MHCC | MARYLAND HEALTH CARE COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2005

(July 1, 2004 through June 30, 2005)

Robert L. Ehrlich, Jr.
Governor

Stephen J. Salamon
Chairman

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.

Please note that following the end of the fiscal year, the Commission said farewell to Commissioners Ernest B. Crofoot and Larry Ginsburg as their terms expired and welcomed new Commissioners Rev. Robert L. Conway, Sharon K. Krumm, R.N., Ph.D., and Nevins W. Todd, Jr., M.D.

The Commission is composed of thirteen 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, Chairman 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.

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.

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 lives 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.

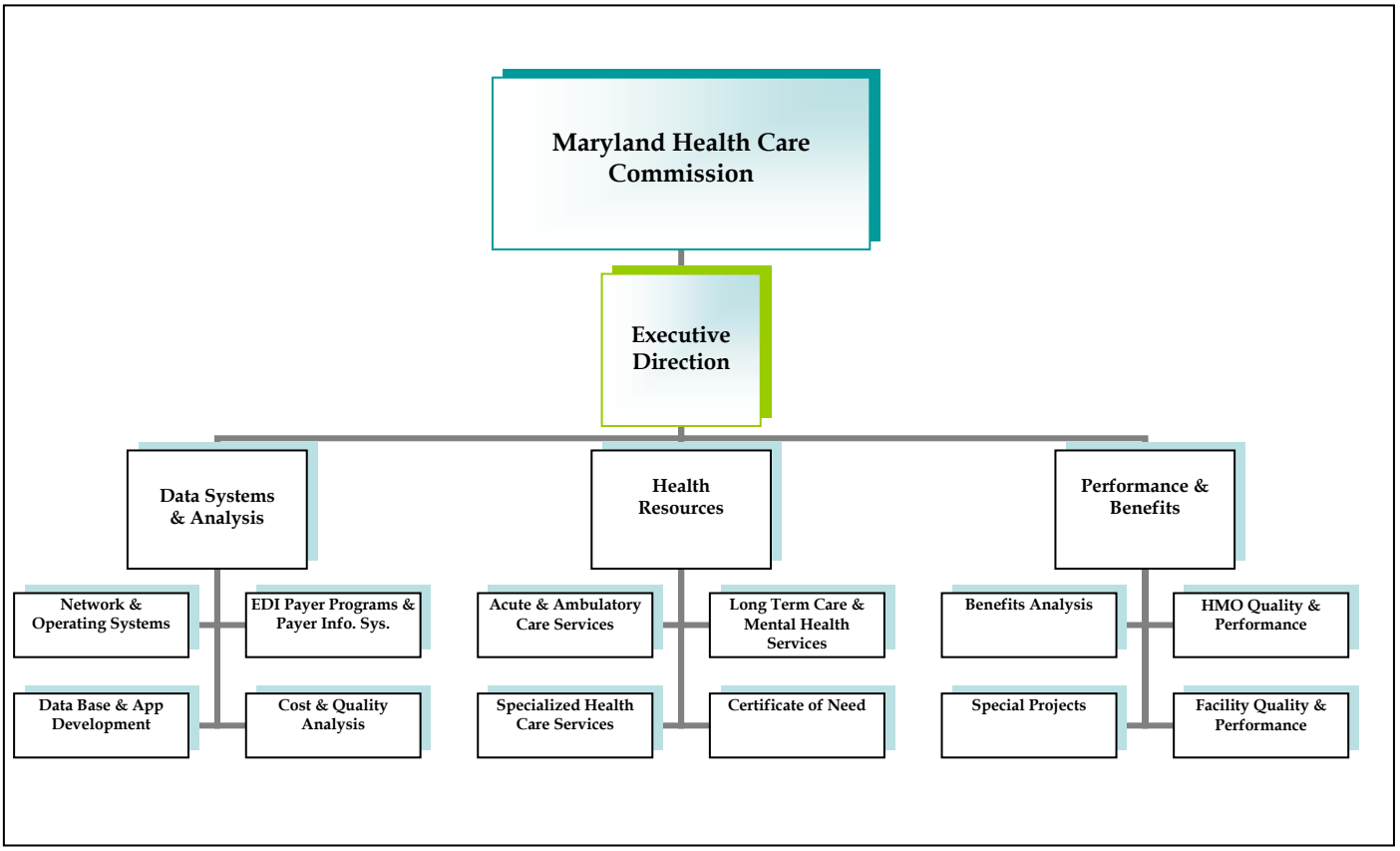
Andrew N. Pollak, MD, is Associate Professor of Orthopaedics at the University of Maryland School of Medicine. He is also a part-time instructor of Orthopaedic Surgery at the Johns Hopkins University School of Medicine. Dr. Pollak has led major research in orthopaedic trauma surgery and emergency medical 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.

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.


Maryland Health Care Commission
Executive Direction
Data Systems & Analysis
Health Resources
Performance & Benefits
Network & Operating Systems
EDI Payer Programs & Payer Info. Sys.
Data Base & App Development
Cost & Quality Analysis
Acute & Ambulatory Care Services
Long Term Care & Mental Health Services
Specialized Health Care Services
Certificate of Need
Benefits Analysis
HMO Quality & Performance
Special Projects
Facility Quality & Performance

EXECUTIVE STAFF

Rex W. Cowdry, M.D.
Executive Director

Pamela W. Barclay
Deputy Director of Health Resources

Bruce Kozlowski
Deputy Director of Performance and Benefits

Ben Steffen
Deputy Director of Data Systems and Analysis

EXECUTIVE SUMMARY

The Maryland Health Care Commission (the Commission, or MHCC) was created in 1999. The Commission operates under the authority of the *Annotated Code of Maryland,* Health General Article § 19-101, *et seq.*

CURRENT STAFF
The Commission staff is led by Executive Director Rex W. Cowdry, M.D., and three deputies: Ben Steffen, Deputy Director of Data Systems and Analysis; Bruce Kozlowski, Deputy Director of Performance and Benefits; and Pamela W. Barclay, Deputy Director of Health Resources.

Executive Direction: This unit centralizes the key functions of budget, assessment and billing of user fees, personnel, procurement, public affairs, and legal services. Bridget Zombro, the Associate Deputy Director, manages the day-to-day operations of the Commission and provides the Executive Director with ongoing status reports of activities within each functional area. The Legal Services unit

(composed of three Assistant Attorneys General) provides advice to both the Executive Director and the Commission. During FY 2005, the Commission had an appropriation for 65.0 full time positions.

Data Systems and Analysis: Three divisions are responsible for the analysis, collection, management, and reporting of information on health care costs and utilization. A fourth division promotes the adoption of electronic data interchange (EDI) for administrative health care transactions between Maryland providers and payers, provides expertise regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and administers the Maryland Trauma Physician Services Fund.

The Data Base and Application Development Division has three main functions: (1) creation and maintenance of the data bases collected by MHCC; (2) administration of all aspects of survey operation, including software design, help desk operation, and quality control; and (3) development of specialized software in support of the Commission's research and Internet efforts.

The Cost and Quality Analysis Division is responsible for the preparation of the annual state health care expenditure and physician utilization reports that are mandated by law. The division staff members conduct specialized studies of specific conditions and examine broader health care issues, including the use of health care services by specific populations and issues affecting the uninsured.

EDI Programs and Payer Compliance Division staff members develop programs to expand the use of EDI and manage insurance companies' regulatory responsibilities on EDI and data reporting. Staff members coordinate activities with the state's professional health care associations in order to develop select EDI adoption programs. Staff members also provide health care providers and payers with an overview, analysis, and training on compliance with the federal regulations arising from the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).. In addition, this division's staff members administer the Maryland Trauma Physician Services Fund.

Network Operations and Administration Systems staff members maintain the internal computer networks, monitor utilization of resources, and enforce computer security measures. This division's staff also provide support to Commission staff on standard office software and financial systems.

Performance and Benefits: The four divisions reflect diverse projects; however, they are unified by the common theme of providing information to consumers, providers, and employers to make the health care marketplace more competitive in terms of increased quality and lower cost.

Benefits Analysis staff are responsible for two major projects that are both related to the provision of health insurance. The first responsibility is to monitor the provision of coverage in the small employer group market. The second area of responsibility is an annual evaluation of state mandated benefits, which may influence the individual and fully insured large group markets.

Special Projects: The Maryland General Assembly has increasingly required the Commission to undertake new projects and provide numerous ad hoc studies and reports. This Division responds to special requests for information by the Maryland legislature, executive departments, and other external groups on health care delivery system issues. The Division also serves as an incubator for newly mandated Commission activities, laying the groundwork for full implementation. Typically, the Division establishes a workgroup or steering committee of interested parties to conduct a more detailed analysis of existing literature or programs currently being undertaken in other states, and to discuss policy issues related to a new mandate. Under most circumstances, a workgroup will design and implement a pilot project before recommending a final implementation strategy to the Commission.

HMO Quality & Performance Division is charged with collecting information to compare the performance and overall quality of commercial HMOs and Point of Service (POS) plans operating in Maryland and making that information available to the public. The reports assist various groups of consumers, purchasers, and policy makers in assessing the relative quality of services offered by commercial managed care plans. This information is expected to affect purchasing and enrollment decisions as well as the health care marketplace to improve the overall quality of care provided by commercial POS plans and HMO to their enrollees.

Facility Quality & Performance Division staff fulfill the mandate to undertake projects and provide numerous reporting systems regarding nursing homes, hospitals, and ambulatory surgery facilities. The purpose of the facility report cards is to give consumers clear and objective information, as well as to improve the quality of care provided by these facilities, by establishing a common set of performance measures and disseminating the findings of comparative evaluations.

Health Resources: The first three divisions develop components of the State Health Plan for Facilities and Services (State Health Plan, or SHP) that are promulgated as state regulation. The fourth division administers the Certificate of Need program that reviews and approves new or expanded health care facilities and services based on standards, criteria, and methodologies developed through the State Health Plan.

The Acute and Ambulatory Care Services Division is responsible for development of State Health Plan sections covering the following acute inpatient services: medical-surgical, obstetrics, pediatrics, and ambulatory surgical services, both hospital-based and freestanding. This division is also involved with downsizing the acute care hospital system and implementation of the Hospital Capacity and Cost-Containment Act.

The Specialized Health Care Services Division is responsible for development of State Health Plan sections covering the following services: cardiac surgery and therapeutic catheterization, neonatal intensive care unit services, organ transplant services, and rehabilitation services, including: comprehensive inpatient rehabilitation, brain injury, spinal cord injury, and infant and early childhood injury.

The Long Term Care and Mental Health Services Division is responsible for the development of State Health Plan sections covering the following services: nursing home, subacute, home health, hospice, adult day care, continuing care retirement communities (CCRCs), and other community-based services; Psychiatric Services, including residential treatment centers and acute psychiatric services; and Alcoholism and Drug Abuse Treatment Services.

Certificate of Need program staff review applications that require approval under the Certificate of Need law. Regulated covered services include: acute general hospitals, special hospitals (chronic, psychiatric, rehabilitation, pediatric), comprehensive care facilities (nursing homes), extended care facilities, residential treatment centers, intermediate care alcoholism and drug abuse treatment centers, retardation (ICF-MR) centers, ambulatory surgical facilities, home health agencies, hospice, and specialized services, e.g., open heart surgery, neonatal intensive care, organ transplants, and burn units.

BUDGET

The Commission's allocation for mission and program functions during FY 2005 was $10,124,187. This figure includes a budget amendment for $1,553,263. The budget amendment was submitted to cover: (1) funding for the Cost of Living Adjustment (COLA) that was approved for FY 2005 during the 2004 Legislative Session; (2) indirect costs for the Commission under SB 508; (which required that

the Commission be assessed 32% of its salaries, including special payments payroll; by the Department of Health and Mental Hygiene; and (3) an appropriation increase to cover costs associated with SB 131, which required the Commission, in consultation with the Maryland Insurance Administration, (MIA) to conduct studies of the affordability of health insurance in Maryland. The Commission's cap for FY 2005 was $11,300,000 (increased during the fiscal year by $1.3 million to account for the expenditures incurred under indirect costs.) At the close of FY 2005, the Commission's surplus was $3,498,540. During FY 2005 and FY 2006, the Commission is implementing a reduction plan to return approximately $1.2 million to its payers.

ASSESSMENT

During FY 2005, the Commission assessed: (1) Payers for an amount not to exceed 37.5% of the total budget; (2) Hospitals and Special Hospitals for an amount not to exceed 28.5% of the total budget; (3) The Health Occupational boards for an amount not to exceed 21% of the total budget: and (4) Nursing Homes for an amount not to exceed 13% of the total budget. The amount is derived differently for each group assessed.

