevention and control professionals, hospital epidemiologists, health insurers, critical care nursing, and researchers.

The purpose of the Technical Advisory Committee was to study and develop recommendations to the Commission on the design and content of a system for collecting and publicly reporting HAI data. In conducting its study, the Committee met monthly beginning in November 2006. The Committee reviewed guidelines from the Centers for Disease Control and Prevention and

professional associations, evidence from the medical literature regarding appropriate measures for analyzing and reporting data on healthcare-associated infections, the work of the Maryland Patient Safety Center Intensive Care Unit Collaborative, and the work of other states in implementing legislative mandates to collect and publicly report data on infections.

To gain an understanding of the characteristics of current programs for infection prevention and control, the Technical Advisory Committee developed a statewide survey that was sent to Maryland hospital infection prevention and control program directors. The survey collected information on staffing, infection surveillance scope and approaches, and data collection and reporting systems. The Committee had briefings by representatives from Florida, Pennsylvania, Virginia, New York, Missouri, and Texas to learn about alternative approaches to collecting and reporting healthcare-associated infections data. R. Monina Klevens, DDS, MPH, of the Division of Healthcare Quality Promotion at the National Center for Infectious Diseases, briefed the Committee on the CDC National Healthcare Safety Network. The work of the Technical Advisory Committee will be completed in fiscal year 2008.

Specialized Services Policy and Planning Division

Overview

This division is responsible for health planning and policy functions related to cardiac surgery and percutaneous coronary intervention, organ transplant, neonatal intensive care, acute inpatient rehabilitation (including brain injury, spinal cord, and pediatric programs), and burn intensive care services. This level of health care is provided to segments of the population that are severely ill or injured, require advanced diagnostic and therapeutic services, and are at high risk for poor outcomes. The cost of staffing and equipping specialized health care services is very high. The main function of the division is to develop a State Health Plan that includes the methodologies, policies, and standards for reviewing applications for a Certificate of Need (CON). The division assists in the collection of data to monitor and assess changes in health care access, quality, and cost; identify and analyze policy options; evaluate alternative approaches to regulation; and improve public knowledge about health care issues. The Commission coordinates the exercise of its functions with other State agencies.

Accomplishments

State Health Plan Provisions for Primary PCI Waiver

The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17) requires that hospitals providing PCI services have on-site cardiac surgical services; however, the Commission may waive its policy if the exemption meets specific conditions. Beginning in 1996, the Commission approved and extended an exemption for the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) clinical trial, an innovative project designed to study the use of primary (emergency) angioplasty in treating certain

patients experiencing acute myocardial infarction. This study compared primary PCI and thrombolytic therapy at hospitals without on-site cardiac surgery; data from the study made an important contribution to the knowledge base concerning whether primary angioplasty services can be provided safely by hospitals without cardiac surgical services on-site. The C-PORT trial ended in 1999, and the Commission extended the C-PORT exemption to an ongoing primary angioplasty registry until COMAR 10.24.17 was amended to include the recommendations of the Advisory Committee on Outcome Assessment in Cardiovascular Care on interventional cardiology services. The amended regulations became effective in March 2004.

Under COMAR 10.24.17.05D(1), the Commission may issue a waiver that permits hospitals without on-site cardiac surgery, upon demonstrating the ability to comply with the requirements for primary PCI programs, to provide primary PCI services. Beginning with the hospitals that participated in the Atlantic C-PORT Primary PCI Registry, the Commission initiated its waiver process in 2005. In January 2006, for the purpose of measuring and monitoring program compliance and effectiveness, the Commission established a clinical data registry for patients with ST-segment elevation myocardial infarction (STEMI) who present at hospitals that provide primary PCI under a waiver. After reviewing the registry data on a quarterly basis, the Commission's staff met with representatives of certain hospitals to discuss the status of their compliance with the regulatory requirements of the State Health Plan. The hospitals submitted plans of improvement as indicated. In September 2006, the Commission held a meeting by conference call with all registry participants; in February 2007, the Commission convened a work session on clinical and data management issues. As a result of improved logistics, the median door-to-balloon time of the hospitals declined from a high of 118 minutes in the first quarter of 2006 to 97 minutes in the last quarter. Corresponding to the decline in median door-to-balloon time, the percentage of patients undergoing PCI who had a door-to-balloon time less than or equal to 120 minutes rose from 59% in the first quarter to 86% in the fourth quarter. In February 2007, Mercy Medical Center relinquished its primary PCI waiver because the hospital was not on track to meet annual requirements. As of June 2007, the following hospitals without on-site cardiac surgery had active primary PCI programs: Anne Arundel Medical Center, Baltimore Washington Medical Center, Doctors Community Hospital, Franklin Square Hospital Center, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, St. Agnes Hospital, Shady Grove Adventist Hospital, and Southern Maryland Hospital Center. Additionally, the Commission granted one-year waivers to initiate primary PCI programs at the following hospitals: in March 2007, Frederick Memorial Hospital and Washington County Hospital; and, in May 2007, Upper Chesapeake Medical Center. In May, the Commission docketed a primary PCI waiver application submitted by Montgomery General Hospital. The schedule for the receipt of primary PCI applications is available on the Commission's Web site.

