MHCC | MARYLAND HEALTH CARE COMMISSION

REPORT to the GOVERNOR

Fiscal Year 2006

(July 1, 2005 through June 30, 2006)

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.

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

Stephen J. Salamon, 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.

Garret A. Falcone is the Nursing Home Administrator of Renaissance Gardens, a skilled nursing home facility located in Catonsville. He has over 13 years experience in long term care. Commissioner Falcone is a graduate in Business Management from Fairleigh Dickinson

University in New Jersey and earned his Masters Degree in Health Services Administration from Russell Sage College in Albany, New York. He is a member of the Mid-Atlantic Non-Profit Health and Housing Association and served as Chairman from 1996-1998. He was awarded the MANPHA Chairmen's Award in 2001 and the Special Chairmen's Award, AEGIS Inc., in 2001. He resides in Carroll County.

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

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

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

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

Moore was awarded an Honorary Doctor of Science degree in recognition of his distinguished public health career by Tuskegee University. He has served on the Board of Directors and the Executive Committee for Montgomery General Hospital in Olney, Maryland.

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

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

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

Constance Row is a nonprofit association executive, consultant, and university teacher with a special interest in healthy communities. Many volunteer boards and community groups have created new initiatives to meet community needs under her leadership. Ms. Row is a graduate of Barnard College, Columbia University and has an MPA from the Maxwell School at Syracuse University. Her career includes nearly a decade of experience at the federal level in health policy, legislation, and administration, and a second career in hospital and health care system administration, having served for ten years as a CEO in four community/teaching hospitals and health systems.

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

was the Co-Founder, charter member and past Vice President of the Women's Economic Development Council

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

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

EXECUTIVE STAFF

Rex W. Cowdry, M.D.
Executive Director

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

Our mission is simply stated:

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

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

INFORMATION GATHERING AND DISSEMINATION

The Commission's redesigned web site arose from discussions with the wide range of communities served by our information gathering and dissemination. We have improved site navigation by tailoring the information to different stakeholders, creating portals that give users immediate access to the information most likely to be of interest to them, such as the Consumers Portal, the Health Care Community Portal, the Small Employers/Employees Portal, and the Policymakers Portal.

Empowering Patients and Families with Information

Our most important constituency is the citizens of Maryland. Maryland's efforts to report quality and performance information to its citizens were in the forefront of a national trend. Public reporting is done through our Consumer Guides, including:

- **MHCC Hospital Guide.** The performance of each Maryland acute care hospital on a series of measures of the quality of hospital care (such as the percentage of patients with a heart attack receiving specific recommended care) and outcomes (such as the rates of readmission within 30 days of discharge) is reported in the Guide. Surgical infection prevention measures are now reported, and efforts to report healthcare associated infections are under development. The Guide also includes descriptive information about each hospital**.**
- **MHCC Nursing Home Guide**. Measures of the quality of care in each nursing home are reported, using national standards and data. Licensing and inspection information is extracted from the federal data base and reported by facility. Family satisfaction measures have been piloted in an MHCC project and will be incorporated into the public

reporting. Collaborations with CMS and AHRQ on patient satisfaction are under consideration.

- **MHCC HMO Guide**. Our Guide has traditionally reported a range of quality and performance measures for HMOs in Maryland, as well as participant satisfaction measures. Two initiatives will substantially improve this guide. The first is a partnership with the Mid-Atlantic Business Group on Health, which conducts its own analysis of health plans using quite different criteria, focusing on the quality of the plan's web site information, its disease management programs, its appeals process, and other dimensions of performance and education. Each organization will report both sets of measures. The second is an initiative to include PPOs in the Guide, so that it becomes a Guide to Health Plans.

As patients increasingly face significant deductibles and coinsurance for health care services, the price of health care has become a more important part of health care decisions. Without better information about both quality and price, the relative value of different care can't be assessed.