- Payers are assessed a fee in a manner that apportions the total amount assessed to be based on a ratio of each payer's total premium collected in the state for health benefit plans to the total collected premiums of all payers in the state;

- Hospitals are assessed the amount equal to one-half of the total fees to be assessed on hospitals times the ratio of admissions of the hospital to total admissions of all hospitals; and the amount equal to one-half of the total fees to be assessed on hospitals times the ratio of gross operating revenue of each hospital to total gross operating revenues of all hospitals;

- Nursing Homes are assessed the amount equal to one-half of the total fees to be assessed on nursing homes times the ratio of admissions of the nursing home to total admissions of all nursing homes; and the amount equal to one-half of the total fees to be assessed on nursing homes times the ratio of gross operating revenue of each nursing home to total gross operating revenues of all nursing homes; and

- Health Occupational Boards are assessed a fee that apportions the total amount assessed based on number of licensees for each board assessed. The Commission currently collects the practitioner assessment from professional counselors and therapists, pharmacists, dieticians, nutritionists, occupational therapists, social workers, speech-language pathologists, audiologists, hearing aid dispensers, psychologists, registered nurses, nurse

practitioners, nurse anesthetists, nurse midwives, podiatrists, chiropractors, massage therapists, physical therapists, acupuncturists, physician assistants, physicians, osteopaths, psychiatrists assistants, medical radiation technologists/radio oncologists, nuclear medicine technologists, respiratory care practitioners, dentists, and optometrists.

Section 12 of Chapter 702 of 1999 of the *Annotated Code of Maryland* (formerly known as HB 995) required the Commission to study and make recommendations on the appropriate funding level for the Commission and user fee allocation among those assessed in 2000. The Commission fulfilled this statutory requirement with the recommendations and subsequent submission of legislation that was passed during the 2001 session of the General Assembly. Key components included: (1) raising the user fee cap to a total of $10 million to accommodate future legislative requests and cost-of-living increases; (2) using a methodology that accounts for the portion of the Commission's workload attributable to each industry assessed; (3) recalculating workload distribution every four years by removing from existing statute the apportionment of each industry and permitting the Commission to promulgate the apportionment into regulation; and (4) broadening the base of licensees that pay the fee from the practitioner boards to include all health care practitioners except those whose hourly/annual wage is substantially below that of other health care practitioners. The Commission implemented these changes during the FY 2003 billing cycle.

OVERVIEW OF FY 2005 ACCOMPLISHMENTS

The Commission's activities throughout the fiscal year focused upon collaborative initiatives related to broadening Marylanders access to high quality and cost effective health care services.

Throughout FY 2005, the Commission accomplished several reforms in the small group health insurance market. New regulations that increased certain cost-sharing requirements went into effect in July 2004, following a thorough review of covered benefits and out of pocket costs in the Comprehensive Standard Health Benefits Plan (CSHBP). In addition, the Commission adopted regulations to bring the CSHBP into conformity with the requirements for health savings accounts enacted in the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The regulations now enable carriers to offer small employers a high-deductible CSHBP in conjunction with these tax-favored health savings accounts.

At the beginning of FY 05, the Commission also began an extensive process to develop a Limited Benefit Plan (capped at 70% of the cost of the CSHBP) that participating carriers could offer to certain small employers. CareFirst and MAMSI, the two carriers required to participate, began offering the capped benefit plan on July 1, 2005.

The Commission's Certificate of Need (CON) program was also the focus of significant study during the fiscal year. The increasing number of hospitals and other health care facilities choosing to seek CON approval for projects involving capital expenditures exceeding the Commission's current inflation-adjusted $1.65 million review threshold continued throughout the fiscal year, and will extend through FY 2006. For example, the Commission granted CON approval to twelve new hospital capital projects, and approved changes to two previously approved projects, for a combined total capital cost of nearly $1.1 billion. It also issued determinations of non-coverage by CON, as either below-threshold or subject to a pledge not to raise rates for the project, to an additional twenty-seven smaller hospital capital projects, for a total cost of more than $127 million.

Chairman Stephen J. Salamon established a Certificate of Need Task Force in the spring of 2005, chaired by Commissioner Robert E. Nicolay, whose work continued into FY 2006. Commissioners Robert E. Moffit, Ph.D., former Commissioner Larry Ginsburg, and twenty-four appointed members including representatives of the Maryland Hospital Association, Med-Chi, CareFirst BlueCross BlueShield, the Health Facilities Association of Maryland, LifeSpan, the Hospice Network of Maryland, the Maryland Ambulatory Surgical Association, and other interested organizations also served on this body.

The Commission has continuously worked collaboratively in updating its performance reporting systems. The nursing home guide offers a broad look at more than 200 comprehensive care nursing facilities and continuing care retirement communities, the date for which is current through March 2005. In addition to quality indicators selected by the Maryland Nursing Home Performance Evaluation Guide Steering Committee, the site also features the quality measures that are reported on the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare Website. Because the Guide has an advanced search capability, it allows Marylanders to search by facility characteristics and specific services.

The Hospital Report Card Steering Committee began an enhancement and redesign process of the Hospital Guide in July 2004. Four major areas of expansion: (1) inclusion of composite measures; (2) inclusion of mortality data; (3) use of different symbols, and (4) development of a hospital comparison function are underway with guidance from the Steering Committee and Commission staff supervision.

Further, following participating in a three-state (Arizona, New York, and Maryland) hospital public reporting project of patient satisfaction that was initiated by CMS in 2003, the Commission further pilot-test a patient satisfaction reporting tool, involving the participation of forty-seven acute care hospitals and the collection of four months of hospital discharge data. The Commission, in concert with the Hospital Guide Steering Committee and representatives from the Maryland Hospital Association,

reviewed the survey results in April 2005 and are in the process of determining the appropriate next steps. Further, a new plan for an incremental approach to reporting infection data and reducing adverse medical events, entitled the "Healthcare Associated Infections Public Reporting Plan" became effective in January 2005. The Commission also participates in the planning process for a new Health Services Cost Review Commission (HSCRC) Quality Initiative designed to evaluate and recommend a system to provide hospitals with rewards and/or incentives for high quality care.

In other areas performance reporting, the Commission's *Policy Issues Report* provided a snapshot of commercial HMOs and their affiliated point of service products, comparing the aggregate performance of Maryland HMOs to the aggregate performance of their counterparts in the Mid-Atlantic region, and throughout the nation, in terms of how these managed care plans ensure that members receive services or report favorable experiences with their health plan. In addition, the report shows how the overall performance of Maryland commercial HMOs has changed over time (from 2002 to 2004) to reveal where improvements or declines have occurred. In the area of ambulatory surgery, the ASF Performance Guide Steering Committee continues to guide the development of the reporting system for ambulatory surgical facilities, including hospital and office-based centers, providing single and multi-specialty services.

Another focus of the Commission's activities throughout the fiscal year was promoting payer and practitioner interest in adopting and expanding the use of electronic data interchange (EDI). The staff developed a series of education and awareness tools aimed at increasing practitioner and heath care facility staff members' understanding of the efficiencies that EDI generates. Use among practitioners and health care facilities increased by about 4.5 percent for the fiscal year.

The number of contributing payers to the Medical Care Data Base (MCDB) remained stable over the last year. The 2003 submissions (reported in 2004) contained information for more than 73 million medical services covered by private payers, more than 23 million outpatient services covered by Medicare and more than 24 million prescription drug services covered by private payers doing greater than $1 million of business annually in the State of Maryland. Analysis of the data submissions is reported by the Commission in several reports.

State Health Care Expenditures: Experience from 2003, released in January 2005, estimated that total spending for health care received by state residents increased 8.4 percent in 2003 to $26.5 billion. *Practitioner Utilization: Trends within Privately Insured Patients, 2002-2003,* was released in March 2005. Total spending for practitioner services used by non-elderly Maryland residents with health insurance grew by six percent in 2003. Private insurers in Maryland in 2003 paid rates that were quite close to the typical Medicare rate, with fee-for-service payments of HMO plans being slightly under the

Medicare rate and non-HMO plan payments being slightly above. *Prescription Drug Use and Expenditures: Trends among Privately Insured Patients, 2003* was released in April. A key finding reported that drug spending is characterized by a relatively small number of users with high expenditures and a large number of users with small expenditures.

The Commission also conducted extensive analyses of the Current Population Survey (CPS) to meet the varied needs of legislators, stakeholders, and state policy makers, and released a report in November of 2004 entitled, *Health Insurance Coverage in Maryland Through 2003.* There was a significant decline in the two-year-average rate of employment-based coverage during this period from about 75 percent to 72 percent, which continued the trend observed during 2000-2002 (from 77 percent to 75 percent.)

Several other activities in the Health Resources division illustrate the Commission's collaborative focus – for example, in the areas of specialized and acute inpatient care, the Steering Committee of the Advisory Committee on Outcome Assessment in Cardiovascular Care endorsed the recommendations in the Long Term Issues, and Quality Measurement and Data Reporting subcommittee reports, resulting in the Commission's release of those reports in February 2005. Commission staff also participate in the MIEMMS-sponsored Yellow Alert Task Force and the Health and Medical Surge Capacity Technical Advisory Committee, which reports to the Health and Medical Committee of the Governor's Emergency Advisory Council. In the long-term care arena, the Commission collaborates with the Office of Health Care Quality (OHCQ) in an Assisted Living Forum and an In-Home Health Services Forum. They also participate in the Maryland Department of Aging's Continuing Care Advisory Committee and the Nursing Home Liaison Committee (chaired by staff of the Medicaid program of the Department of Health and Mental Hygiene) and the Long Term Care Stakeholders group that was used as a sounding board to develop the Community Choice program, which is a mandatory managed care long term care program designed to serve all persons who would be nursing home eligible for Medicaid, as well as dually eligible for Medicare and Medicaid.

ACCOMPLISHMENTS DURING FY 2005

DATE	ACTIVITY
July 2004	The Commission approved COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan (Changes to CSHBP to Allow a Health Savings Account-Compatible High Deductible Health Plan).
	The Commission approved proposed changes to COMAR 10.24.03 – Maryland Long Term Care Survey.
	The Commission approved the appointment of Carol Richardson to the Institutional Review Board.
	The Commission adopted the Reviewer's Recommended Decision following an Exceptions Hearing on the Petition of Shady Grove Adventist Hospital and Washington Adventist Hospital for Acceptance of their Letters of Intent for Partial Relocation of an Existing Cardiac Surgery and Percutaneous Coronary Intervention Program
	The Commission approved a Certificate of Need (CON) for Gladys Spellman Specialty Hospital and Nursing Center for the addition of fifteen Chronic Care Hospital Beds.
	The Commission approved a Modification of Carroll County Hospital Center's Certificate of Need (CON) for capital construction and renovation.
	The Commission released *Spotlight on Prescription Drugs, Maryland Hospital Obstetric Services: Trends and 2008 Utilization Forecast, and the Annual Report on FY 2005 Licensed Acute Care Hospital Bed Capacity.*
August 2004	The Commission did not meet.
September 2004	The Commission approved final action for COMAR 31.11.06 – Comprehensive Standard Health Benefit Plan.
	The Commission approved proposed action for COMAR 10.24.02 – Data Reporting by Hospitals.

The Commission certified Eyefinity, Medifax, and Mutual of Omaha's Medicare Crossover Clearinghouse as Electronic Health Networks (EHNs).

The Commission approved the Reviewer's Recommended Decision on the Certificate of Need Application of Shady Grove Adventist Hospital for a Five-Bed Hospital and Emergency Department following an Exceptions Hearing.

The Commission approved Certificate of Need for Memorial Hospital at Easton to Establish a Twenty-Bed Rehabilitation Unit.

The Commission approved Certificate of Need for Plastic Surgery Center of Maryland for the Addition of One Operating Room.

The Commission released the *2004 Ambulatory Surgery Provider Directory, Report to the General Assembly on the Status of the Maryland Trauma Physicians Fund.*

October 2004

The Commission approved COMAR 10.24.12—State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services for proposed action.

The Commission affirmed the Reviewer's Denial of Request for Evidentiary Hearing in the Metropolitan Washington Open Heart Surgery Certificate of Need Review

The Commission certified GHN-Online as an Electronic Health Network (EHN).

The Commission released a Draft of the Limited Benefit Plan Design for public comment.

November 2004

The Commission held a public hearing on the proposed Limited Benefit Plan.

The Commission's Chairman, Stephen J. Salamon, appointed Dr. Gail Wilensky as Vice Chair.

The Chairman appointed Dr. Thomas Ryan to Chair the Commission's Research Proposal Review Committee.

The Commission posted an ambulatory surgery public use data set and a public use data set for hospice data on its website.

The Commission approved PROPOSED ACTION: COMAR 10.24.01 — Determination of Certificate of Need for Health Care Facilities.

The Commission approved Certificate of Need for an expansion and renovation project for Civista Medical Center to construct a four-level addition. Renovations to the existing hospital will include conversion of two existing inpatient units to ancillary and support services.

The Commission also approved Certificate of Need for St. Agnes Hospital to renovate its emergency department, upgrade its operating suites, and create a cardiovascular suite.

The Commission approved certification of Protologics as an Electronic Health Network.