State Health Plan Provisions for Non-Primary PCI Waiver

COMAR 10.24.17 also includes provisions for the Commission to consider a request for a waiver from its co-location policy for a well-designed, peer-reviewed research proposal. In March

2006, Thomas Aversano, M.D., Associate Professor of Medicine at the Johns Hopkins Medical Institutions, and colleagues sent to the Commission a revised proposal to study non-primary PCI (including elective angioplasty) at hospitals without cardiac surgery on-site (SOS). The comparative study aims to reject the hypothesis that outcomes of non-primary PCI performed at hospitals without SOS are inferior to outcomes of PCI performed at hospitals with SOS. As required by Policy 5.3.2 of COMAR 10.24.17, the Commission appointed a Research Proposal Review Committee to provide advice to the Commission on research proposals that require a waiver under the State Health Plan. Chaired by David P. Faxon, M.D., Vice Chair of the Department of Medicine at Brigham and Women's Hospital in Boston, Massachusetts, the 21 members of the Committee included cardiologists; cardiac surgeons; statisticians; and experts in law, medicine, and bioethics. The Committee began its scientific review in August 2006. In September, the Commission held a public informational meeting about the research proposal and review process. In November, the Committee met by conference call; interested members of the public were present at the Commission's office to listen to the Committee's discussion. In January 2007, the Commission retained a consultant to provide technical assistance to the staff with regard to statistical analysis and issues related to clinical trial design in the area of cardiovascular care. In March 2007, the Research Proposal Review Committee submitted its report to the Commission. Citing noteworthy improvements in the study's design, the Committee found the revised proposal to be scientifically acceptable. Based, in part, on the guidance of its Research Proposal Review Committee, the Commission approved in April the establishment of a waiver process to allow a limited number of qualified hospitals without SOS to participate in the non-primary angioplasty study conducted by the Atlantic Cardiovascular Patient Outcomes Team. In May, the Commission's staff sought informal public comment on draft regulations. After analyzing and responding to the informal comments, the staff recommended certain changes to the draft regulations, which the Commission adopted as proposed regulations in June 2007. COMAR 10.24.05 Research Waiver Applications: Atlantic C-PORT Study of Non-primary PCI establishes a one-time process by which an eligible hospital may seek a waiver and be permitted to provide non-primary PCI services as part of the C-PORT study. The research proposal, Committee report, and related documents are available on the Commission's Web site.

State Health Plan on Neonatal Intensive Care Services

In September 2006, the Commission adopted amendments to update the State Health Plan for Neonatal Intensive Care Services (COMAR 10.24.18). This action made the levels of perinatal care in the State Health Plan consistent with the most recent Maryland Perinatal System Standards, which were developed by the Perinatal Clinical Advisory Committee of the Maryland Department of Health and Mental Hygiene and adopted by the State Emergency Medical Services Board.

Certificate of Need (CON) Division

Overview

The Certificate of Need (CON) Program implements the Commission's statutory authority, under the *Annotated Code of Maryland,* Health-General Article §§ 19-103 and 19-120 through 19-127, to review and approve certain new or expanded health care facilities and services. In its administration of this program, the Commission uses the policies and standards it develops and adopts as regulation in the State Health Plan for Facilities and Services. The procedural regulations that guide CON reviews, at COMAR 10.24.01, establish administrative rules and procedures under which all reviews are conducted, and all decisions are brought to the Commission for action.

The Commission may approve, approve with conditions, or deny applications by health care providers to establish new facilities or services, to modify existing facilities or previously approved projects, to relocate existing service capacity, to undertake capital projects over a set dollar threshold, or to close certain facilities or services. In administering the program, the Commission also issues determinations of non-coverage for certain types of projects which, while not requiring a CON, may be required by law to provide certain information to the Commission and obtain such determinations. Statute also permits the Commission to exempt certain other projects from the requirement to obtain Certificate of Need, so long as the applicants and/or their projects have specified characteristics.