- **The Price of Hospital Services**. The General Assembly asked that the prices charged by hospitals for their most common Diagnosis Related Groups be published. The MHCC and HSCRC have published case-mix-adjusted prices for the 15 most common of these DRGs for each of Maryland's hospitals.
- **The Price of Physician Services**. Using our claims database, we have published information giving the price of specific physician services by county and by physician specialty. In each case, the 25^{th}, 50^{th}, and 75^{th} percentile prices are given both for list price (that is, the billed amount) and allowed price.
- **The Price of Nursing Home Services**. This is a work in progress scheduled for 2007-2008.

Cardiac surgery and angioplasty are specific areas of public reporting interest nationwide. The MHCC gathers extensive information on the performance of hospitals performing emergency angioplasty without back-up cardiac surgery on site and uses that information to determine whether that hospital's waiver allowing emergency angioplasty should be continued. The Commission is examining extending public reporting to all angioplasty and cardiac surgery programs, to strengthen quality monitoring and provide citizens with additional information essential to informed choices.

The Commission publishes two additional guides that provide general information about Maryland providers, without quality and price information: the Maryland Ambulatory Surgery Facility Guide and the Maryland Guide to Assisted Living Facilities. Further useful consumer information is found in sections devoted to purchasing health insurance, buying prescription drugs (including a link to the Attorney General's prescription drug price guide), and filing consumer complaints about health care and health insurance.

Information for Providers

The Commission's regulatory role requires good communication with the regulated providers and with other interested parties. In many cases, the best available data about industry trends in Maryland comes from surveys conducted by the Commission, including hospice and home health surveys, or from data collected and analyzed by the Commission, including utilization and pricing reports derived from the Medical Care Database. Many of these analytic reports are outlined in the health policy section of this briefing.

The State Health Plan chapters are developed through an extensive process of consultation, addressing both broad policy issues and specific technical questions about methodology, statistics, and modeling. In some cases, particularly those in which the issues are both technical and controversial, formal committees may be constituted to address the questions. The Cardiac Surgery section of the State Health Plan is a particularly good illustration of policymaking in a setting of high passion and inadequate clinical and health services research data to guide decisions. The key is transparency. Although transparency does not prevent challenges or litigation, it does build goodwill and is essential to credible policy. To further transparency, documents, deliberations, and reports are made available on the MHCC web site.

Achieving this same efficiency and transparency in our certificate of need (CON) regulatory process is a work in progress. Our goal is to have a site with electronic filings and automatic notification of potentially interested parties.

Information for Insurance Purchasers

The Commission provides a Guide to Purchasing Health Insurance for small business owners and employees, together with information about the Comprehensive Standard Health Benefit Plan (CSHBP). Information about appeals and complaints is also available. The Commission is strengthening its purchasing guide and examining other tools that may help employers and individuals make informed choices among the many benefit designs.

Information to Guide Health Policy Decisions

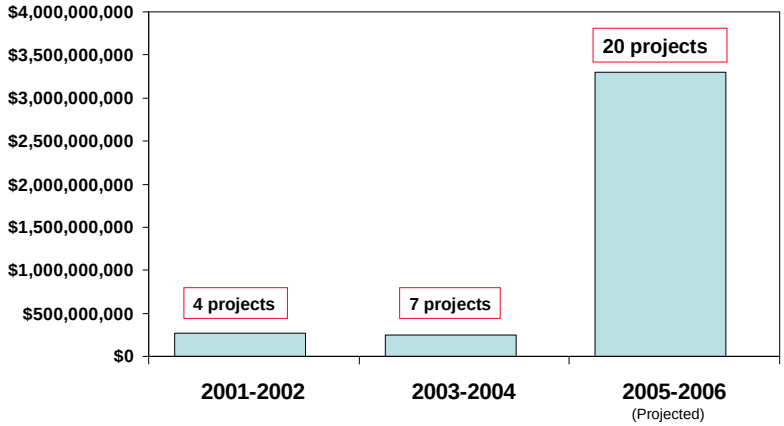
The Commission has a long and distinguished history of providing data-driven analyses of a broad range of health policy issues. The Commission's publications and reports are found on the MHCC web site under the appropriate topic area.

Our overarching goal is to provide objective, non-partisan analyses of policy issues, drawing on the most meaningful and reliable data available.