The Commission approved the release of *Health Insurance Coverage in Maryland Through 2003.*

December 2004

The Commission appointed Pamela W. Barclay as Interim Executive Director.

The Commission approved COMAR 31.11.12 — Limited Health Benefit Plan as Proposed Permanent and Emergency Regulations.

The Commission approved Hospital Measures and HMO Measures for the 2005 and 2006 Consumer Guides.

The Commission approved Certificate of Need for Mercy Medical Center to implement four comprehensive patient care information systems.

Staff briefed the Commission on the *Statistical Brief: Cardiac Surgery and Percutaneous Coronary Intervention Services,* including recent trends in the utilization of cardiac surgery and percutaneous coronary intervention (PCI) services for hospitals in Maryland and Washington, D.C.

The Commission approved the release of the 2004 *EDI Progress Report: Summary of Findings.*

January 2005

The Commission welcomed newly appointed Commissioner Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc.

The Commission approved COMAR 32.11.06 – Comprehensive Standard Health Benefit Plan, COMAR 10.24.02 – Data Reporting by Hospitals; and COMAR 10.24.12 – State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services as permanent regulations.

The Commission approved the release of the *Study of the Affordability of Health Insurance in Maryland (Required Under SB 131/HB 845).*

The Commission approved Certificate of Need for Union Hospital of Cecil's new construction and renovation.

The Commission approved certification of PracticeWorks as an Electronic Health Network.

The Commission released *State Health Care Expenditures, Experience from 2003* and the *Annual Mandated Health Insurance Services Evaluation* reports.

Dr. Deborah Chollet, Senior Fellow with Mathematica Policy Research, presented a summary of *Spotlight on Maryland: Insurance Underwriting and Carrier Surpluses.*

The Chairman and Commission staff presented a Legislative Report on this year's session of the Maryland General Assembly.

February 2005

The Commission approved Certificate of Need for an expansion and renovation project for Shady Grove Adventist Hospital, for replacement hospital facilities for Johns Hopkins Hospital, a modification of the Certificate of Need approved in November 2003 for Potomac Ridge Behavioral Health, and Lutherville Surgicenter to construct an additional operating room and related support space.

Dr. Timothy Lake of Mathematica Policy Research presented a summary of findings and the Commission released *Trends in Diabetes Prevalence and Care Among Medicare Beneficiaries in Maryland – 2002.*Medical expenses may be moderating, employers and consumers may see some relief in 2005.

The Commission's Interim Executive Director briefed the Commission on the final reports of subcommittees of the Advisory Committee on Outcome Assessment in Cardiovascular Care and updated the Commission on the status of a proposal to study elective PCI at hospitals without on-site cardiac surgery.

The Commission released *Final Report of the Advisory Committee on Outcome Assessment in Cardiovascular Care: Quality Measurement and Data Reporting and Long Term Issues.*

The Chairman and Commission staff presented a Legislative Report on the Commission's activities in the Maryland General Assembly.

March 2005

The Commission approved COMAR 10.24.01 – Determination of Certificate of Need for Health Care Facilities as permanent regulation.

The Commission approved COMAR 31.11.12 **–** Limited Health Benefit Plan as permanent regulation.

The Commission approved COMAR 10.25.02 — User Fee Assessment of Health Care Practitioners, COMAR 10.25.03 — User Fee Assessment of Payers, Hospitals, and Nursing Homes as Permanent Regulation.

The Commission approved the Institutional Review Board's Release of Data from the Medical Care Data Base for – Johns Hopkins University - Study of Patients with Immune Thrombocytopenic Purpura in Maryland.

The Commission approved Certificate of Need for Asbury-Solomons, Inc. is a 42-bed nursing facility serving the continuing care retirement community ("CCRC") in Calvert County to add eight new comprehensive care facility beds in neighboring St. Mary's County.

The Commission also approved Certificate of Need for Keswick Multi-Care Center to replace one building on its campus and to undertake related facility improvements, and to Lorien LifeCenter-Baltimore County for a new CON for a site change for seventy comprehensive care facility beds that were granted a CON in 1998, but remained undeveloped; for Exemption from Certificate of Need for Potomac Ridge at Anne Arundel for the transfer of two Residential Treatment Center Beds; for Washington County Hospital for the Closure of its Subacute Extended Care Facility and for the transfer of two Residential Treatment Center Beds.

The Commission released *Practitioner Utilization: Trends Within Privately Insured Patients 2002*-2003 and the *Assisted Living Utilization Guide: Version One.*

The Commission's Chairman announced the formation of the Task Force on the Certificate of Need Program, to be chaired by Commissioner Robert E. Nicolay. He appointed Commissioners Larry Ginsburg and Robert Moffit and stakeholders to study the Certificate of Need process and ways to improve efficiency.

The Chairman and Commission staff presented a Legislative Report on the Commission's activities in the Maryland General Assembly.

April 2005

Staff briefed the Commission on the process for the Comprehensive Standard Health Benefit Plan annual review.

The Commission approved Certificate of Need for Julia Manor Health Care to relocate thirty-three comprehensive care beds from Washington County Hospital to Julia Manor Health Care.

The Commission approved the Certification as Electronic Health Networks for SSI and Health Data Exchange.

Dr. Claudia Schur, Principal Research Scientist at the National Opinion Research Center at the University of Chicago (NORC) presented a summary of findings in

Prescription Drug Use and Expenditures: Trends Among Privately Insured Patients.

The Commission released *Privately Insured Maryland Children with Conditions Related to Being Overweight.*

Commissioner Andrew N. Pollak , M.D. presented an update on a meeting of the Research Proposal Review Committee.

The Commission's Chairman presented highlights of the 2005 General Assembly Session.

May 2005

Commissioner Ernest B. Crofoot presented information on a resolution adopted by the Health Services Cost Review Commission regarding the nursing shortage in Maryland.

The Commission approved COMAR 31.11.12 – Technical Corrections to the Limited Benefit Plan as Emergency and Proposed Action.

The Commission approved Certificate of Need for Upper Chesapeake Medical Center for new construction between the existing hospital building and the adjacent Harford Surgical Pavilion, as well as renovation of existing space, as well as for approval to construct a three-story addition on the east end of the facility.

The Commission approved Certificate of Need for Chesapeake Eye Surgery Center's Establishment of a Two Operating Room Ambulatory Surgery Facility.

The Commission also approved modification of Frederick Memorial Hospital's Certificate of Need in order for the hospital to complete the project in a more timely manner and make better use of available space.

Staff briefed the Commission on the *Summary of Carrier Experience for Year Ending December 31, 2004.*

June 2005

The Commission approved Certificate of Need for Washington County Hospital to replace and relocate the hospital to a site approximately three miles from the existing campus.

The Commission approved Shady Grove Ambulatory Surgery Center's application for Certificate of Need to establish a free-standing ambulatory surgical facility, with four operating rooms, to be developed in leased space at the Fallsgrove Village Center Office Building in Rockville, Maryland.

The Commission also approved Stella Maris, Inc. for Certificate of Need for renovations in connection with re-licensing 42 temporary de-licensed comprehensive care facility beds and to improve accommodations for patients.

The Commission approved the Certification of Per-Se Technologies as an Electronic Health Network.

Commission staff presented an update on the Maryland Trauma Physician Services Fund.

DATA SYSTEMS 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 and enrollment in HMOs. The Commission's Medical Care Data Base is a key data source for several publications.

Accomplishments

During FY 2005, the Cost and Quality Analysis division released seven publications, including five reports and two *Spotlight on Maryland* issue briefs.

State Health Care Expenditures: Experience from 2003 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 January, the report estimated that total spending for health care received by state residents increased 8.4 percent in 2003 to $26.5 billion. The 2003 rate of increase reflects the national growth estimate and is 3 percentage points lower than the growth rate MHCC reported for 2002. The rapid escalation in health care spending, which began in 1999 and peaked in 2001, has trended modestly lower since 2002. Nevertheless, growth in health care spending remains high when measured against overall growth in personal income, which increased by 4 percent in 2003. In addition to detailing expenditures by service type (e.g., inpatient) and payer type (e.g., private insurance), the report included information on the distribution of health care

spending in both the nonelderly (under age 65) and elderly populations. Health care spending is highly skewed: among the nonelderly, the bottom half of the population accounts for less than 4 percent of all nonelderly health care spending, while the top 20 percent generates 80 percent of the expenditures. Consequently, expenditures for the typical (median) nonelderly person are well below the average for the group: $467 versus $1,944 in 2001. Average health care expenditures among the elderly are about three times the average among the nonelderly, and the gap in median spending is even greater. The median and average expenditures for an elderly person in 2001 were $2,891 and $6,791, respectively.

Practitioner Utilization: Trends within Privately Insured Patients, 2002-2003, based on analyses of the MCDB, was released in March. The report examined how payments to physicians and other health care practitioners for the care of privately insured Maryland residents under age 65 changed from 2002 to 2003, including a comparison to Medicare reimbursement rates. The purpose of the annual analysis is to provide an understanding of the factors underlying increases in insured expenditures for practitioner services. Total spending for practitioner services used by nonelderly Maryland residents with health insurance grew by 6 percent in 2003. Spending grew – in spite of a 2 percent reduction in the number of reported users – due to a 2 percent increase in payment rates coupled with 3 percent increases in both the average number of services per user and the intensity of the average service. The decline in users was driven by a 5 percent reduction in users from non-HMO plans, which more than offset a 2 percent increase in the number of HMO users. This small rebound in HMO enrollment in 2003 followed several years of a declining HMO share. Private insurers in Maryland in 2003 paid rates that were quite close to the typical Medicare rate, with fee-for-service payments of HMO plans being slightly under the Medicare rate and non-HMO plan payments being slightly above. The report also examined selected legislative issues, including a comparison of the share of practitioner payments paid out-of-pocket by plan type (e.g., public employees, small firm employees), payments for services and procedures assigned high malpractice risk, and the use of imaging procedures by the privately insured.

Two *Spotlight on Maryland* issue briefs – one related to state health care spending and the other based on an analysis of practitioner services in the MCDB – were released this fiscal year. *Health Insurance Premiums, the Underwriting Cycle, and Carrier Surpluses* (March) examined the relationship between insurer surpluses, premium levels, and insurer market share, highlighting the relatively recent change from fluctuating surplus levels to the maintenance of relatively high surpluses by most insurers. The possible consequences of sustained high surpluses on future premium levels and on the entrance of new health insurers into the Maryland market were also discussed. *Privately Insured Maryland Children*

with Conditions Related to Being Overweight: Characteristics, Services, and Spending (April) identified children in the 2003 MCDB likely to be overweight or obese and compared their use of practitioner services with that of other children in the MCDB. Controlling for utilization differences due to other medical conditions, age, gender, and insurer, the predicted annual payment to practitioners for children with an overweight-related condition were 80 percent (ages 12-19) and 66 percent (ages 6-11) higher than the average predicted annual payments for these respective age groups among children lacking an overweight-related condition.

Prescription Drug Use and Expenditures: Trends among Privately Insured Patients, 2003 was released in April. It is a study of prescription drug utilization among nonelderly Maryland residents with private drug coverage, with the MCDB as the key data source. This report was possible due to recent improvements in the consistency and quality of drug claims submitted to the MCDB. 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 2003, the highest 20 percent of users accounted for about 75 percent of prescription drug expenditures; the bottom half of users accounted for only about 6 percent of expenditures. Branded drugs accounted for about 55 percent of the prescriptions and 83 percent of prescription spending, with generic drugs making up the balance. Overall prescription drug spending on behalf of nonelderly insured Maryland residents increased by about 8 percent in 2003. Increased spending for the typical (median) user and prescription, however, was more modest: 5 percent and 4 percent, respectively. The Maryland prescription drug market continues to be dominated by retail sales: in 2003 only about 3 percent of prescriptions in the MCDB were dispensed by a mail order pharmacy. These mail order prescriptions accounted for about 8 percent of total payments, reflecting the fact that mail order prescriptions are typically for a 90-day supply. Nationally, use of mail order is considerably higher.

The division staff conducted extensive analyses of the Current Population Survey (CPS) to meet the varied needs of legislators, stakeholders, and DHMH staff and released a report in November of 2004 entitled, *Health Insurance Coverage in Maryland Through 2003.* Maryland did not experience a statistically significant increase in its two-year-average, nonelderly uninsured rate during 2001-2003, which was 15.3 percent in 2002-2003. However, there was a significant decline in the two-year-average rate of employment-based coverage during this period from about 75 percent to 72 percent, which continues the decline from 77 percent to 75 percent observed during 2000-2002. Apparent slight increases in the rates of Medicaid and other public coverage during 2001-2003, while not statistically significant, offset enough of the reduction in employment-based coverage to keep the uninsured rate stable. Adults without dependent children comprise the majority (61%) of the state's uninsured, and most of them are single. Young

adults, ages 19-29, have the highest risk of being uninsured of any age group, mainly because they are the least likely to have employer-based coverage. More than 60 percent of Maryland's uninsured are employed adults, and the majority of uninsured workers have family incomes above 200 percent of the poverty level. However, a reduction in family income in Maryland during 2001-2003 increased the share of uninsured workers with family incomes below 200 percent of the poverty level from 31 percent to 40 percent.

