Preliminary Evaluation of the Maryland Health Care Commission

Department of Legislative Services
Office of Policy Analysis

Annapolis, Maryland

November 2000

This document was prepared by:

Office of Policy Analysis
Department of Legislative Services
General Assembly of Maryland

November 2000

For additional copies or further information, contact:

Library and Information Services
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, MD 21401-1991

Baltimore/Annapolis Area: 410-946-5400/5410
Washington Area: 301-970-5400/5410
Other Maryland Areas: 1-800-492-7122, ext. 5400/5410
TTY: 410-946/301-970-5401
TTY users may also use the Maryland Relay Service
to contact the General Assembly

E-Mail: libr@mlis.state.md.us
Home Page: http://mlis.state.md.us

Preliminary Evaluation of the Maryland Health Care Commission

Recommendations: Waive from Full Evaluation

Extend Termination Date by Five Years to July 1, 2008

Require Follow-Up Report by October 1, 2001

The Sunset Review Process

This preliminary evaluation was undertaken under the Maryland Program Evaluation Act (§ 8-401 *et seq.* of the State Government Article), which establishes a process also known as sunset review. Enacted in 1978, the Maryland Program Evaluation Act requires the Department of Legislative Services (DLS) to periodically evaluate certain State agencies according to a statutory schedule. The agencies subject to review are usually automatically terminated unless legislative action is taken to re-authorize them. The Maryland Health Care Commission is one of 68 entities currently subject to evaluation. The Legislative Policy Committee decides whether to waive an agency from full evaluation. If waived, legislation to re-authorize the agency must be enacted.

The commission, created in 1999 when the Health Resources Planning Commission (HRPC) and the Health Care Access and Cost Commission (HCACC) were merged, has not undergone evaluation as part of sunset review. The former HCACC, created in 1993, has not undergone evaluation either; however, the former HRPC, created in 1982, did undergo full evaluation in 1991.

This preliminary sunset review explored the recent merger of the former Health Resources Planning Commission and the former Health Care Access and Cost Commission into the new commission and the merger's impact on the commission's operations. It also examined the potential merger between the commission and the Health Services Cost Review Commission (HSCRC). Information was gathered through interviews with the executive director and chairman, review of meeting minutes and budgetary information, and a study of statutes and regulations pertaining to health care regulation. The Maryland Health Care Commission reviewed a draft of this preliminary evaluation and provided the written comments attached as **Appendix 1**.

Prepared by: Susan John • Department of Legislative Services • Office of Policy Analysis • November 2000

The Maryland Health Care Commission

As noted above, the Maryland Health Care Commission was established in 1999 by merging two of Maryland's three primary health care regulatory entities. The commission is a quasi-independent entity under the authority of the Deputy Secretary for Health Care Financing at the Department of Health and Mental Hygiene (DHMH). Most recent legislation, as shown in **Exhibit 1**, has centered around this merger and the creation of new commission responsibilities.

The commission consists of 13 members, of whom, seven may not have any connection with the management or policy of a health care provider or payor. Of the remaining six members, only two may be physicians and only two may be payors. The former chairman of HCACC serves as the chairman of the new commission. The commission employs 68 full-time staff, with daily operations overseen by an executive director. Staff of the new commission has been organized into three main areas of responsibility: 1) data systems and analysis; 2) health resources; and 3) performance and benefits.

Merger of HRPC and HCACC Consolidated Responsibilities

Chapter 702 merged HRPC and HCACC to more effectively regulate health care delivery in the State. Faced with continuous increases in both public and private health care spending as well as a growing number of uninsured Marylanders, the two former commissions were merged in an effort to integrate and streamline their respective regulatory functions as shown in **Exhibit 2.** Chapter 702 requires the commission to keep the General Assembly apprised of the merger process through a series of reports.