EFFECTIVE AND EFFICIENT PLANNING AND REGULATION: CERTIFICATE OF NEED AND THE STATE HEALTH PLAN

Maryland is now in the middle of a remarkable phase of capital investment in new hospital facilities, brought about by an increasing need to replace an aging hospital infrastructure on the one hand and rate setting policies at the Health Services Cost Review Commission (HSCRC) intended to encourage new capital investment on the other. In 2005-2006, both the number of CON applications and their dollar value increased dramatically, as shown in the following chart:

Cost of Hospital Construction Projects Submitted for Review Under the Certificate of Need Program:
Maryland, 2001-2006 (Projected)



We anticipate that this construction-intensive phase will last another 1-2 years and then decrease substantially.

Such dramatic variations in workload pose a serious staffing problem for regulatory agencies. Health care planning and certificate of need analysis are specialized areas of knowledge. Recruitment of experienced staff is difficult – and hiring permanent employees is not the best response to a transient surge in review volume. While we have done some recruitment and hiring, we have also emphasized streamlining and prioritization. Unfortunately, those efforts have not been sufficient to prevent a modest increase in review time in the midst of a 10-fold increase in the total value of projects reviewed. In view of these difficulties, it is remarkable that there is not more discontent among the regulated providers. We believe this is, in part, attributable to the professionalism of the staff and reasonably good communication with our stakeholders.

Because there is overlap between the Commission's CON and health planning personnel, the markedly increased CON workload has had an adverse effect on our health planning capacity as well. However, health planning and revisions of the State Health Plan lend themselves more readily to prioritization. Although we are required to revise the SHP every 5 years, some parts of some chapters are a low priority for revision, while other chapters deal with rapidly changing,

controversial services, such as cardiac surgery. These changing, high-priority areas are revised more frequently – every three years in the case of cardiac care. We have recently revised the acute care chapter, are in the process of revising the long-term care chapter, and early next year will begin to revise the cardiac care chapter, yet again.

Our efforts to streamline the workflow, already well underway, will continue, as will efforts to hire experienced staff to address this period of particularly high activity. Frankly, although we expect to reduce the review time somewhat through process improvement, we do not anticipate solving this problem until our hospitals have substantially rebuilt their aging infrastructure and the current extraordinary CON workload diminishes. At that point, our professional staff will have conducted thorough reviews of between $4 billion and $6 billion dollars in projects over only 3-4 years.

EFFECTIVE AND EFFICIENT PLANNING AND REGULATION: THE MARYLAND SMALL GROUP INSURANCE MARKET

The Commission is responsible for designing the Comprehensive Standard Health Benefit Plan (CSHBP), a set of standard delivery systems and benefits that insurers can offer to employers in the small group market (2-50 employees). The current CSHBP allows for a number of different delivery systems (PPO, PPO with a Health Savings Account, HMO, and high-deductible HMO with HSA), each with a specific floor for cost sharing through deductibles and copayments/coinsurance. Insurers can enhance the benefits of one of the CSHBP plans through riders, but cannot offer a plan with fewer benefits.

The covered services are also defined in regulation and are comprehensive. All but three of Maryland's more than 40 mandates applicable to the non-group market have been voluntarily adopted as covered benefits under the CSHBP.

Policies are guaranteed issue. Premiums reflect the average age of the employee group and the location, but do not reflect health status (modified community rating). Prices for health insurance in the small group market continue to rise faster than inflation and somewhat faster than other markets, posing a challenge to small businesses and their employees. The number of insured individuals has dropped 10% in 5 years, a trend seen in employer-sponsored health insurance more generally. There is an "affordability cap" in statute, requiring the Commission to take action when the average cost of policies sold exceeds 10% of the average annual wage in Maryland. The action generally involved increasing the deductible or the copayment/coinsurance, reducing the premium by reducing the value of the benefits.

The market is highly concentrated – two insurers account for 86% of the covered lives. This market concentration poses issues for insurance purchasers and for providers other than rate-regulated hospitals. The challenge is to find ways to encourage new entrants – a difficult task in a highly structured and regulated market, since insurers have to design policies specifically for the Maryland small group market.