Also during the fiscal year, division staff collaborated with DHMH's Diabetes Prevention & Control Program (DPCP) to produce information on the number and demographics of elderly persons with diabetes in Maryland, their use of preventive services, and the frequency of negative outcomes. A contract, funded jointly by the Commission and DPCP, was awarded to Mathematica Policy Research, with staff serving as contract monitors. The study relied on Medicare data routinely obtained by the Commission from CMS for use in both the MCDB and the state health expenditures report. The findings were reported in a technical report, *Diabetes Prevalence, Outcomes, and Preventive Services Among Maryland Medicare Beneficiaries, 2002*, and in an issue brief, *Trends in Diabetes Prevalence and Care Among Medicare Beneficiaries in Maryland* – 2002. Results from the study were presented to the Commission and to the Maryland county health officers. The technical report was provided to the Diabetes Prevention and Control Coalition, chronic disease staff in the local health departments, and staff in CDC's Division of Diabetes Translation.

Prevalence of diabetes among Medicare beneficiaries in Maryland increased from 14 percent in 1997 to 17 percent in 2002, a trend consistent with national estimates. Use of preventive services by beneficiaries with diabetes appears to be increasing compared with previous state estimates. Rates of HbA1c testing have increased and exceed the Health People 2010 national goal. However, rates of dilated eye exams are below national targets and appear to be decreasing, a pattern that deserves more attention. Although rates of adverse outcomes, such as lower-limb amputation, appear to be decreasing, the percent of beneficiaries with diabetes with this outcome remained above the national target for 2010. the study also identified certain groups disproportionately affected by diabetes: African Americans, nonelderly disabled beneficiaries, and those dually enrolled in Medicare and Medicaid.

EDI Programs and Payer Compliance

Overview

The Annotated Code of Maryland, Title 10, Subtitle 25, grants the Commission the authority to promote the adoption of electronic data interchange (EDI) in

Maryland, including certification of clearinghouses and electronic health networks (EHNs). The Commission has pursued this responsibility via a statewide electronic health care information strategy intended to promote increased quality in the electronic environment, reduce administrative costs, and promote the adoption of electronic health care transactions throughout Maryland. A guiding principle in that strategy has been that technology adoption must serve the business and clinical interests of providers, particularly smaller providers. In that framework, the Commission has sought to promote, rather than mandate, provider adoption. COMAR 10.25.07 establishes a certification process for EHNs that operate in Maryland using national standards established by the Electronic Healthcare Network Accreditation Commission (EHNAC). COMAR 10.25.09 requires insurance companies, HMOs, and Medicaid Managed Care Organizations (MCOs) to accept electronic transactions from only those EHNs certified by MHCC using the EHNAC standards. In addition, COMAR 10.25.09 requires payers to submit EDI healthcare transaction data annually. This data is used to measure EDI activity among payers and providers. Payers identified under COMAR 10.25.09 may also be required to report specific encounter level data under COMAR 10.25.06. This information is compiled into the Medical Care Data Base (MCDB) and is used in developing the State Health Care Expenditure Report and the Practitioner Utilization Report

In 2003, the Maryland General Assembly created the Maryland Trauma Physician Services Fund to aid Maryland's trauma system by reimbursing trauma physicians for uncompensated care losses and by raising Medicaid payments to one hundred percent of the Medicare rate when a Medicaid patient receives trauma care at a designated center. The bill allowed trauma centers to apply for compensation for their trauma-related on-call expenses for trauma surgeons, orthopedists, neurosurgeons, and anesthesiologists and directed the Health Services Cost Review Commission (HSCRC) to ensure that hospitals are able to include trauma-related standby expenses in HSCRC-approved hospital rates. Governor Ehrlich signed the bill in May 2003 as Chapter 33 of the 2003 Laws of Maryland, and COMAR 10.25.10 implements that action.

Accomplishments

Health Care EDI Promotion

Payer and practitioner interest in adopting and expanding the use of EDI continued to grow during the past fiscal year. The staff developed a series of education and awareness tools aimed at increasing practitioner and heath care facility staff members' understanding of the efficiencies that EDI generates. The *2003 EDI-HIPAA Progress Report* indicates that EDI use among practitioners and health care facilities increased by about 4.5 percent.

Many practitioners and health care institutions have relied on the Commission for accurate information on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Administrative Simplification requirements. Staff provided industry awareness training on HIPAA to various medical, non-medical, and institutional providers. Staff also developed educational guides to assist small providers with implementation of HIPAA security standards and the National Provider Identifier (NPI). The Payer Internet Guide, a tool summarizing the internet capabilities of leading Maryland payers, was updated and expanded to include an additional payer. The guide is posted on the Commission's Website and is intended to promote medical office efficiencies in obtaining patient eligibility information, benefits, and claim status. Staff also released the "2004 Dental EDI Review" which provides an analysis of 2003 dental EDI claim transactions and reviews the state of EDI within the dental provider and payer community.

The cornerstone of the EDI strategy is a certification program that uses national standards and industry "best practices" for certifying electronic health networks (EHNs) doing business in the state. Currently, eighteen EHNs are MHCC-certified and eight are in candidacy status. MHCC-certification ensures that EHNs conform to industry best practices and reassures providers that vendors meet high quality performance standards. Over the lat year, MHCC participated with the Electronic Health Network Accreditation Commission (EHNAC) in the development of an e-Prescribing certification program. EHNAC and MHCC developed criteria that will be used by both EHNAC and MHCC to accredit or certify e-Prescribing networks that transmit prescription transaction information among providers, pharmacies, and prescription benefit managers. It is expected that MHCC certification of these vendors will commence in late 2005.

Maryland Trauma Physician Services Fund

In FY 2005, the Motor Vehicle Administration (MVA) collected slightly more than $11.7 million in revenue for the Maryland Trauma Physician Services Fund (Fund). Revenue for the Fund is derived from a $5 surcharge fee on automobile registrations and renewals. The Fund had two payout cycles in FY 2005 covering the reporting period April 1, 2004 through June 30, 2004 and the period July 1, 2004 through December 31, 2004. Taking into account the payments made in FY2005, as well as outstanding obligations incurred in July 2005, the Fund has a total fund balance of approximately $12.4 million.

During FY 2005, the Fund issued payments that totaled approximately $4.5 million. These payments include about $2.3 million to trauma centers for the costs of having physicians on-call at the trauma center, around $1.7 million in payments to trauma physicians for the care provided to uncompensated care patients, approximately $231,000 in elevated payments to physicians providing care to patients enrolled in the Medicaid program, a $206,250 payment to Children's

National Medical Center for incurring standby services that benefited Maryland trauma patients, and about $110,000 to contract with an auditing firm that reviews on-call, uncompensated care, and standby applications submitted to the Fund.

In addition, the Fund has outstanding obligations for expenses incurred after the close of FY 2005. The first obligation was for trauma centers and physician practices that submitted applications by July 31, 2005. These applications totaled about $2.9 million in payments for on-call and uncompensated care services provided during the reporting period January 1, 2005 through June 30, 2005. The Fund also owes the Medicaid program approximately $190,000 for trauma services provided at the elevated Fund rate by Medicaid and its managed care organizations.

MHCC expects the trauma fund balance to increase in FY 2006. Staff believes that while on-call payments to trauma centers are expected to increase in FY 2006, these payments will not reach a level where each trauma center receives the maximum amount allowed without legislative changes to expand the number of specialties eligible for on-call payments. The amount paid to trauma physicians for uncompensated care services is not expected to increase in the next year.

MHCC expects that payments for services provided to Medicaid enrolled patients will decrease. The passage of the Maryland Patients' Access to Quality Health Care Act of 2004 increases the amount that Medicaid reimburses for orthopedic and neurosurgical procedures as well as for five commonly performed evaluation and management (E & M) procedures performed by emergency room physicians. The passage of this legislation will decrease the amount that the Fund reimburses trauma physicians for services provided to Medicaid enrolled patients. This projected decrease in payments to Medicaid will help create a surplus in the trauma fund balance in FY2006.

The Fund's auditor, Clifton-Gunderson, LLP, reviews the on-call, standby, and uncompensated care applications submitted to the Fund. Clifton-Gunderson completed reviews of applications submitted for the six-month reporting cycle that ran from October 1, 2003 through March 31, 2004 and the three-month reporting cycle from April 1, 2004 through June 30, 2004. For FY 2005, the auditor identified adjustments in payments that totaled $398,195.42 due from physician practices and trauma centers to the Fund.

MHCC submitted a list of recommendations in its Report to the Maryland General Assembly for FY 2005 on ways to expand participation without adversely impacting the existing trauma centers and providers currently benefiting from the Fund. The recommendations addressed ways to increase (1) on-call payments, (2) uncompensated care payments, (3) payments to Medicaid participants, and (4) administrative changes. The recommendations will increase the amount paid to

existing trauma centers and physicians above the projected FY 2006 spending levels. MHCC will work with the Maryland General Assembly in determining whether one or more of these recommendations should be implemented in FY 2006.

Data Base and Application 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 psychiatric hospital data, outpatient ambulatory surgery data, Medicare and private payer outpatient claims data, large private payer pharmacy data, and various CMS data systems of including the Minimum Data Set. 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

Physicians and Health Care Professionals
The Data Base and Application Development and EDI Program and Payer Compliance Divisions have joint responsibility for managing and developing the Medical Care Data base. The 2004 Medical Care Data Base marks the ninth year of data collection. The total premium volume of the thirty insurance companies contributing to the 2004 Medical Care Data Base was approximately $3.5 billion.

MCDB	Due Date	Premium Volume of Contributing Payers	Number of Contributing Payers	Number Identified Payers before MHCC screening
1998	June 1999	$2,665,821,073	55	91
1999	June 2000	$2,996,950,069	54	79
2000	June 2001	$3,014,647,309	47	78
2001	June 2002	$3,063,658,273	35	50
2002	June 2003	$3,131,780,487	33	42
2003	June 2004	$3,305,228,162	30	54
2004	June 2004	$3,538,951,336	30	49

Over the last year, the number of contributing payers remained stable. The prior year was marked by several payer consolidations. United Health Group acquired MAMSI, the Maryland Fidelity Insurance Company, and Golden Rule. These payers continued to report independently during this data collection cycle. This is the third year that staff provided payers with an overview report of their data submission quality and discussed steps for making any needed improvements prior to payers submitting their data.

Once collected, the 2003 Medical Care Data Base information is edited and organized for internal research use. This data base contains over 73 million medical services covered by private payers, over 23 million outpatient services covered by Medicare and over 24 million prescription drug services covered by private payers doing more than $1 million of business annually in the State of Maryland.

Web Licensing Applications

The data staff continue to support online license renewal applications developed for the Maryland Board of Physicians and the Maryland Board of Pharmacy, which allow over 25,000 physicians, 6700 pharmacists, and 1300 pharmacies to renew and pay for their licenses electronically. These applications verify the quality of data being entered by the physician and are pre-populated with previous year renewal data so the user only needs to update the information previously provided. Each application comes with an online administrative section that allows staff to monitor and track license renewals, and an evaluation section that allows for user input regarding the online renewal process. Completed data is electronically transported to the main database for each application. The application was modified this year to collect the type of information technology used and physicians can now pay the renewal fee using a credit card.

Nursing Homes and Subacute Care

COMAR 10.24.03 directs the Commission to collect data for the Maryland Long Term Care Survey from facilities with the following licensure categories: comprehensive care, extended care, chronic care, subacute facilities, assisted living facilities, and adult day care centers. The Commission uses a separate quarterly subacute care survey of resident-specific data for hospital-based facilities offering comprehensive, chronic, and extended care. During FY 2005, Commission staff implemented a web-based pre-survey questionnaire, which was sent to facilities prior to the 2005 survey collection that reduced verification and updating of facility information by eighty percent. Commission staff also implemented an electronic survey response system that relies on e-mail communications.

During the first quarter of 2005, Commission staff used data from the 2003 Annual Long term Care Survey to implement a web-based publicly accessible Assisted

Living Facility Guide. The Guide contains information on 330 facilities having ten beds or more that participate in the Maryland Long Term Care Survey. The Guide provides information on the facility characteristics, recent utilization, and charges one would expect to pay per room for standard types of care. The Commission received favorable reviews from the facilities on this application.

Summary reports for the facilities that participate in the Maryland Subacute Care Survey were made available online for the first time during the fiscal year. Each facility page lists general facility information and statistics, such as number of discharges, the mean and median of the number of days of treatment, and the mean of the Length of Stay. The reports cover therapies the patients received, demographics (age, race, sex), the primary payment source, discharge destination, principal diagnosis codes by specialty groups, the number of other diagnosis codes for patients on admission, and the number of diagnosis codes that are identified during a patient's stay.