To facilitate the merger, the commission created nine transition teams, each responsible for major reorganizational issues. The transition teams addressed such issues as:

- physical space;
- information systems;
- the transfer of local health planning functions to DHMH;
- training and support for the new commissioners;
- budgetary and operational issues;
- implementation of the Hospital Capacity and Cost Containment Act (Chapter 672, Acts of 1999);

Exhibit 1

Major Legislative Changes Since Establishment of Commission

Year	Chapter	Change
1982	108	Established HRPC
1992	20	Extended the termination date for HRPC by ten years to July 1, 2003
1993	9	"Maryland Health Insurance Reform Act" established HCACC and required it to develop the Comprehensive Standard Heath Benefit Plan for small employers
1995	3	"Health Care Reform Act of 1995" streamlined the certificate-of-need (CON) process for the HRPC
1996	273	Established a non-lapsing HRPC special fund, scheduled to sunset July 1, 2003
1997	134	Repealed the sunset provision on HCACC's user fees, originally set to sunset on May 31, 1998
1998	588	Required HCACC to: (1) annually evaluate the social, medical, and financial impacts of proposed mandated benefits; and (2) conduct an initial evaluation of the cost of existing mandated benefits as a percentage of Maryland's average wage and health benefit premiums
1999	382	Required MHCC to comparatively evaluate the quality of care in nursing homes and issue nursing home "report cards" -- the evaluation system must be implemented by July 1, 2001
1999	657	Required MHCC to evaluate hospitals and ambulatory surgical centers and issue "report cards" -- the evaluation system must be implemented by July 1, 2001
1999	678	"Hospital Capacity and Cost Containment Act" facilitated the closing or downsizing of certain hospitals by broadening certificate-of-need exemptions, establishing a category of "limited service hospital," providing for the retraction of excess hospital bed licenses, and financing of closing costs of a hospital that converts to a limited service hospital
1999	702	Consolidated the former Health Resources Planning Commission and the Health Care Access and Cost Commission into the new Maryland Health Care Commission
2000	375	Clarified that the user fees assessed on hospitals, nursing homes, payors, and health care practitioners may be used by the commission to cover only the actual documented costs of the commission

Source: Laws of Maryland

Exhibit 2
Effect of Merger

Former Commissions		Consolidated Commission
HCACC Responsibilities		**Inherited Responsibilities**
Oversee the Comprehensive Standard Health Benefit Plan, established for the small group health insurance market.	→	Oversee the Comprehensive Standard Health Benefit Plan, established for the small group health insurance market.
Maintain the provider encounter data system.	→	Maintain the provider encounter data system.
Implement quality and performance report cards for health maintenance organizations (HMOs).	→	Implement quality and performance report cards for health maintenance organizations.
Maintain electronic clearing houses.	→	Maintain electronic clearing houses.
HRPC Responsibilities		
Oversee the State Health Plan.	→	Oversee the State Health Plan.
Administer the certificate-of-need process.	→	Administer the certificate-of-need process.
Project future State health care needs.	→	Project future State health care needs.
		New Additional Responsibilities
		Examine the current CON process.
		Review policies associated with hospital rate regulation.
		Transfer local health planning functions to the Department of Health and Mental Hygiene.
		Examine a potential merger of the commission and the HSCRC.

Source: Laws of Maryland

- communications;
- legal issues; and
- strategic planning.

Most of these reorganizational issues have been completed. The commission continues to examine issues associated with the certificate-of-need process, hospital rate regulation, and small group market reform. The commission expects to address these issues in the upcoming year. In addition, the commission is reviewing its user fee apportionment among its various payors and will report to the General Assembly on January 1, 2001, regarding any recommended changes.

The Fiscal Status of the Commission Is Good

The commission is special funded and is statutorily limited to assessing a maximum of $8.25 million in user fees annually. Consequently, its expenditures cannot exceed this cap in any given year. The commission's budgetary appropriations for the past three fiscal years have remained under the $8.25 million cap, as shown in **Exhibit 3**; however, expenditure projections for fiscal 2002

Exhibit 3
Fiscal History of the Maryland Health Care Commission
FY 1996 - 2001

	1996	1997	1998	1999	2000	2001
Revenues						
(former HCACC)	$4,306,791	$4,841,162	$3,931,220	-	-	-
(former HRPC)	3,057,073	2,848,190	2,865,713	-	-	-
MHCC	-	-	-	$6,465,436	$7,203,787	$5,148,620
Total Costs	5,307,794	5,455,227	6,796,934	465,436	311,173	766,679
Direct Costs	5,307,794	5,455,227	6,702,955	6,371,457	7,160,141	7,766,679
Indirect Costs	-	-	93,979	93,979	151,032	0
Surplus/(Deficit)	$2,056,010	$2,234,125	($1)	$0	($107,386)*	($2,618,059)

*The commission's increasing deficit reflects its plan to spend down its fund balance surplus.

Note: Fiscal 2001 figures are projected.