MHCC conducted a six month reform process including six community meetings across the state. The result was a decision to change the CSHBP by offering greater flexibility and more benefit design choices, resulting in lower base prices. The pharmacy benefit was completely redesigned, offering great design flexibility while retaining the consumer protections of guaranteed issue, guaranteed renewal, and modified community rating. A new delivery system was introduced – a high deductible HMO plan offered with a Health Savings Account. Actuarial consultants estimated price reductions of over 10%.

HEALTH POLICY ANALYSIS

One of the key functions of the Commission is to provide information and policy analysis on health care issues to the Administration and General Assembly. Sometimes the analysis is conducted in response to specific requests or legislation; sometimes the analysis arises as a Commission initiative to fulfill its broad statutory responsibilities to improve access, address costs, and improve quality.

Improved access to health care and to health insurance is one of the central goals of the MHCC. The Commission has launched a more aggressive program of health policy analysis to identify the strengths and weaknesses, the costs and savings, and the effects on access for a range of proposals. Our forthcoming report to the General Assembly will encompass:

- subsidized reinsurance
- possible changes in rating principles to protect risk pools
- state-wide insurance exchanges
- merging of risk pools
- low income premium subsidies
- tax credits
- principles of individual responsibility

However, access to health care cannot be addressed effectively without also addressing health care costs – a complex and recalcitrant issue. Progress reining in costs will require a broad set of coordinated steps, including changing patient and provider incentives and expectations, bringing better information to providers and patients, emphasizing evidence-based medicine, encouraging high-value health care, and preventing waste, duplication, and error. The Commission is exploring the cost-saving potential of a consumer-directed plan with narrower benefits delivered through a high-performance HMO network, but there is not yet consensus regarding acceptable strategies to promote high-value health care.

Health and health care disparities are another important aspect of access to health care. Over the next two years, the MHCC disparities initiative will not only provide data on health care disparities but will also explore their many causes.

Health information technology offers great potential to help control costs and improve quality by assuring appropriate treatment, by avoiding inappropriate treatment, and by preventing costly errors. To advance health IT, we will establish a new Center for Health Information Technology

and have collaborated with the HSCRC on a strategy to fund the pilot phases of a secure health information exchange for the state.

REORGANIZATION

Since its creation in 1999, the Commission has been organized primarily by functions, such as planning and regulation, data gathering and analysis, and quality and public reporting. In part, this structure continued to reflect the two very different commissions that were merged to create the Maryland Health Care Commission.

During the year, we reevaluated our mission and concluded that the Commission should be organized around the health care systems we seek to evaluate, regulate, or influence, bringing a wide range of tools (data gathering, public reporting, planning and regulation) to improve quality, address costs, or increase access. At the end of the year, five Centers were established to reflect this new approach.

A brief description of each of the Centers follows.

The Center for Hospital Services

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

The Center for Long-Term Care and Community-Based Services

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

The Center for Healthcare Financing and Health Policy

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

The Center for Information Services and Analysis

The Center for Information Services and Analysis has expertise in the creation, maintenance, and mining of large databases, in the management of information technology and networks, and in the analysis and interpretation of population surveys under the leadership of Ben Steven, the Center Director.

The Center for Health Information Technology

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

The Maryland Health Care Commission's budget can be found in Appendix A.

The Maryland Health Care Commission's current organizational chart can be found in Appendix B.

The Maryland Health Care Commission's reorganizational chart can be found in Appendix C.

OVERVIEW OF FY 2006 ACCOMPLISHMENTS

July 2005

The Commission approved a Certificate of Need (CON) to Suburban Hospital Center for the establishment of an OHS/PCI Program in the Metropolitan Washington Regional Planning Area.

The Commission approved a CON for Renovation of St. Joseph's Nursing Home.

The Commission approved an Exemption from CON for the Transfer of 5 CCF Beds.