During FY 2005, Commission staff converted facility data for adult day care, ambulatory surgery, assisted living, hospice, chronic care, and comprehensive care facilities into public use datasets in Microsoft Access, Excel and SAS formats and made these files available for download from the Commission's website.

CMS Nursing Home Minimum Data Set

The Commission is using the Minimum Data Set from the Centers for Medicare and Medicaid Services to supplement the facility level data collected by the Long Term Care Survey in order to assess the quality of care at Maryland's nursing homes reported in the Commission's Nursing Home Report Card. The Minimum Data Set also covers all hospital-based subacute facilities. The Commission's contractor has completed conversion of the raw data into calendar year analysis files that cover all visits by patients to nursing homes, sub acute facilities, and continuing care retirement communities that are required to fill out resident assessments for 1999 through 2004. Under a separate contract, an existing bed need forecasting program was converted to use the Minimum Data Set and a new bed need scenario using linear regression techniques was developed. The new data base is being used for Certificate of Need analysis for nursing homes. The Minimum Data Set is expected to become the fundamental data system for all future patient level nursing home analysis to support the Commission's long term care planning and regulatory programs.

Hospitals, Inpatient and Outpatient

The Commission has authority under COMAR 10.24.02 to use information on hospital and outpatient services collected by the HSCRC. This data is used for utilization projections, trend reports, hospital policy reports, and responses to queries from the Maryland legislature, Commissioners, the Executive Director and

Commission staff, industry members, and others for hospital services. The hospital discharge abstract data is also used to compute patient safety indicators modeled on Agency for Healthcare Research and Quality programs.

Internal Data Processing Efficiencies

Web publishing activities have now been more widely distributed among staff so that critical updates to the website can be made in the absence of primary web staff. Staff now use CMS file downloads to get data for portions of the nursing home website instead of waiting for an internally generated file. The ambulatory surgery web directory was converted to a data-driven application so that multiple web-pages for each facility no longer need to be maintained. Email addresses on the website have been encrypted to eliminate spam generated by email harvesting. Web statistics programs have been improved and now report web visits across applications on a monthly basis. The website has been converted to a simplified url and consumer applications have been grouped into one location.

Commission staff have significantly reduced the need for external mapping support by developing in-house mapping expertise. Analysis output has been streamlined using SAS/ODS procedures so that many types of SAS output are generated in batch mode directly into the specific formats needed by the Commission's staff.

Network Operations and Administration 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 2005, the Commission's LAN was available to staff more than 99% of the time.

The network staff began a complete upgrade of the LAN to maintain high availability and response time. A new domain structure, built on two new domain controllers and an MS Windows 2003 server, has been put in place with a temporary bridge to the old domain. Several servers have already been moved to the new domain. Looking to the future, plans were finalized to replace hardware and software for the MHCC mail and database servers in the coming year and to upgrade the operating system on the main file server.

The MHCC web site was reconfigured and its address was changed to a simpler and easier to remember address: www.mhcc.maryland.gov.

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.

PERFORMANCE AND BENEFITS

Benefits Analysis Division

This division has the ongoing responsibility for two major projects related to the provision of health insurance. The first responsibility is to monitor the provision of coverage in the small employer group market. The second area of responsibility is an annual evaluation of state mandated health insurance services that may influence the fully insured individual and large group markets.

Small Group Market Reform

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 required for 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 upon 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 2005, the Commission accomplished several goals relating to the CSHBP. At the beginning of FY 05, after a thorough review of benefits and out of pocket costs in the CSHBP, new regulations that increased certain cost-sharing requirements went into effect on July 1, 2004 in an effort to keep the overall cost of the CSHBP below the statutory cap.

In May 2005, Commission staff presented the results of the annual financial survey of carriers participating in the small group market entitled *Summary of Carrier Experience for the Year Ending December 31, 2004.* The results of the survey indicated that the CSHBP has grown since 1995 and now impacts almost forty-two percent of the small employers in the state (50,820) and covers more than 450,000 lives. Other results included: (1) CSHBP premiums were estimated to have exceeded the affordability cap by about 2%; (2) increases in CSHBP premium (7.8%) were comparable to cost increases in insurance markets elsewhere; and (3) there was still a choice of carriers, but domination by two major carriers remained an issue.

In addition, the Commission adopted regulations effective July 1, 2004 to bring the CSHBP into conformity with the requirements for health savings accounts as

enacted in Section 1201 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173 (codified at § 223 of the Internal Revenue Code). These regulations now enable carriers to offer small employers a high-deductible CSHBP in conjunction with these tax-favored health savings accounts.

Limited Benefit Plan*:*
At the beginning of FY 05, staff began an extensive process of developing the Limited Health Benefit Plan (LBP) that participating carriers could offer to certain small employers beginning 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 Mid Atlantic Medical Services, LLC (MAMSI), 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 MAMSI, the two carriers required to participate in the LBP, began offering the capped benefit plan on July 1, 2005.

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 required 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 exceeds 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 2005, Mercer prepared its seventh study of the impact of mandated services. Commission staff presented this report to the General Assembly in January 2005. A complete copy of the mandated services report entitled, *Mandated Health Insurance Services Evaluation, December 31, 2004,* 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 2005 legislative session, included 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.

Facility Quality and Performance Division

Health General Article, §§ 19-134(d) and (e), originally enacted in 1999, directed the Commission to establish and implement, on an objective basis, a system to evaluate and compare the performance and quality of care of nursing homes, hospitals, and ambulatory surgery facilities.

Nursing Home Performance Evaluation System

Overview

Chapter 382 (SB 740) of the Acts of 1999 required the Commission, in consultation with DHMH and the Department of Aging, to develop a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis and to annually publish the summary findings of the evaluation. The purpose of the nursing facility comparative evaluation system ("nursing home performance evaluation guide") is to improve the quality of care provided by nursing facilities by establishing a common set of performance measures and disseminating the findings of the comparative evaluation to Marylanders, nursing facilities, and other interested parties.

Additionally, the law required that, as appropriate, performance information be solicited from Marylanders and their families. The Commission has proceeded to begin collecting resident or family satisfaction data utilizing a survey to measure satisfaction related to quality of care received in Maryland nursing home facilities.

To provide guidance in the development of a nursing home performance guide, the Commission convened a steering committee of interested parties including representatives of relevant state agencies, the nursing home industry, academic experts in data collection issues, and consumers. The public release of the first Maryland Nursing Home Performance Evaluation Guide ("Guide") was in August 2001. The Guide has been updated approximately every six months and is available on the Commission's website.

Accomplishments

The Commission has been continually updating the Guide since the first release and currently includes data through March, 2005. The Guide offers a broad look at more than 200 comprehensive care nursing facilities and continuing care retirement communities. It offers Marylanders the opportunity to review information on facility characteristics such as ownership information, the number of beds, and clinical services. Resident characteristics including gender, age, and functional status of the residents are also available. In addition to quality indicators selected by the Maryland Nursing Home Performance Evaluation Guide Steering Committee, the site also features the quality measures that are reported on the CMS Nursing Home Compare Website. The CMS measures are consistent with the consensus recommendations from the National Quality Forum. The Guide also provides information regarding recent state inspection deficiencies, general information on patient rights, how to pay for nursing home care, and what to look for when visiting a nursing home. Nursing home data may be accessed by name or geographical area, including county and zip code. Because the Guide has an advanced search capability, it allows Marylanders to search by facility characteristics and specific services.

The Commission contracted with the Lewin Group to perform an evaluation of both the Nursing Home and Hospital Guides. The purpose of the evaluation was to determine the utility of the Guides. Specific attention focused on: (1) assessing visitor usage, preferences, and understanding, (2) assessing users' trust levels of the information provided, (3) suggesting guide improvements, and (4) recommending outreach strategies to increase Guide utilization. The Lewin Group presented the results of the survey to the Steering Committee in March and the final report to the Commission in April 2004.

During FY 2004, the Steering Committee recommended that the Commission proceed with a self-administered family satisfaction survey. The RFP for the family satisfaction survey was released on November 1, 2004; the deadline for receipt of proposals was extended to December 8, 2004. The selected proposal was taken to the Board of Public Works for final approval in April 2005 and the contract was awarded to Market Decisions, LLC and the Institute for Health, Health Care Policy and Aging Research at Rutgers University. Currently, the survey is in its final stage, and the Commission anticipates that it will be mailed to Marylanders and their families by the end of 2005. The survey tool was developed with input from focus groups consisting of family members (i.e., responsible parties) and includes fifty (50) satisfaction questions covering six (6) specific domains: Administrative and Patient Care staff, Environmental Features, Resident Activities, Personal Care Services, Food , and Residents Personal Rights.

In June, Market Decisions and its research partners conducted a workshop to provide information on the Commission's goal of measuring family satisfaction of the care provided to their loved one's in long term care facilities. A key objective of the workshop was to prepare nursing home administrators for participation in the survey conducted in the fall of 2005. Results of the family satisfaction survey are scheduled to be available for public review on the Nursing Home Guide in the spring of 2006 following the review and approval of the Steering Committee and MHCC.

Another related activity addressing patient satisfaction in nursing homes focused on obtaining resident information. During FY 2004, the Steering Committee recommended that MHCC pursue a pilot project in collaboration with the federal Agency for Healthcare Research and Quality (AHRQ) and CMS to pilot test the Nursing Home CAHPS tool for resident satisfaction. Division staff will continue working with AHRQ and CMS to explore the feasibility and efficacy of collecting resident satisfaction data and information.

In the spring of 2005, the Steering Committee began discussion of nursing home patient safety measures that are appropriate for public reporting. The Committee was presented with an overview of the literature and activities in other states as well as a list of ten common patient safety measures. The Steering committee agreed that the Commission should begin with the reporting of health care facility-acquired infections and staff-to-patient ratios as two safety indicators.

Throughout the year, staff continued to identify national, regional, and local models and resources for quality measurement and patient safety.

Hospital Performance Evaluation System

Overview

Chapter 657 (HB 705) of the Acts of 1999 required the Commission to develop a similar performance evaluation system for hospitals. The Commission contracted with the Delmarva Foundation, in partnership with ABT Associates, to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Hospital Performance Evaluation Guide, and (2) design and execute a Marylander-oriented website for the Guide. The initial version of the Hospital Performance Evaluation Guide was unveiled on January 31, 2002. In May 2003, a new addition of the Guide was released and, for the first time, included quality of care measures.

The latest edition to the hospital guide, released in January 2005, features the addition of six new acute myocardial infarction (AMI) treatment measures. Trend information for the past two years associated with these measures has been collected and will be publicly reported for the first time in December of 2005. This latest version of the Guide also provides information on differences emerging in hospital practices and identifies a trend that, in general, shows improvement in the quality measures selected. Also included in this version of the Guide are obstetrics data, which were updated in December 2004 for admissions occurring during calendar year 2003.

The Guide, which is website based, enables Marylanders to review information on various facility characteristics, such as location of the hospital, number of beds, and accreditation status. Thirty-three high volume diagnosis-related groups (DRGs) are featured. For each hospital, Marylanders are able to compare the volume, risk adjusted length-of-stay, and risk adjusted readmission rate for each DRG. General information on patients' rights and how hospitals are regulated in Maryland is also presented, as well as guidance on what to expect in a hospital setting, and a checklist to help consumers select a hospital.

Accomplishments

As previously noted, the Commission contracted with the Lewin Group to evaluate the utility of the hospital guide in addition to that of the Nursing Home Guide. In both cases, the Commission's intent was threefold:

- To improve the performance and quality of the Guides;
- To enhance informed, value based decision making; and
- To demonstrate accountability to Maryland residents.

The evaluation consisted in large part of one-on-one interviews with Maryland residents, physicians, and hospital discharge planners. A draft report of the findings was presented to the Hospital Performance Evaluation Guide Steering Committee for review and comment in March, 2004. As noted earlier, a final report was presented by the Lewin Group to the Commission in April 2004.

The Hospital Report Card Steering Committee met in July 2004 to begin the enhancement and redesign process of the Hospital Guide web-site. During this meeting, the Committee approved four major areas of expansion: (1) inclusion of composite measures; (2) inclusion of mortality data; (3) use of different symbols, and (4) development of a hospital comparison function. The Committee met in October 2004 for a discussion of detailed redesign issues, facilitated by TechWrite, Inc., a subcontractor of Delmarva Foundation. The Committee agreed to a design that would specify portals for three major users—prospective patients, hospital leaders, and hands-on providers. Website changes were prioritized and the redesign work is currently underway.

A workgroup of the Hospital Guide Steering Committee met in May 2005 to decide on a methodology for calculating composite scores for the clinical measures posted on the site. It was agreed that several methodologies would be tested with current data and reported back to the workgroup.