Source: Maryland Governor's Budget Books, Fiscal 1997 - 2001; MHCC

exceed $7.8 million and are likely to continue increasing over the next few fiscal years. Most of the commission's expenditures are attributable to legislative mandates such as the research and development of nursing home and ambulatory surgical center quality report cards. The commission hires consultants to assist with these types of projects, and expenditures may fluctuate depending on the complexity of the legislative mandate. The commission plans to introduce legislation during the 2001 legislative session to increase the user fee assessment cap to $10 million to accommodate increasing expenditures necessary to fulfill its statutory duties.

Fund Balance Surplus Being Spent Down

The commission is in the process of returning a surplus fund balance to health care entities. The commission is solely funded by special funds collected from assessments on various health care entities. It collects fees from hospitals, nursing homes, health insurance payors, and health care practitioners. By law, the commission may only assess fees necessary to cover the actual documented costs of fulfilling its statutory and regulatory duties.

As shown in **Exhibit 4**, the commission carried over a $3.95 million surplus into fiscal 2000 and a balance of $3.84 million into fiscal 2001. While a moderate fund balance is necessary to cover

Exhibit 4

Maryland Health Care Commission: Financial Status

Fiscal 2000 Fund Balance	
Balance Carried Forward from Fiscal 1999	$709,924 (HRPC)
	3,242,291 (HCACC)
	3,952,215 (total)
Revenue in Fiscal 2000	7,203,787
Total Available Revenue	11,156,002
Actual Expenditures	(7,311,173)
Fund Balance at End of Fiscal 2000	**$3,844,829**
Targeted Fund Balance in Fiscal 2001	
Anticipated Revenue	$5,148,620
Budgeted Expenditures	(7,766,679)
Anticipated Fund Balance	1,226,770
Target Balance @ 10% of Budget	776,679
Excess Fund Balance	**$450,091**

Source: Maryland Health Care Commission

unanticipated costs, the current fund balance is excessive. A more reasonable fund balance would be approximately 10 percent of the commission's annual budget, or $777,000 for fiscal 2001. This amount would adequately cover several unanticipated projects or legislative mandates during any given fiscal year.

The commission has implemented a fee-reduction plan over two fiscal years to bring its fund balance more in line with its actual annual costs. The fee-reduction plan reduces fiscal 2001 and 2002 user fees and should reduce the commission's surplus by more than $2.6 million during fiscal 2001. The fee-reduction plan will take two years to implement because the fees levied on health care practitioners are collected by the health occupation boards as part of the practitioners' biennial license renewals.

Indirect Costs Eliminated by Statute

The Department of Legislative Services conducted an audit of the State's health regulatory commissions in 1999, which disclosed that the calculation and assessment of the commission's user fees had not accounted for indirect costs. Approximately $338,000 should have been assessed as part of the user fees in fiscal 1998, 1999, and 2000, and subsequently paid to the general fund as reimbursement for indirect costs associated with procurement services, rental space, legal services, and other similar services that DHMH may provide to the commission. As a result of the audit's findings, MHCC paid $338,000 to the general fund for indirect costs incurred during fiscal 1998, 1999, and 2000.

Before the commission consolidation, HRPC was required by statute to use fees assessed on hospitals and nursing homes to cover both direct and indirect costs. DHMH, however, had never charged HRPC for any indirect costs, and HRPC in turn had never based its fees on indirect costs. HCACC had never been required to take indirect costs into account when assessing fees on its payors and providers. To better reflect current practice, Chapter 375, Acts of 2000 clarifies that the commission's user fees may be used only for direct costs, thus eliminating the requirements that DHMH assess the commission, and the commission pay, for indirect costs associated with services the commission performs itself.

Report on User Fees Due Before Session

Chapter 702 requires the commission to conduct a study on the appropriate level of funding necessary to carry out the commission's statutory duties. In addition, the commission must examine the allocation of its user fees among the different payors that fund the commission. Initially, the commission was directed to report its findings on user-fee assessments to the General Assembly by September 1, 2000. This date has been extended to January 1, 2001.

As noted above, the commission plans to introduce legislation during the 2001 session that increases the user fee cap from $8.25 million to $10 million to accommodate increasing expenditures necessary to fulfill the commission's duties. The commission is also in the process of examining the current fee apportionment among payors (**Exhibit 5**) and will recommend realigning the fees to better reflect the commission's services to each industry.