The Commission approved a Postponement of Consideration of Request for Declaratory Ruling for Dimensions Health Corporation: Impact of Supplement 4 to the State Health Plan for Facilities and Services: Acute Care Hospital Services (COMAR 10.24.10) on the Status of Bowie Hospital CON.

August 2005

The Commission did not meet.

September 2005

Staff briefed the Commission on short and long term goals to reform the Small Group Market.

Staff briefed the Commission on the Report of the Research Proposal Review Committee – Review of the Scientific Merit of the Atlantic C-Port Trial: Proposed Non-Primary PCI Study (Version 2.5, March 22, 2005).

Staff provided an update for Petition for Declaratory Ruling, Dimensions Health Corporation: Impact of Supplement 4 to the State Health Plan for Facilities and Services: Acute Care Hospital Services (COMAR 10.24.10) on the Status of the Bowie Hospital CON.

The Commission approved a CON for Washington Adventist Surgery Center for a 4- Operating Room Freestanding Ambulatory Surgery Center.

The Commission approved the Expansion of Children's Outpatient Center at Montgomery County.

The Commission approved technical Corrections to COMAR 31.11.12 – Limited Benefit Plan.

The Commission approved the release of the Final Report on the Maryland Trauma Physician Services Fund.

October 2005

The Commission approved a CON for Clifton T. Perkins for the addition of 48-Special Hospital Psychiatric Beds.

The Commission approved a CON for Sinai Hospital of Baltimore for the addition of 4 – Mixed Use Operating Rooms and Expanded Support Services.

The Commission approved a CON for Lorien LifeCenter for the Relocation of an Approved, but Unbuilt 63-Bed Nursing Home.

The Commission approved Electronic Health Network certification for Health Care Administration Technologies and renewal of certification for ANS, Health Data management, ProxyMed, and EMDEON.

November 2005

The Commission approved The Commission approved short term options for reforming the Small Group Market

The Commission approved the release of the Final Report of the Certificate of Need Program Task Force for Public Comment.

The Commission approved proposed action to COMAR 10.24.10 – State Health Plan for Facilities and Services: Acute Inpatient Services.

The Commission approved a CON for Anne Arundel Medical Center for Construction of a Nine-Story patient tower, Expansion of Inpatient Beds, Emergency Department, and Surgical and Recovery Areas.

The Commission approved a CON for Baltimore Washington Medical Center for an Eight-Story Patient Tower (West) and Two-story Addition (South), Replacement and Expansion of Inpatient Beds, Expansion of the Emergency Department, and Establishment of a New Obstetric Service.

The Commission approved a CON for Johns Hopkins Bayview Medical Center for 4-Mixed use Operating Rooms, Expanded Support Services, and Upgrades to Air Handling Equipment.

The Commission approved a CON for Lorien LifeCenter-Baltimore County, Inc. for the Relocation of 15-Existing, Temporary Delicensed Beds to the Proposed LorienLife Center-Baltimore County Nursing Home project.

The Commission approved a CON modification for the Construction of Emergency Department and Ambulatory Care Departments for Memorial Hospital at Easton.
Staff briefed the Commission on the results of the Maryland Sample of the Medical Expenditures Survey (MEPS) Insurance Component.

The Commission approved the Release of the Report on Developing Patient Safety Initiatives that Extend Beyond Hospitals and Into Health Care Practitioners' Offices required under House Bill 2 of the 2004 Special Session of the Maryland General Assembly.

December 2005

The Commission approved proposed action to COMAR 31.11.06 – Comprehensive Standard Health Benefit plan adopting the short term options for small group market reform.

The Commission approved the Final Report of the Certificate of Need Program Task Force – Review of Public Comments and Action on Recommendations and approved changes to COMAR 10.24.01 – Certificate of Need for Health Care Facilities.

The Commission approved the proposed repeal of COMAR 10.24.05 – Development of Subacute Care Units.

The Commission granted a CON Exemption for Civista Medical Center to close their subacute care unit.

The Commission approved a CON for Peninsula Regional Medical Center for Renovation and Expansion Project.

The Commission approved the release of the Final Report on the Affordability of Health Insurance in Maryland Required under Senate Bill 131 passed during the 21004 Session of the Maryland General Assembly.