MHCC participated in a three-state (Arizona, New York, and Maryland) hospital public reporting project of patient satisfaction initiated by CMS in 2003. The Hospital Guide Steering Committee was briefed on the results of this pilot project in January, 2004 and agreed that MHCC should pursue the use of the HCAHPS tool to collect patient satisfaction data and information. MHCC staff later consulted with representatives from CMS and AHRQ to discuss an additional pilot test of the revised HCAHPS patient satisfaction tool. A proposal was submitted to AHRQ in April, 2004 and subsequently approved. Pilot testing of the revised survey tool began in October 2004, involving the participation of 47 acute care hospitals and the collection of four months of hospital discharge data. The survey process concluded in February 2005 with a response rate of approximately fifty percent of the 10,023 surveys issued to patients discharged for medical, surgical, or obstetrical services. Division staff, in concert with the Hospital Guide Steering Committee and representatives from the Maryland Hospital Association, reviewed the survey results in April, 2005 and is determining the appropriate next steps

The Commission recognizes the importance of reporting infection data and is mandated to develop a system for reducing preventable adverse medical events. In October 2004, in consultation with the Hospital Performance Evaluation Guide Steering Committee, the "Healthcare Associated Infections Public Reporting Plan" was developed. This plan was finalized in December 2004 and became effective in

January 2005. The plan proposed an incremental approach to reporting, beginning with the collection of infection prevention measures focused on ensuring that: (1) the appropriate antibiotic is given; (2) it is given at the appropriate time; and (3) it is discontinued within 24 hours of surgery. The collection of this data is currently required for all colon surgeries, knee and hip arthroplasties. A sub-group of the Steering Committee (Patient Safety) also endorsed the use of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Patient Safety measures when they become available for public reporting.

Division staff has also worked with the Maryland Patient Safety Center in a collaborative effort to reduce and eliminate both blood stream infection rates and ventilator associated pneumonia for intensive care unit patients. This information is projected to be collected and reported by hospitals by the end of 2005 or the early part of 2006, and should be available for public review in late 2006.

Quality Initiative

Division staff members continue to participate in the planning process for a new HSCRC Quality Initiative designed to evaluate and recommend a system to provide hospitals with rewards and/or incentives for high quality care HSCRC Quality Initiative Steering Committee meetings on an ongoing basis. The draft report of the HSCRC Steering Committee was presented to the Hospital Performance Evaluation Guide Steering Committee in January 2004 for review and comment. Since that time, HSCRC developed an implementation framework that staff presented to the Commission in January 2005. Throughout the year, staff continued to identify national, regional, and local models and resources for quality measurement and patient safety.

Ambulatory Surgical Facility Performance Evaluation System

Overview

Chapter 657 (HB 705) of 1999 also required the Commission to develop a performance report for Ambulatory Surgery Facilities (ASFs). The Commission developed a web-based report that was first released in May 2003.

The website contains structural (descriptive) facility information, including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. The site also includes several consumer resources.

An ASF Performance Guide Steering Committee convened to guide the development of the reporting system, consisting of representatives from a multi-specialty facility, a large single specialty facility, an office-based facility, a hospital-

based facility, and a consumer representative. An exploratory meeting was held with a subset of this group in January 2003. Subsequently, the Steering Committee provided input on several of the Guide's proposed web pages, including a consumer checklist, glossary, and list of resources. Staff continues to research recent developments in performance measurements in ambulatory surgery.

Accomplishments

The ASF Performance Guide Steering Committee continues to meet in order to improve the information available in the Consumer Guide and to explore the potential of providing measures directly related to quality.

Special Projects Division

Overview

The Maryland General Assembly has increasingly required the Commission to undertake new projects and provide numerous ad hoc studies and reports. This Division responds to special requests for information by the Maryland legislature, executive departments, and other external groups on health care delivery system issues. The Division also serves as an incubator for newly mandated Commission activities, laying the groundwork for full implementation. Typically, the Division establishes a workgroup or steering committee of interested parties to conduct a more detailed analysis of existing literature or programs currently being undertaken in other states, and to discuss policy issues related to a new mandate. Under most circumstances, a workgroup will design and implement a pilot project before recommending a final implementation strategy to the Commission.

Accomplishments

The Maryland General Assembly passed SB 131 in 2004, requiring the Commission and the Maryland Insurance Administration (MIA) to study issues related to the affordability of private health insurance in Maryland. A preliminary report, defining and explaining the drivers of health care spending and addressing issues through a literature review, defined and assessed how residents and businesses in the State of Maryland may attempt to curb the growth of spending in health care costs, increase access to health care, and improve the quality of care. The preliminary report was released by the Commission in January 2005. A final report to the General Assembly is due in January 2006.

HMO 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 to disseminate 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), 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 sixty-five percent of their enrollees covered through the Medicare and Medicaid programs are not required to submit HEDIS reports to the Commission. (Please note that appropriate state and federal agencies are measuring the quality and performance of managed care plans serving Medicare and Medicaid enrollees.)

Accomplishments

The Division of HMO Quality and Performance is charged with collecting, and making available to the public, information with which to compare the performance of commercial HMOs operating in Maryland. That information is intended to assist consumers, purchasers, academics, and policy makers in assessing the relative quality of services provided by commercial managed care plans.

Division staff collaborated with contractor staff having special expertise in health quality measurement to develop the eighth series of annual HMO reports. During the autumn of 2004, three publications: *Measuring the Quality of Maryland HMOs and POS Plans: 2004 Consumer Guide* (often referred to as the "HMO Report Card"); *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland*; and *Measuring the Quality of Maryland HMOs and POS Plans: 2004 State Employee Guide*, were completed and released.

The *Comprehensive Report* compiled the collective results reported by plans in 2004 to form a statistical compendium of HEDIS (clinical) and CAHPS (survey) data. Results for all seven plans were compared by creating a state average based upon their combined performance. The report incorporates results for access to care, rates of delivery of preventive services, and treatment of chronic conditions. A sub-set of data was used to develop the consumer-oriented version. While the

Consumer Guide targeted a general audience, the *Comprehensive Report* targeted an audience of health benefit plan managers. These reports were offered in paper and electronic versions to reach the broadest audience. The HMO Quality & Performance Division adjusted its use of electronic formats by discontinuing the production of an interactive version of the *Consumer Guide* in 2004. With fewer plans for consumers to select from, navigating through the report has become less cumbersome, making the additional associated design and production costs unwarranted. All reports in this HMO performance report series were posted on the Commission's website in a PDF format. In January 2005, the fourth publication, *Maryland Commercial HMOs and POS Plans: Policy Issues* was released, completing the 2004 HMO report series. The release of the publication is timed to coincide with the convening of the general assembly, the primary audience for the report.

Upon their release, the reports were sent to businesses, HMOs, libraries, policy makers, and academic health care programs, with distribution continuing throughout the fiscal year. Outreach activities by staff generated an increase in the volume of paper copies of the *Consumer Guide* distributed resulting in a reprint of the report. Staff contacted a diverse base of interested parties including employers, associations, colleges, and universities as both employer and distribution sources. The *Maryland Commercial HMOs and POS Plans: Policy Issues* report was distributed to all Maryland legislators, HMO contacts and CEOs, and other interested parties. All Maryland libraries received copies for their reference sections.

The *Policy Issues Report* provides a snapshot of commercial HMOs and their affiliated point of service products. It compares the aggregate performance of Maryland HMOs to the aggregate performance of their counterparts in the Mid-Atlantic region, and throughout the nation, in terms of how these managed care plans ensure that members receive services or report favorable experiences with their health plan. In addition, the report shows how the overall performance of Maryland commercial HMOs has changed over time (from 2002 to 2004) to reveal where improvements or declines have occurred.

Division staff also represented the Commission a statewide Diabetes Prevention and Control Coalition created by DHMH to develop a multi-year state strategic plan for diabetes surveillance and management.

2005 Report Series

The Commission approved revised measures for behavioral health, low back pain, C-Section and Vaginal Birth After Cesarean (VBAC), and outpatient/after-hours urgent care and emergency department utilization measures to be collected in the Health Plan Employer Data and Information Set (HEDIS) for calendar years 2005 and 2006.

Administration of the 2005 survey of HMO and POS members was completed in the spring 2005 using the CAHPS 3.0H survey tool for the seventh year. The data collected for this report series followed the most recent survey protocol that required a sample composed of 1,100 members from each of the seven HMOs submitting performance data during calendar year 2005. Because six plans have proportionally large point of service memberships, the sample of members surveyed for those plans included both HMO only and HMO/POS members. This allowed plans to capture more accurately how delivery occurs within their plans. The Commission agreed to submit CAHPS survey results to the National CAHPS Benchmarking Database, a public sector database, for the Maryland plans that consented to have their data included. Participation by the Commission and Maryland plans ensures that data will be available against which the performance of individual health plans can be measured for further research and analysis. In addition, Division staff modified the timelines for the State Employees' *Consumer Guide* to accommodate the Maryland Department of Budget and Management's change of the Open Enrollment timeframe from calendar year to fiscal year.

HEALTH RESOURCES

Acute and Ambulatory Care Services Division

Overview

This program is responsible for the development of the sections of the State Health Plan for Facilities and Services (State Health Plan, or SHP) covering actions taken by acute care general hospitals and other providers of health care services involving the following medical services: medical-surgical, pediatric, obstetric, and ambulatory surgical services, both hospital-based and freestanding. This program is also involved in other aspects of policy development concerning Maryland's acute care hospitals and ambulatory surgical facilities, including emergency department services and implementation of Maryland's patient census-based acute care hospital licensure procedures. The "Hospital Capacity and Cost Containment Act" of 1999 established an annual maximum licensed capacity for each acute care hospital reflecting its actual utilization. In addition, over the last year, this program has been involved in reviews of several Certificate of Need requests, and statewide planning efforts regarding "surge capacity."

Accomplishments

State Health Plan
Revision of the State Health Plan for Facilities and Services chapter for acute inpatient obstetric services, COMAR 10.24.12., began in July 2004 with the release for informal public comment of proposed changes to the Plan chapter. Written comments were received by the October 2004 deadline from the Department of Pediatrics at Mercy Medical Center, the University of Maryland Medical System, MedStar Health, and North Arundel Hospital. The Commission approved revised changes as proposed permanent regulations in October 2004. Notice of the proposed action was published in the *Maryland Register* on November 29, 2004, initiating a thirty-day public comment period. Written comments were received

by the December 30, 2004 deadline from Adventist HealthCare, MedStar Health, and the Maryland Chapter of the American Academy of Pediatrics. The changes were approved by the Commission at its January 2005 meeting as final regulations, and Supplement 1 of the Plan chapter became effective March 1, 2005.

In August 2004, the Commission released the third version of *Maryland Hospital Obstetric Services: Trends and 2008 Utilization Forecast.* This report describes major trends in, and projects future utilization of, hospital obstetric services. The report also includes projections of births and population of the 15 to 44 year old female age group from Maryland's Department of Planning. This report is available on the Commission's website.

Annual Acute General Hospital Bed Licensure

A Commission report entitled *Annual Report on Licensed Acute Care Hospital Bed Capacity, Fiscal Year 2006, Effective July 1, 2005,* describes the sixth year of the annual licensure procedure for acute care general hospitals. Based on inpatient census, this process establishes an annual maximum licensed capacity for each acute care hospital reflecting its actual utilization. The procedure has standardized the measurement of licensed acute care hospital beds throughout the state. In collaboration with staff from the MHCC, the HSCRC, and the Office of Health Care Quality (OHCQ), Commission staff determine the number of licensed acute care beds for each acute general hospital based on 140% of the calculated average daily census for the most recent twelve-month period. This formula assumes that all hospitals should operate at an average annual occupancy rate of 71.4%.

New fiscal year 2006 licensed bed totals for Maryland hospitals were established based on the calculated average daily census for the twelve-month period ending on March 31, 2005. Effective July 1, 2005, the new licensed acute care capacity is 10,323 beds, which is virtually the same as the previous year's total of 10,321. Initial implementation of this procedure in October of 2000 resulted in a statewide 23% reduction in the licensed acute care hospital bed capacity of 2,773 beds, which reflected the large number of "paper beds" existing in the system at that time. In each of the following four years, the total number of licensed beds increased at an average of about 2% per year, reflecting increasing hospital utilization. Not all of these beds are actually available for use. Some hospitals are licensed for more beds than they can physically accommodate, meaning that they have been operating at well above the 71.4% implied occupancy rate. Other hospitals have patient care space they are not using, reflecting the continued existence of some excess capacity. To determine where each of these capacity issues may be, the MHCC surveyed hospitals about their actual physical inpatient capacity. The results of that survey are included in the report. The report also includes the results of a survey of emergency department treatment capacity that may prove

helpful in the state's disaster preparedness planning. This report is available on the Commission's website.

Ambulatory Surgery Provider Directory
The Commission's survey of ambulatory surgery providers (the source of the Directory's information) is updated annually with input and feedback from representatives of the Maryland Ambulatory Surgery Association. The seventh edition of the Commission's Ambulatory Surgery Provider Directory was released in September 2004 and was posted on the Commission's website. It contained data for calendar year 2003, and profiled every licensed ambulatory surgery provider in Maryland, including acute general hospitals, freestanding ambulatory surgery centers, and physicians' offices with ambulatory surgical capacity. The profiles provide information such as the number of operating rooms, the number of ambulatory surgical cases performed, certification and accreditation information, and the specialties practiced at the facility. This Directory is the source of the information provided in the Commission's Consumer Guide for Ambulatory Surgery. At the end of the fiscal year, staff was in the process of preparing the 2005 Directory.