All projects requesting CON approval are evaluated for consistency with review standards and need projections in the State Health Plan for Facilities and Services, and five additional criteria; need, financial viability, impact on costs, charges, and other existing providers, cost-effectiveness, and the applicant's track record in complying with conditions placed on previously approved projects.

Accomplishments

Certificate of Need Applications, Exemptions, and Modifications

During FY 2007, the Commission reviewed fifteen (15) CON applications, approving all fifteen. It approved seven (7) modifications to previously approved projects. Two CON applications in review were withdrawn by applicants and four (4) Certificates of Need that had been issued by the Commission were relinquished by the holders.

Three hospital expansion and renovation projects reviewed and approved in FY 2007 were modified during the course of review in response to staff input or a Commission Reviewers' recommendations. Fort Washington Medical Center's project was scaled back, in terms of beds, space, and cost, prior to approval. Staff requested that Mercy Medical Center redefine its project in the course of review as a multi-phased project, with late phases replacing existing

hospital capacity, rather than a single-phase project with large amounts of shell space. This modification gave the Commission oversight regarding the service capacity of the hospital, as required by statute. Doctors Community Hospital substantially redesigned its expansion project after staff's initial review questions revealed problems with the feasibility of the initial design.

The era of substantial investment in replacing, expanding, and renovating hospital physical plants, that began in Maryland in the 2002-2003 period, continued in FY 2007.

In FY 2007, the Commission approved new hospital CON projects totaling over $1.167 billion in estimated project cost and also authorized additional spending of $98.5 million for previously approved hospital capital projects. The fiscal year saw four hospital "pledge" projects, projects exceeding the capital spending threshold defining reviewability but not otherwise including elements requiring CON review, totaling an additional $78.5 million.

Approved CONs

Franklin Square Hospital (Baltimore Co.)
New construction and renovation – addition of 16 medical/surgical/gynecological/addictions and pediatric beds
Approved with conditions - $224,878,180

Fort Washington Medical Center (Prince George's Co.)
Expansion and renovation – increase in 29 medical/surgical/gynecological/addictions beds and an increase in 16 emergency department treatment rooms
Approved - $57,738,000

University of Maryland Medical Center (Baltimore City)
Construct a new ambulatory care tower
Approved with conditions-$357,462,000

Sheppard Pratt Hospital (Baltimore Co.)
Reduce the number of licensed "Lisa L" residential treatment center beds from 17 to 10
Approved with conditions- $0

Fairland Nursing & Rehabilitation Center (Montgomery Co.)
Renovation and new construction – transfer of 55 comprehensive care facility beds from Springbrook Nursing & Rehabilitation Center
Approved with conditions -$24,861,421

Frederick Memorial Hospital (Frederick Co.)
Establish a Level IIIa perinatal program including a Level IIIa Neonatal Intensive Care Unit
Approved with conditions -$147,000

Southern Maryland Hospital Center (Prince George's Co.)
New construction and renovation
Approved - $43,516,251

Peninsula Regional Medical Center (Wicomico Co.)
Establish a Level IIIa perinatal program including a Level IIIa Neonatal Intensive Care Unit
Approved with conditions - $10,000

Homewood at Williamsport (Washington Co.)
Construction of a replacement comprehensive care facility
Approved with conditions - $17,214,500

Johns Hopkins Hospital (Baltimore City)
Relocation of 6 operating rooms from the hospital to a new building
Approved with conditions - $20,940,177

Montgomery General Hospital (Montgomery Co.)
New construction and renovation
Approved with conditions - $33,994,392

Mercy Medical Center (Baltimore City)
New construction and renovation
Approved with Conditions - $406,584,515

Gladys Spellman Specialty Hospital and Nursing Center (Prince George's Co.)
Conversion of 26 comprehensive care facility beds to 26 specialty hospital-chronic care beds
Approved - $751,506

Massachusetts Avenue Surgery Center (Montgomery Co.)
Conversion of a procedure room to an operating room to establish a 2-operating room facility
Approved with conditions - $69,000

Doctors Community Hospital
New Construction and renovation
Approved - $54,052,981

CON-Approved Projects Modified
Memorial Hospital of Easton (Talbot Co.)
$6,544,998 increase in cost

Stella Maris (Baltimore Co)
$1,947,000 increase in cost

Baltimore Washington Medical Center (Anne Arundel Co.)
Change in physical plant design, addition of 2 floors of shell space and $10,027,662 increase in cost

Western Maryland Health System Medical Center (Allegany Co.)
$41,131,821 increase in cost