Exhibit 5
Fee Apportionment Among Payors in Fiscal 2001

Type of Payor	Number of Payors	Estimated Assessment	Average Assessment Per Payor*
Health Insurance Payors	136	$2,851,343	$20,965
Health Practitioners	172,698	$1,354,388	$8
Nursing Homes	261	$365,418	$1,400
Hospitals	56	$2,566,209	$45,825

*The assessed fees are based proportionately on the individual payor's facility admissions, revenues, or individual health benefit plan premiums and may deviate significantly from the averages provided.

Source: Maryland Health Care Commission

Potential Merger of the Commission and the Health Services Cost Review Commission on Hold

Chapter 702 requires the commission and the HSCRC, in consultation with the Maryland Insurance Administration and the Department of Health and Mental Hygiene, to study the feasibility, desirability, and the most efficient method of merging the commission and the HSCRC. The commission issued its final report on the potential merger to the General Assembly on July 1, 2000.

HSCRC Responsibilities Center on Hospital Rate Setting

The HSCRC consists of seven commissioners and is primarily responsible for hospital rate setting. It also administers the Substantial, Available, and Affordable Coverage (SAAC) product offered to the medically uninsurable and is responsible for collecting various data on hospital finances and discharges.

The HSCRC sets hospital rates in an effort to contain costs and to maintain the Medicare waiver granted by the federal government in 1977. This waiver exempts Maryland hospitals from Medicare's prospective payment system that reimburses hospitals at a rate specified by Medicare, thus allowing Maryland to maintain an all-payor system and help keep health care costs down. Medicare instead reimburses Maryland hospitals at a rate set by the HSCRC. The HSCRC must ensure that Maryland's cumulative rate of growth in hospital costs is slower than the national average in order to maintain the Medicare waiver.

The HSCRC also administers the SAAC differential to health insurers who offer coverage to the medically uninsurable. The differential provides SAAC insurers with a 4 percent discount on their hospital rates and requires insurers who do not offer a SAAC product to pay higher hospital rates to offset the discount. The MHCC, on the other hand, is responsible for determining the SAAC product's benefit package.

Study Concludes Merger Should Not Take Place

The report concluded that the two commissions should not be merged at this time. The commission reasoned that there was little functional overlap between the two commissions; consequently, no real administrative savings could occur. In addition, the report cited that such a combined workload on the volunteer commissioners would be onerous and would likely deter individuals from accepting appointments as commissioners.

Recommendations

The commission has been aggressive in meeting its statutory and regulatory responsibilities in a timely and thorough manner since its inception in 1999. The commission is in good financial standing with the exception of an excessive fund balance; however, it has taken steps to significantly reduce this surplus over the next two fiscal years. **Therefore, the Department of Legislative Services recommends that the Legislative Policy Committee waive the Maryland Health Care Commission from full evaluation at this time. In light of the inherently volatile nature of the health care industry, the department recommends that legislation be enacted to extend the commission's termination date by five years to July 1, 2008.** In five years, the commission's activities related to the certificate-of-need process, the report card evaluation system, and the State Health Plan can be evaluated more thoroughly. A ten-year extension would not be appropriate for the commission, since industry standards may change significantly during that time.

The Department of Legislative Services also recommends that the commission submit a follow-up report to the Legislative Policy Committee by October 1, 2001, addressing its fund balance surplus. The commission is required to report to the General Assembly on such issues as its user-fee apportionment and the potential merger with the HSCRC. Consequently, it is not necessary for the commission to address these issues in a follow-up report.

Appendix 1. Written Comments of the Maryland Health Care Commission

STATE OF MARYLAND

Donald E. Wilson, M.D.
CHAIRMAN

George S. Malouf, M.D.
VICE CHAIRMAN

John M. Colmers
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4201 PATTERSON AVENUE —5TH FLOOR— BALTIMORE, MARYLAND 21215
AREA CODE 410-764-3460 FAX (410) 358-1236

October 30, 2000

Warren G. Deschenaux
Director
Department of Legislative Services
Office of Policy Analysis
90 State Circle
Annapolis, Maryland 21401-1991

Dear Mr. Deschenaux:

The Maryland Health Care Commission (MHCC) has reviewed the draft copy of your report to the Legislative Policy Committee for accuracy and finds the report to be factually correct.

We appreciate your thorough review of our activities and concur with your conclusions.

Sincerely,

John M. Colmers
Executive Director

TOLL FREE
1-877-245-1762

TDD FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258