Policy Coordination with the Health Services Cost Review Commission
The division's staff holds regular joint meetings 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, rates setting policies, and rate reviews.

Other Policy Coordination
The division's staff enjoys a good, professional working relationship with other state agencies and with hospital and ambulatory surgery providers. Staff has a membership position on the Health and Medical Surge Capacity Technical Advisory Group, reporting to the Health and Medical Committee of the Governor's Emergency Advisory Council, on the Review Panel of the Maryland Loan Assistance Repayment Program, and on the Yellow Alert Task Force sponsored by the Maryland Institute for Emergency Medical Services Systems (MIEMSS). In addition, members of the MHCC staff coordinate with MIEMSS staff and DHMH staff, such as the Family Health Administration, on other issues of mutual interest. Division staff members also meet regularly with providers to discuss a variety of issues such as current utilization trends, future capital needs, pending capital improvement projects, and the regulatory process.

Specialized Health Care Services Division

Overview

This program 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 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 program is to develop a State Health Plan that includes the methodologies, policies, and standards for reviewing applications for a Certificate of Need (CON). The program 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 to ensure that the health care policy for Maryland is integrated and effective.

Accomplishments

State Health Plan on Cardiac Surgery and Percutaneous Coronary Intervention Services

Cardiac surgery and percutaneous coronary intervention (PCI) services continue to be a priority of the Commission. Under the State Health Plan for Facilities and Services: Specialized Health Care Services – Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17), existing providers of cardiac surgery and PCI services are to collect and report certain data; review conformance to standards for minimum volumes; and comply with the conditions of an approval, exemption, or waiver issued by the Commission. In December 2004, the Commission released its second annual *Statistical Brief on Cardiac Surgery and Percutaneous Coronary Intervention Services*, which provides the most recent data on the availability and utilization of cardiac surgery and PCI services in the four Regional Service Areas established by the Commission.

State Health Plan Provisions for Primary PCI Waiver

The State Health Plan on Cardiac Surgery and Percutaneous Coronary Intervention Services requires that hospitals providing coronary angioplasty services have on-site cardiac surgical backup; 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. The data from this study made an important contribution to the knowledge base concerning whether primary angioplasty services can be provided safely by hospitals without on-site cardiac surgery programs. The C-PORT trial closed 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.

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 all requirements for primary PCI programs, to provide primary PCI services. Those requirements include monitoring the outcomes of care for patients presenting with acute ST-segment elevation myocardial infarction, which will facilitate ongoing quality improvement efforts and provide the opportunity to measure program compliance, safety, and effectiveness. The Advisory Committee recommended that the Commission develop, collect, and analyze a uniform data set from all hospitals in Maryland offering primary PCI services. The Commission established the Primary PCI Data Work Group to develop specific recommendations related to the collection and reporting of data required by COMAR 10.24.17.

The Commission's staff met with the C-PORT Medical Director, other staff at Johns Hopkins Medical Institutions, and the developer of the database application for the Atlantic C-PORT Primary PCI Registry. Participants at that meeting discussed technical issues related to the transition from the C-PORT registry to the waiver registry to be established by the Commission.

In November 2004, the Primary PCI Data Work Group completed its preliminary recommendations on data collection forms and instructions for use in a pilot test. Between January and May 2005, the following hospitals tested a printed version of the recommended forms: Holy Cross Hospital, Howard County General Hospital, North Arundel Hospital, Sacred Heart Hospital, St. Agnes Hospital, Southern Maryland Hospital Center, and Washington Adventist Hospital. These hospitals represent a cross section of facilities performing primary PCI, varying in terms of their inclusion by necessity in the C-PORT registry, the length of their C-PORT participation, and the level of staff assigned to data collection and other data coordination activities. After the pilot test, the Commission's staff prepared a draft report based upon direction from the Chairman of the Primary PCI Data Work Group. The staff will incorporate the final recommendations into a request for proposals to implement a primary PCI data coordinating center.

In February 2005, the Commission amended its regulations governing the reporting of data by hospitals (COMAR 10.24.02) to assure that hospitals collect and report uniformly the data needed by the Commission to perform its duties. The amendments also included several technical corrections.

State Health Plan Provisions for Non-Primary PCI Waiver
COMAR 10.24.17 requires that hospitals providing elective PCI services have on-site cardiac surgical services. The State Health Plan includes provisions for the Commission to consider a request for a waiver from its policies for a well-designed, peer-reviewed research proposal. In January 2005, Thomas Aversano M.D., Associate Professor of Medicine at the Johns Hopkins Medical Institutions, and colleagues submitted to the Commission a proposal to study elective PCI at hospitals without on-site cardiac surgery. The Commission appointed the Research Proposal Review Committee to advise Commission on research proposals that require a waiver under the State Health Plan. The committee, chaired by Thomas J. Ryan, M.D., MACC, held a public meeting in April to consider the proposal. In its scientific analysis, the panel focused on the study design; structure; data acquisition, management, and validation; the sample size and statistical considerations. In May, the Commission's staff prepared a summary of the meeting and in June, the chair of the committee forwarded a draft report to the members for their review and comment. Under COMAR 10.24.17, the Executive Director shall prepare a recommendation for presentation to the Commission to issue or deny issuance of the waiver and shall set forth the reasons supporting the recommendation. In preparing a recommendation, the Executive Director will consider the advice of the Research Proposal Review Committee.

Advisory Committee on Outcome Assessment in Cardiovascular Care
The Commission appointed the Advisory Committee on Outcome Assessment in Cardiovascular Care to promote the development of a Maryland model for continuous quality improvement in cardiovascular care. The Commission structured the Advisory Committee to include a Steering Committee and four subcommittees: (1) Quality Measurement and Data Reporting, (2) Interventional Cardiology, (3) Inter-Hospital Transport, and (4) Long Term Issues. The formation of the Advisory Committee reflected the priority of the Commission to strengthen its ability to integrate quality measurement into plan development and Certificate of Need review activities involving specialized cardiac care programs.

In November 2004, the Steering Committee of the Advisory Committee met via telephone conference call to review the two remaining subcommittee reports: Long Term Issues, and Quality Measurement and Data Reporting. The Steering Committee endorsed the recommendations in the draft reports and the final reports were presented to the Commission in February 2005.

State Health Plan on Acute Inpatient Rehabilitation Services
Under the State Health Plan (COMAR 10.24.09), existing providers of acute inpatient rehabilitation services in Maryland are to collect and report certain data, demonstrate the efficient use of bed capacity, and comply with the requirements of accreditation. In November 2004, the Commission released the first *Statistical Brief on Acute Inpatient Rehabilitation Services*, which includes the most recent annual data available.

Long Term Care and Mental Health Services Division

Overview

This program is responsible for health planning functions related to community-based and institutional long term care and mental health services. This includes monitoring changes in demographics, medical technology, financing and reimbursement, and their impact on current and projected utilization of long term care and mental health 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 and mental health services. The Commission coordinates its long term care and mental health service 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

Long Term Care in Maryland: A Pocket Chartbook, 2005
The Commission's *Long Term Care in Maryland: A Pocket Chartbook, 2005* was released in June 2005. This report updates a previous Long Term Care Chartbook that was released in August 2000. The 2005 Chartbook contains current data as well as trend analysis for variables including population demographics; disability and dependency in activities of daily living (ADLs); distribution of nursing home residents by admission source and discharge sites; trends in length of stay; and other factors. This report was distributed to all nursing homes in Maryland as well as the state nursing home associations, and is posted on the Commission's website.

Chronic Hospital Occupancy Update
As required under COMAR 10.24.08, a notice was published in the January 21, 2005 *Maryland Register* to update Chronic Hospital Occupancy for 2003. 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.

2002 Report on Maryland Nursing Home Occupancy Rates and Nursing Home Utilization by Payment Source

The Commission's *2002 Report on Maryland Nursing Home Occupancy Rates and Nursing Home Utilization by Payment Source* is based on data that were obtained from the 2002 Maryland Long Term Care Survey, 2002 Medicaid Cost Reports, and the Commission's nursing home bed inventory.

Following an introduction in Part I of that report, Part II provided an overview of statewide and regional nursing home operating occupancy and utilization during fiscal year 2002. Data on facility-specific licensed and operating occupancy and utilization rates were presented in Part III. Occupancy rates were presented in two ways: those *including* temporarily delicensed beds (licensed bed capacity) and those *excluding* temporarily delicensed beds (operating bed capacity). Part IV provided a summary of trends in regional and statewide operating occupancy, while Part V provided a summary of trends in regional and statewide utilization rates by payment source since 1996. The report was released in June of 2004 and is also available on the Commission's website.

Medicaid Patient Days Update

As required under COMAR 10.24.08, a notice was published in the April 15, 2004 *Maryland Register* to update the Percent of Total Patient Days Paid by Maryland Medical Assistance Program by Jurisdiction and Region for fiscal year 2002. The *2003 Report on Maryland Nursing Home Occupancy Rates and Nursing Home Utilization by Payment Source* is nearly complete and will be followed by publication of the required notice in the *Maryland Register*.

Home Health Agency Data

Staff continues to analyze home health agency utilization data based on information submitted to the Commission. In addition, work is underway to create and update an overall home health agency inventory. The FY 2004 Home Health Agency annual survey instrument was revised and updated to be consistent with terms and definitions used by CMS and OHCQ, as well as with the proposed changes to the Commission's Certificate of Need regulations (COMAR 10.24.01). Due to changes in federal reimbursement under the Interim Payment System (IPS) moving towards a prospective payment system (PPS), the Commission did not produce reports on home health utilization for FY 2000 and 2001. Staff has begun work on the Home Health Annual Reports for FY 2002 and 2003, which will be available at the end of 2005.

Use of the Minimum Data Set (MDS) for Nursing Home Resident Assessment and Care Screening

In January 2003, the Commission awarded a contract to Myers and Stauffer (a national accounting firm with extensive experience with the MDS) to assist staff in an analysis of the use of the MDS and to create data sets for planning and policy development. In the past, the nursing home bed need methodology and policy analysis were based on data obtained through the Commission's Long Term Care Survey. With the implementation of the MDS on a national level, the Commission staff began the effort to substitute this data source for the Long Term Care Survey in 1998.

The first year's work focused on the following: database design and construction; nursing home resident census; construction of episodes of care; and data verification reports. Output for the second year focused on: creating levels of care; creating a variable for "diversion potential"; and following up on missing data elements. The database developed under this contract now contains all of the MDS data for 1999 through 2003.

This contract was renewed for a third year, with a focus on building the database so new MDS data could be added. Areas of work included: creating levels of care; following up on missing zip code data; development of a "diversion" variable; and development of short-stay vs. long-stay analysis. MDS data was also used to develop tables for the Chartbook described above.

Nursing Home Bed Need Projection Methodology

Under an existing contract with Social and Scientific Systems and a subcontract with Mathematica Policy Research, the Commission is working to adapt the MDS data set for use in updating and revising the nursing home bed need projection methodology. Work is underway with these consultants to develop various scenarios and approaches to determine bed need, including development of a regression analysis to project nursing home utilization based on selected hospital discharges as well as other variables.

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 (which has developed data collection tools for the National Hospice and Palliative Care Organization) to develop an online hospice survey. All hospices in Maryland

submitted data online by May 2004 and a public use data set was developed by November 2004.

Perforum is also assisting the Commission in collecting 2004 hospice data. The 2004 survey was available for data entry as of February 2005. This data is being analyzed and will be used to update the hospice chapter of the State Health Plan for Facilities and Services. The current survey process was reviewed with members of the Hospice Network of Maryland November 2004 who suggested revisions for the 2004 survey process.

Petition for State Health Plan Change: Hospice
The Commission is in the process of updating the State Health Plan chapter for hospice services. This process involves a review of trends in hospice utilization, review of current need projection methodology, and a review of the current standards for Certificate of Need (CON) review of proposed hospice programs. During this review process, the Commission received a request from Erickson Retirement Communities proposing a revision to the hospice CON standards to permit a continuing care retirement community (CCRC) to submit a CON application to establish a specialty hospice that would solely serve residents of the CCRC, rather than contracting with existing hospices for services. This specialty provision is currently applied to home health agencies but is not addressed in the regulations governing hospice programs. The Commission requested comments on a draft of current standards and proposed revisions to the current CON standards for review of hospice services.

Presentations
Staff of the Long Term Care division has made presentations to associations representing those components of long term care for which the Commission plans, i.e., home health, hospice, and nursing homes. Staff made a presentation to the Maryland National Capital Homecare Association in March 2004 as part of its Annual Policy and Legislative Conference.