Ruxton Surgery Center (Baltimore Co.)
$10,890 increase in cost

Surgery Center of Potomac (Montgomery Co.)
Change in physical facility design and $198,775 increase in cost

Howard County General Hospital (Howard Co.)
Change in physical plant design and $30,000,000 increase in cost

CON Applications Withdrawn
Baltimore Washington Medical Center (Anne Arundel Co.)
New construction and renovation and addition of 68 medical/surgical/gynecological/addictions beds (filed as alternative to project authorized in FY 2006)
$96,793,790

Jewish Geriatric Center at Owings Mills (Baltimore Co.)
Construction of a new 228-bed comprehensive care facility
$44,103,200

CONs Relinquished
Washington Adventist Surgery Center (Montgomery Co.)
Establishment of a free-standing ambulatory surgery center
$3,896,903

Shady Grove Adventist Ambulatory Surgery (Montgomery Co.)
Establishment of a free-standing ambulatory surgery center
$3,798,224

Clifton T. Perkins Hospital Center (Howard Co.)
Addition of 48 special hospital psychiatric beds
$17,845,000

Sinai Hospital of Baltimore (Baltimore City)
Expansion of operating room capacity (4 mixed-use, general purpose rooms) and other surgical department space
$15,120,051

Determinations of Non-Coverage and Other Actions

In FY 2007, the Commission issued 166 determinations involving actions proposed by persons or health care facilities requiring a decision with respect to the need for CON review or other Commission authorization. These actions were made in accordance with statutory and regulatory provisions outlining: (1) The scope of CON coverage; (2) The types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and (3) The notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled on the following page. Chief among these types of determinations are those involving establishment of single operating room ambulatory surgical facilities, acquisitions of health care facilities, hospital capital expenditures for which the hospital is taking "the pledge," temporary delicensure of beds (for up to one year), primarily nursing home beds, and small increases in the bed capacity of facilities, primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time. Additionally, the Commission reviewed three requests by holders of CONs to implement their projects or parts of their approved projects ("first use review"). Finally, the Commission acknowledged nine cases in which facilities with temporarily delicensed beds did not take timely action to bring these beds back into operation or extend temporary delicensure status, thus eliminating these beds from the state's inventory.

Capital projects with costs below the threshold of reviewability	**12**
Hospital "pledge" projects [1] (8 received determination of non-coverage/1 denied)	**4**
Acquisitions of health care facilities	**39**
Hospitals	**2**
Nursing Homes	**33**
Ambulatory surgery centers	**1**
Other	**3**
Establishment of new ambulatory surgery center (no more than one sterile operating room) **Montgomery (7), Baltimore County (12), Anne Arundel (7), Frederick (4), Howard (4), Baltimore City (3), Calvert (1), Harford (2), Cecil (2), Carroll (1), Prince George's (3), Washington (1), Worcester (1)**	**48**

Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	**6**
Temporary delicensure of ambulatory surgery center	**1**
Temporary delicensure of beds (242 total beds)	**18**
Restoration of temporarily delicensed beds (142 total beds)	**17**
Extensions to temporarily delicensed beds	**3**
Modification to an existing facility	**8**
Add "waiver" beds [2] (70 total beds)	**9**
Addition of CCF beds by continuing care retirement communities [3] (132 total beds)	**1**
TOTAL COVERAGE DETERMINATIONS	**166**
Pre-licensure and/or first use approval for completed CON-approved projects	**3**
Abandonment of beds (158 beds)	**9**

[1] Projects with capital costs above the threshold of reviewability but no other element specifically requiring CON approval. Hospitals confirming that such expenditures will not require, over the entire period or schedule of debt service associated with the project or plant, a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs associated with the project, may receive a written determination of non-coverage for any capital expenditures it proposes to obligate without Certificate of Need approval.

[2] Facilities other than hospitals may add beds in limited increments over time without obtaining CON approval, subject to conditions outlined in regulation.

[3] Continuing care retirement communities can create comprehensive care facility ("CCF") or nursing home bed capacity without CON approval, subject to limitations outlined in regulation.

Other Activity Bearing on the CON Program

The Commission promulgated regulatory amendments to COMAR 10.24.01, which became effective in April, 2007. These amendments create "participating entities" as a new category of participant in CON review, apart from "interested parties," and outlined the qualification requirements and the modes of participation available to these entities.

The Center for Health Information Technology

Health information technology (HIT) promises to bring vital clinical information to the point-of-care, helping to improve the safety and quality of health care while decreasing overall health care costs. HIT requires two crucial components to be effective – the widespread use of both electronic health records (EHRs) and electronic health information exchange (HIE). The Center for Health Information Technology is responsible for the Commission's HIT initiatives that include:

- Planning and implementing a statewide HIE;
- Identifying challenges to HIT adoption and use, and formulating solutions and best practices for making HIT work;
- Increasing the availability and use of standards-based HIT through consultative, educational, and outreach activities;
- Promoting and facilitating the adoption and optimal use of HIT for the purposes of improving the quality and safety of health care;
- Harmonizing service area HIE efforts throughout the state;
- Certifying electronic health networks that accept electronic health care transactions originating in Maryland; and
- Developing programs to promote electronic data interchange between payers and providers.

Health Information Technology Division

Overview

The Health Information Technology Division is responsible for promoting the adoption of HIT among health care providers and facilities. HIT has the potential to significantly increase the efficiency of health care by helping providers and consumers manage information. Widespread adoption of EHRs is considered by many as a key component in improving quality and efficiency

in health care. EHRs record patient clinical and demographic data, allows for viewing and managing results of laboratory tests and imaging, permits order entry including e-prescribing, and includes clinical decision support. EHRs can help both providers and patients by documenting that correct procedures were used and highlighting outliers before they become serious issues. Generally speaking, HIT offers the promise of transforming health care in many positive ways; privacy and security of patient information are paramount challenges that pose unique concerns. This division is responsible for addressing stakeholder concerns related to privacy and security to prevent unauthorized access of personal data.

Health Information Exchange Division

Overview

The Health Information Exchange Division is responsible for advancing HIE statewide. Electronic data sharing is critical to the delivery of quality patient care and to increasing efficiencies in health care. An interoperable data sharing system holds many potential benefits for consumers, including better coordination of health care regardless of patient location, higher quality and more efficient care, increased system transparency, and patient access to information about providers that allows them to make better decisions. HIE holds great promise; the many possible benefits will not be realized unless appropriate policy measures are established up front. Data sharing raises serious concerns among consumers about privacy and security, and the potential misuse of their information. This division manages various initiatives focused on privacy and security, technology, interoperability, standards utilization, harmonization, and business information systems. The division is also responsible for promoting the adoption of electronic data interchange (EDI), and certifying electronic health networks (EHNs) that exchange transactions originating in Maryland.

Leading Accomplishments

Centers for Medicare & Medicaid Services – Electronic Health Record Demonstration
Staff collaborated with MedChi, the Maryland State Medical Society and the Medical Society of the District of Columbia to participate in the Centers for Medicare & Medicaid Services (CMS) electronic EHR demonstration project. This is a five year project designed to show that widespread adoption and use of EHRs will reduce medical errors and improve quality of care. Approximately 200 primary care physician practices whose size is less than 21 physicians are eligible to participate in the demonstration project. Participants can receive an incentive payment ranging from $58,000 (per physician) to $290,000 (per physician practice). Physician practices must meet defined criteria in order to take part in the demonstration project. Staff expects to provide support to the CMS demonstration project throughout the project's lifecycle.

Electronic Data Interchange & Electronic Health Networks

COMAR 10.25.07, *Electronic Health Network Certification,* establishes a certification process for electronic health networks (EHNs) that operate in Maryland, in conjunction with using national standards developed by the Electronic Healthcare Network Accreditation Commission. Currently, 32 EHNs have obtained MHCC certification; and two additional EHNs are in candidacy status. Over the last year, staff increased the number of certified EHNs by seven with two additional EHNs in candidacy status. MHCC certification is for a two-year period. EHNs consistently report value in the certification process in strengthening policy development. The certification criterion focuses on privacy and security, technical performance, business practices, and resources.

COMAR 10.25.09, *Requirements for Payers to Designate Electronic Heath Networks,* requires public and private payers to report health care transaction census data on an annual basis. These regulations also require payers to contract only with MHCC-certified EHNs. In 2006, private payer practitioner and hospital EDI increased by approximately four percent to roughly 81 percent. Conversely, private payer dental EDI increased by nearly two percent to about 35 percent.

Consumer-Centric Health Information Exchange – Planning Phase

Staff issued a Request for Applications (RFA) for *a Citizen-Centric Health Information Exchange for Maryland.* Two multi-stakeholder groups were chosen by a panel of well-known experts on HIT: the Chesapeake Regional Information System for our Patients and the Montgomery County Health Information Exchange Collaborative. Both groups received approximately $250,000 to take part in a planning phase for a statewide HIE. The planning phase is funded through the Health Services Cost Review Commission's all-payer system. A final report is due in early 2009 that will address governance, privacy and security, access policies, strategies to ensure appropriate patient engagement, general architecture, proposed hardware and software, estimated costs, and a possible sustainable business model. The best ideas from the two planning groups will be merged together and an RFA to build a statewide HIE will be released in mid-2009.