In January 2005, staff made a presentation for Maryland Hospice Day in Annapolis. Staff presented information on the 2003 public use data set, the hospice section of the State Health Plan, changes made for the 2004 Maryland Hospice Survey, and a schedule for implementation of the 2004 survey.

In June 2005, staff made presentations at the Health Facilities Association of Maryland (HFAM) regional meetings. HFAM is a long term care association that represents nursing homes, assisted living providers, and continuing care retirement communities. These presentations focused on an update of activities in planning and long term care, including the CON Task Force, updated bed need projections, updated occupancy report, and the Long Term Care Chartbook.

Assisted Living Forum
This group was convened by OHCQ to receive input from providers 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.

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. Staff was also involved with the Long Term Care Stakeholders group that was used as a sounding board to develop the Community Choice program, which is a mandatory managed care long term care program designed to serve all persons who would be nursing home eligible for Medicaid, as well as dual eligible (Medicare and Medicaid). Community Choice is proposed as a pilot program, and is planned for future development statewide. A waiver application will be submitted to the CMS.

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; nursing referral service agencies; and hospices. This group will continue meeting during 2005 and possibly draft legislation for the 2006-2007 legislative session. Division staff participate in this Forum as well as with the Regulations and Structural Requirements Workgroup.

Continuing Care Advisory Committee
The Maryland Department of Aging has convened this group, as needed, to address any changes that need to be made in its continuing care regulations. Since the Commission regulates nursing home care in continuing care retirement communities, and collects data on limited direct admissions to continuing care retirement communities, the changes in Maryland Department of Aging regulations have an impact on the work of the Commission. This group met from January through June 2005.

Certificate of Need (CON) Division

Overview

The Certificate of Need (CON) Program manages 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 new or expanded health care facilities and services subject to this authority under the law. Through CON review, the Commission implements the policies it develops and adopts as regulation in the State Health Plan for Facilities and Services governing the development, supply, and allocation of health care resources throughout the state. 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 previously approved projects, to relocate existing service capacity, to undertake capital projects over a set dollar threshold, or to close certain facilities or services. Many proposals from health care practitioners or facilities do not require CON review, resulting in the Commission issuing over one hundred such determinations of non-coverage in a typical year; its statute also permits the Commission to exempt certain other projects from the requirement to obtain Certificate of Need.

Underlying all of the Commission's CON decisions is its statutory mission to shape a system of broad access to health care services of consistently high quality at a reasonable cost. Applications for Certificate of Need are evaluated according to review standards and need projections in the State Health Plan for Facilities and Services, and weighed against five additional general CON review criteria, which examine the need for a proposed new or expanded service as well as its financial viability, impact on existing providers, cost-effectiveness, and history of compliance with quality standards and previous approvals.

Accomplishments

Certificate of Need Decisions and Determinations of Coverage
Between July 1, 2004 and June 30, 2005, the Commission acted on twenty-four Certificate of Need-related matters, and issued 166 written determinations stating whether a proposed action by an existing or proposed health care facility required CON review and approval, and the reason for that determination. (Of the 166 requests for determination of CON coverage, only three actions were found to require CON review.) The Commission granted new CON approval to twenty of

the twenty-four proposals, denied one application, and approved significant changes to three projects that had previously received CON approval.

Also during this fiscal year, five CON-approved projects received confirmation that, as completed, they continued to conform to the terms of their CON approval; this "first-use" approval authorizes the facility to seek state licensure and other necessary certifications, and begin operation. The new facilities that came on line during FY 2005 included Lorien-Taneytown, a 63-bed nursing facility in Carroll County; Haven Nursing Home, an 80-bed replacement facility for two smaller and older facilities in northwest Baltimore City; and ManorCare-Woodbridge Valley, a new 110-bed nursing facility re-developing both delicensed and existing beds at four other ManorCare facilities, in Catonsville, Baltimore County. Two other existing facilities completed and began operating expanded and renovated space: Good Samaritan Hospital in northeast Baltimore City, and Arundel Ambulatory Surgery center, in Annapolis.

The trend noted in the Commission's reports on the last three fiscal years -- the increasing number of hospitals choosing to seek CON approval for projects involving capital expenditures exceeding the Commission's current inflation-adjusted $1.65 million review threshold — continued during this fiscal year, and will extend through the next. During FY 2005, the Commission granted CON approval to twelve new hospital capital projects, and approved changes to two previously-approved projects, for a combined total capital cost of nearly $1.1 billion. It also issued determinations of non-coverage by CON, as either below-threshold or subject to a pledge not to raise rates for the project, to an additional twenty-seven smaller hospital capital projects, for a total cost of more than $127 million. As the reporting period ended in June 2005, the division staff had thirteen more major hospital capital projects under review, whose capital costs total $1,583,569,076. When the Commission completes review of the $1.5 billion in new projects before it during Fiscal Year 2006, it will have made decisions, over a five-year period, that will result in the replacement, expansion, or renovation of a substantial portion of the acute care hospital infrastructure in Maryland.

FY 2005 Certificate of Need Projects in Brief

During this reporting period, the Commission approved ten new capital projects at Maryland acute care hospitals, and approved significant changes to two acute care hospital capital projects previously granted CON approval.

By far the largest of these hospital projects, the largest single project approved to date by the Commission or its predecessor health planning agencies, was the $577,774,237 project through which The Johns Hopkins Hospital will transform its East Baltimore campus by constructing two 10-story clinical towers, one for obstetrics and pediatrics and the other for critical care and medical/surgical

services, renovating space in eight existing buildings for hospital use, and demolishing all or part of ten other buildings. In addition, Johns Hopkins will replace its existing adult and pediatric emergency departments, expanding its service capacity to a total of 104 treatment spaces, and will replace and expand its surgical facilities, placing 30 operating rooms into new construction with a net increase of 6 ORs.

The Commission also granted Certificate of Need approval to the Washington County Hospital Association for the construction of a replacement for the present hospital on a site adjacent to the Robinwood Medical Center, at a cost of more than $233 million.

The Commission reviewed eight hospital capital projects with costs under $100 million, including Shady Grove Adventist Hospital in Rockville, which received CON approval for a $98.9 million project involving both new construction and renovation that will result in a new four-story addition to the hospital, an expanded emergency department, a new surgery department, additional medical/surgical bed capacity in private rooms, and upgrades to its mechanical systems and infrastructure. Civista Medical Center in La Plata received CON approval to construct a four-level addition that will house a new emergency department, two 30-bed medical/surgical units with all private rooms, upgraded surgery services, and new ancillary and support services created in renovated existing space.

Upper Chesapeake Medical Center in Bel Air, Harford County, received two Certificates of Need from the Commission, one to construct a three-floor addition, expand its emergency department, expand its medical/surgical and obstetric bed capacity, and construct a new critical care unit, and the other to construct new space to connect the hospital to the adjacent Harford Surgical Pavilion, and add four new general use operating rooms to the hospital's total surgical capacity. The total capital cost of the two projects will be $41,114,551. Union Hospital of Cecil County in Elkton also received CON approval for a $20 million project to construct a three-story building, with 48 new beds on the second and third floors, and to renovate space in the existing hospital building.

Three other hospital capital projects reviewed and approved by the Commission during FY 2005 included a $14.9 million project at St. Agnes Hospital in southwest Baltimore, which will renovate and expand its emergency department, increase its operating room capacity, and undertake other service relocations and renovations; a capital project at Mercy Medical Center in Baltimore City, which will enable the installation and implementation of $5.7 million in information systems related to improving patient safety and clinical outcomes; and a new twenty-bed inpatient rehabilitation unit, with $4.3 million in renovations, at Memorial Hospital at Easton.

The Commission denied one Certificate of Need application by an acute care hospital, a proposal by Shady Grove Adventist Hospital to establish a five bed hospital and emergency department in Germantown. Two hospital projects previously granted CON approval by the Commission returned to propose modifications to their projects: Frederick Memorial Hospital required action on a cost increase of $6.6 million and significant changes to physical plant design, and Carroll Hospital Center in Westminster received Commission approval for an additional $533,000 in capital costs, and modifications to its phased performance requirements.

An additional modification request came from Potomac Ridge Behavioral Health in Rockville, which required an increase in the original $900,000 capital cost to renovate space at the Rockville private psychiatric hospital to establish a twelve-bed inpatient child psychiatry unit. The Commission approved this change, necessitated by the nearly $500,000 in additional costs resulting from more extensive engineering and mechanical requirements than originally anticipated, for the renovated space.

Among the other CON actions by the Commission on non-acute care projects during FY 2005 were a fifteen-bed increase in the special hospital-chronic bed capacity at Gladys Spellman Specialty Hospital in Prince George's County; establishment of three new freestanding ambulatory surgical facilities (two in Baltimore and one in Anne Arundel County) with two operating rooms each, through the documentation of sufficient volume at these existing single-OR facilities to support two rooms at optimal capacity; the establishment by Shady Grove Adventist Hospital of a four-OR ambulatory surgical facility away from the hospital campus.

In addition, the Commission approved five CON projects proposed by existing comprehensive care facilities: a change in location for Lorien-Baltimore County; a capital renovation of three floors at Stella Maris in Baltimore County; a new building on the campus of Keswick in Baltimore City in which existing beds, acquired beds, and waiver beds will be implemented; the addition of eight publicly-available beds at the nursing facility of the Asbury-Solomons continuing care retirement community in Calvert County; and the relocation of thirty-three comprehensive care beds formerly operated as the Extended Care Facility at Washington County Hospital to nearby Julia Manor Health Care Center in Hagerstown.

Determinations of Non-Coverage by Certificate of Need Review in FY 2005
In FY 2004, the Commission issued six determinations of non-coverage by Certificate of Need review to capital projects proposed by hospitals; during FY 2005, that number jumped to twenty-seven such projects. Of the twenty-seven, ten

involved capital costs below the current $1.65 million CON review threshold. The remaining seventeen projects proposed capital expenditures exceeding the review threshold, and received approval under the "pledge" not to seek rate increases related to the projects for the entire period of their debt service, above the $1.5 million limit established in statute. Of the seventeen over-threshold capital projects, four proposed expenditures in excess of $10 million. Sinai Hospital of Baltimore will spend $25 million to construct two floors above its existing "ER-7" emergency department building, to house relocated Cardiology Department services (second floor), and a thirty-six-bed medical/surgical unit with all private rooms (third floor.) Johns Hopkins Hospital received a determination of non-coverage for a $20 million office building on its campus to house pediatric and adolescent outpatient services and clinics. Another significant pledge project was proposed by the University of Maryland Medical Center, a $13.8 million outpatient cancer center at the hospital. Harford Memorial Hospital in Havre de Grace will undertake a $10.5 million renovation of inpatient units, an expansion of the emergency department, and an upgrade of its mechanical systems.

Thirteen hospital "pledge" projects involved capital costs ranging from the $5.6 million that Good Samaritan Hospital will spend to establish an assisted living facility and an adult medical day care center on its campus to the $1.76 million renovation and expansion of the neonatal intensive care unit at Johns Hopkins Hospital.

The non-hospital proposals receiving determinations of non-coverage by Certificate of Need review during FY 2005 included eighteen transactions that resulted in either outright acquisitions of existing health care facilities, or in mergers or corporate reorganizations that changed control of numerous existing entities. As in FY 2004, the Commission issued eleven determinations of non-coverage by CON review for acquisitions of nursing facilities across the state.

Fifty-eight CON determination letters issued to facilities proposing changes in their licensed bed capacity, or to facilities that did not act in accordance with regulatory provisions designed to maintain bed capacity in good standing. The requests for determinations related to changes in bed capacity during FY 2005 were distributed fairly evenly among those requesting Commission authorization for a period of temporary delicensure (nineteen), those seeking permission to relicense beds (twenty-one), and those informing the Commission of their intent to relinquish unused bed capacity (eighteen).

Also during this period, the Commission issued authorization for bed increases without Certificate of Need review – through the so-called waiver, or "creep" bed provision in statute – to fourteen health care facilities. Thirty-three physician practices requested determinations from the Commission concerning various

actions related to office-based ambulatory surgical capacity, including the establishment of single operating rooms in freestanding settings, the addition of physicians or specialties to surgical staffs, or the establishment of non-regulated procedure rooms.

Other Activities

Near the end of the reporting period, Commission Chairman Stephen J. Salamon established a Certificate of Need Task Force, whose objectives are to:

- Review and recommend modifications in the scope of services and facilities regulated under the Certificate of Need program;
- Review and recommend enhancements in the Certificate of Need application review process; and
- Review and recommend enhancements in the monitoring of Certificate of Need projects under development.

Commissioner Robert E. Nicolay chairs the Task Force, whose work continues in FY 2006. Commissioners Robert E. Moffit, Ph.D. and Larry Ginsburg also serve on this body, and the twenty-four appointed members include representatives of the Maryland Hospital Association, Med-Chi, CareFirst BlueCross BlueShield, Health Facilities Association of Maryland, LifeSpan, Hospice Network of Maryland, the Maryland Ambulatory Surgical Association, and other interested organizations.