Health Information Security and Privacy Collaboration

Staff is participating on a national Health Information Security and Privacy Collaboration Workgroup (Workgroup) to develop the *National Health Bridge (NHB): Basic Policy Requirements for Authentication and Audit* that supports cross network HIE for the purpose of treatment for individuals and populations. This includes developing an implementation plan that can be used by participating states to guide the adoption of the NHB. The Workgroup developed a comprehensive environmental scan tool to assess authentication and audit policy development. Research Triangle Institute, under contract with the Office of National Coordination for Health Information Technology (ONC), facilitated this initiative.

Hospital HIT Survey
Staff developed an annual hospital HIT adoption and utilization survey. Working with hospital chief information officers (CIOs) and through a review of existing national HIT surveys, staff identified key questions that will track HIT activity among hospitals. In the future, the survey will become part of the Hospital Performance Evaluation Guide. The survey is designed to coordinate with national data on technology that has demonstrated value to improve safety, quality, and efficiency of health care delivery. The survey also includes questions aimed at measuring hospital planning activities for implementing data sharing with other health care providers in their service area.

Privacy and Security Study
Staff convened a Privacy and Security Workgroup (Workgroup) to assess variations in organization-level business policies and state laws that affect HIE. The Workgroup's charge was to identify and propose practical solutions to HIE, while preserving the privacy and security requirements in applicable federal and state laws, and to identify solutions. The Workgroup produced the report entitled *An Assessment of Privacy and Security Policies and Business Practices: Their Impact on Electronic Health Information Exchange*. The final report provided an in-depth assessment of privacy and security policies and business practices related to exchanging electronic health information.

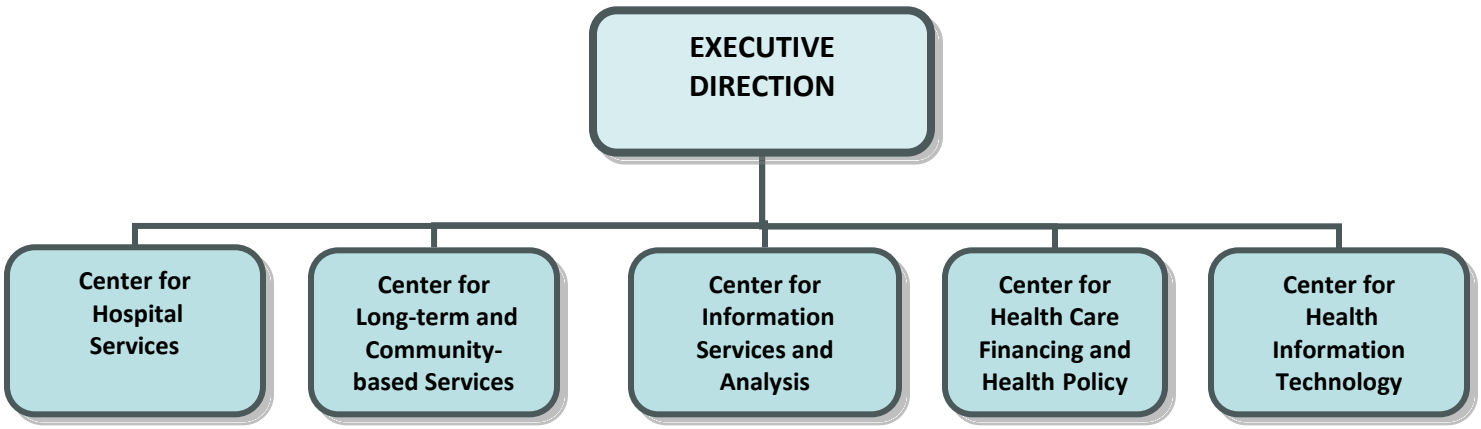
Privacy and Security Solutions and Implementation Workgroup
Staff convened a Privacy and Security Solutions and Implementation Workgroup (Workgroup) to formulate solutions and develop implementation activities to address organization-level business practices that affect statewide privacy and security policies in order to support interoperable HIE. Workgroup participants developed guiding principles for exchanging patient information electronically, and evaluated privacy and security barriers to HIE that impacts all stakeholder groups. The Workgroup also evaluated the impact of these barriers on the guiding principles, and proposed implementation activities to guide the development of HIE in Maryland. The Workgroup produced the report entitled *Privacy & Security Solutions & Implementation Activities*. The final report identified key principles and barriers and provided the framework for the solutions developed by the Workgroup.

Service Area Health Information Exchange
Staff convened a Hospital CIO Workgroup to develop a Service Area Health Information Exchange (SAHIE) Resource Guide. The purpose of the guide is to identify a policy framework for communities that are beginning to exchange patient information electronically. Components of the guide include: defining a patient's right to access information; identifying technical standards required for providers to connect to an HIE; creating a communications mechanism for community exchanges to ask questions and share lessons learned with other communities; and highlighting key technical, financial, organizational, and legal challenges. The Resource Guide is an evolving resource that is tentatively planned for release in late 2008.

Task Force to Study Electronic Health Records

In 2005, the Maryland Legislature enacted Senate Bill 251, which created the Governor's Task Force to Study Electronic Health Records (Task Force). The Task Force consisted of 26 volunteer members and included representatives from a diverse group of individuals with a broad range of interests in health care and HIT. The Task Force was required to study EHRs; the current and potential expansion of their utilization in Maryland, including electronic transfer, e-prescribing, computerized provider order entry; and the cost of implementing these functions. Staff provided support to the Task Force in developing the final report that was submitted to the Governor and legislature in December 2007. The report entitled *Task Force to Study Electronic Health Records, Final Report* included 13 recommendations related to financial, technology, legal/regulatory, consumer education, and school health records.

APPENDIX 1 – Maryland Health Care Commission's organizational chart effective July 1, 2006



APPENDIX 2

Sunset Review: Recommendations

Pursuant to the Maryland Program Evaluation Act, the Department of Legislative Services evaluated the Maryland Health Care Commission (Commission) and issued its Evaluation of the Maryland Health Care Commission in October 2006.

Recommendation 1: The Maryland Health Care Commission should update its web site to reflect the Commission's reorganization into five health care sector-based centers.

Recommendation 2: Statute should be amended to provide that a quorum is a majority of the full authorized membership of the Commission and that decisions on any issue shall be by a majority of the quorum present and voting.

Recommendation 3: Uncodified language should be adopted to require that, in its next workload study due in 2008, the Maryland Health Care Commission:

- Include in the study the extent to which other health care providers, not currently subject to a user-fee assessment, utilize the Commission resources;
- Discuss the feasibility and desirability of extending a user fee to additional types of providers regulated by the Commission; and
- Report its findings and recommendations to the General Assembly by December 1, 2008

Recommendation 4: Statute should be amended to increase the ceiling on user fees from $10.0 million to $12.0 million.

Recommendation 5: The Maryland Health Care Commission should continue to implement the recommendations of the Certificate of Need Task Force and should continue to include stakeholders and the Department of Health and Mental Hygiene in this process. The Maryland Health Care Commission should report to the General Assembly by October 1, 2007, with a follow-up report by October 1, 2008 regarding the progress of implementation. The Maryland Health Care Commission should also include in the reports its progress in implementing recommendations of the 2001 – 2002 evaluation, particularly recommendations involving a research project for elective angioplasty and a reorganization of the licensing and CON laws for home-based health care services. These areas have been the subject of legislation in recent years.

Recommendation 6: To promote more comprehensive analysis of health care spending, statute should be amended to specifically authorize the Maryland Health Care Commission to obtain data on payments to hospitals. The Maryland Health Care Commission should report to

the general Assembly by October 1, 2007, on its plans to collect data on (1) facility, as well as practitioner costs; and (2) insurance project design and how that data would be used to promote quality and affordable health care.

Recommendation 7: To provide sufficient time for the Maryland Health Care Commission to prepare and obtain approval for the annual report on the trauma fund, statute should be amended to modify the due date to November 1. In addition, the report which would be due on November 1, 2007, should include a discussion of options for reducing the fund surplus. The options should include one-time-only uses for eliminating the large surplus that has accrued in the early years of the fund and, if the surplus is continuing to grow, on-going uses to align annual expenditures with annual revenues. The discussion of options should also examine the desirability of providing funds directly to the trauma centers for the purpose of subsidizing trauma physician costs at the centers. A grant to the trauma centers, with strong accountability for the use of the funds, could achieve the purpose of maintaining adequate physician coverage at the trauma centers, but with less red tape.

Recommendation 8: The Maryland Health Care Commission should include on its web site information on the Center for Health Information Technology's coordination of efforts of the Task Force on Electronic Health Records, the collaboration with the Health Services Cost Review Commission on funding health information technology initiatives, and the work on the privacy and security study. The web site should also include updates on the Maryland Health Care Commission's communication and coordination with the federal government on health information technology issues as the country moves toward the widespread adoption of health information technology.

Recommendation 9: Section 19-139 of the Health-General Article requires the Maryland Health Care Commission to study the feasibility of developing a system for reducing the incidences of preventable adverse medical events in the State, which was completed in 2003. Statute should be amended to repeal as obsolete § 19-139 of the Health-General Article.

Recommendation 10: The Maryland Health Care Commission should continue to monitor evolving patient-safety issues by including patient-safety measures in the consumer guides published by the Commission.

Recommendation 11: The Joint Legislative Task Force on Small Group Market Health Insurance is required to review numerous issues confronting the small group market and report to the General Assembly by July 1, 2007. Given the strong interest expressed by Commissioners, insurers, and business representatives in expanding the range of offerings available to small employers, the task force should consider the desirability of altering statute to allow carriers to sell other health benefit plans, in addition to the standard plan.

Recommendation 12: In light of advice of counsel and the disappointing sales of the limited benefit plan, the limited benefit plan should be allowed to terminate on June 30, 2008, as provided by law. In its report due to the General Assembly on January 1, 2008, regarding the limited benefit plan, the Maryland Health Care Commission should discuss other options for individuals enrolled.

Recommendation 13: The Maryland Health Care Commission should present the results of its studies of health care coverage expansion to the Joint Legislative Task Force on Small Group Market Health Insurance. The studies should discuss the number of individuals who could potentially obtain health care coverage, the cost of the coverage, how the cost could be paid for, and the impact on existing coverage.

Recommendation 14: As a cost-saving measure, the annual determination of the full cost of existing mandated health insurance services in the State should be repealed. Statute should be amended so that the comprehensive study of mandated benefits every four years incorporates all of the information currently required every year.

Recommendation 15: Statute should be amended to modify the date by which the Maryland Health Care Commission must undergo sunset review to July 1, 2017. In addition, the Maryland Health Care Commission should report to the Senate Finance Committee and the House Health and Government Operations Committee, on or before October 1, 2007, on the implementation of the recommendations contained in this sunset evaluation report.

APPENDIX 3

MARYLAND HEALTH CARE COMMISSION

UPCOMING REPORTS AND REGULATORY CHANGES*

Executive Direction

- Health Insurance Exchange Study letter from Chairmen regarding SB 149 and HB 754 (Jan. 1, 2008)
- Personal Responsibility Study – HB 572 (Jan. 1, 2008)
- Uninsurance among Adults 19-29 Study – HB 1057 (Jan. 1, 2008)

Combined report

- Chronic Care Management and Wellness Study – letter from Chairman and sponsor regarding HB 171 (Jan. 1, 2008)
- Implementation of MHCC Sunset recommendations – HB 800 (Oct. 1, 2007)
- MHCC role regarding uncompensated care – HB 844 (Dec. 1, 2007)

Center for Health Care Policy & Financing

- Comprehensive Standard Health Benefit Plan (small group market) – HB 579 (Dec. 1, 2007)
- Mandated Benefits – current statute & HB 800 (Jan. 1, 2008)
- Alternative options for individuals in current Limited Benefit Plan – HB 800 (Jan. 1, 2008)
- Regulatory change requiring carriers to collect and report data – HB 339 (adopted by Oct.1, 2007)
- Habilitative Services – Joint Chairman's Report (Dec. 1, 2007)

Center for Long Term Care & Community Based Services

- Long Term Care Needs Through 2030 – 2006 statute (Dec. 1, 2007)
- Health Care Services for Children with Life-threatening Conditions – HB 797 (Dec. 1, 2007)

Center for Information Services & Analysis

- Maryland Trauma Fund – HB 800 (Nov. 1, 2007)
- Plans to gather data to promote quality and affordable health care – HB 800 (Oct. 1, 2007)
- Task Force on Health Care Access and Reimbursement – SB 107 (technical support)

Center for Hospital Services

- Acute Psychiatric Services Study – Joint Chairmen's Report (Nov. 1, 2007 – extended to December 1, 2008)
- Freestanding Emergency Medical Facilities and proposed regulations for review process – 2005 statute (Dec. 31, 2007 and July 1, 2008, respectively)

- Implementation of recommendations from CON Task Force and 2001/2002 studies of CON – HB 800 (Oct. 1, 2007/2008)

Center for Health Information Technology

- Task Force on the Electronic Health Record (staff and studies) – 2006 statute (Dec. 31, 2007)
- RFAs for Health Information Exchange

**Annual reports not included*