The Commission approved the release of the report on Maintenance Drug Prescriptions Mail Order Purchase Required under Senate bill 885 passed during the 2005 Session of the Maryland General Assembly.

The Commission approved an Interim Waiver for C-PORT Hospitals Applying for the Primary PCI Waiver.

Staff briefed the Commission on Uncompensated Care for Physicians with at least 25% of their Practice in a Hospital Setting.

Staff briefed the Commission on updates to the final reporting requirements for Maryland Commercial HMOs for 2006 and the projected requirements for 2007.

January 2006

The Commission approved a CON for Howard County General Hospital for the Addition and Renovation of Hospital Facilities.

The Commission approved a CON modification for Union memorial of Cecil County for a proposed change to the physical design of the project and the capital cost increase.

The Commission approved Electronic Health Network recertifications for McKesson Corporation and RealMed.

The Commission approved the release of the Annual Mandated Health Insurance Services Evaluation Report.

The Commission approved the release of State Health Care Expenditures 2004 Report.

Staff briefed the Commission on the Revalidation Study

Staff briefed the Commission on key policy issues surrounding financing physician based uncompensated care.

February 2006

The Commission approved a CON Modification for Frederick Memorial Hospital for a change to their financing plan.

The Commission approved a Con Modification for Lorien LifeCenter – Ellicott City for a design change.

The Commission approved a CON Modification for Upper Chesapeake Medical Center for a design change.

The Commission approved the release of Hospital-Based Under and Uncompensated Care Provided by Maryland Physicians as required under House Bill 627 passed in the 2005 session of the Maryland General Assembly.

March 2006

The Commission approved final action for COMAR 10.24.10 – State Health Plan: Acute Inpatient Services.

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

The Commission approved the Repeal of COMAR 10.24.05 – Development of Subacute Care Units.

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

The Commission approved a CON for Western Maryland Health Systems Medical Center for a replacement facility.

The Commission approved a CON for Carroll Hospital Center for expansion and renovation.

The Commission approved a CON for Alice Byrd Tawes Nursing Home for a replacement facility.

The Commission approved a CON modification for Children's Outpatient Center at Montgomery County for budget and design.

April 2006

The Commission approved an Extension of Interim Primary PCI Waiver for Suburban Hospital.

The Commission approved a CON for Ruxton SurgiCenter for the addition of one operating room.

The Commission approved a CON for Surgery Center of Potomac for the addition of one operating room.

The Commission approved Electronic Health Network certification for Gateway EDI and M Transaction Services and Electronic Health Network recertification for Passport Communications.

Staff briefed the Commission on Results of the Pilot Nursing Home Satisfaction Survey

Staff presented Practitioner utilization Report 2003-2004, Trends within Privately Insured Patients.

May 2006

The Commission approved proposed action to COMAR 10.24.18 – State Health Plan: Specialized Health Care Services: Neonatal Intensive Care Services.

The Commission approved proposed action to COMAR 10.24.06 – Data Reporting by Freestanding Medical Facilities.

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

The Commission approved a CON modification for Johns Hopkins Hospital for changes to the physical plant design to reconfigure and add floors to the new clinical towers.

The Commission approved 7 hospitals for a PCI Waiver: Anne Arundel Medical Center – 2 years; Baltimore Washing Medical Center – Conditional (1) year; Franklin Square Hospital Center – Conditional (1) year; Howard County General Hospital – Conditional (1) year; Johns Hopkins Bayview Medical Center – Conditional (1) year; Mercy Medical Center – Conditional (1) year; St. Agnes Hospital – Conditional (1) year.

Staff presented to the Commission Summary of Small Group Carrier Experience for Calendar year 2005.

Staff presented results from Focus Groups.

June 2006

The Commission approved emergency and proposed changes to COMAR 10.25.10 – Maryland Trauma Physician Services Fund.

The Commission approved proposed action to COMAR 10.25.13 – Health Information Technology Funding Applications.

The Commission approved the proposed repeal of COMAR 10.24.01 – Conduct of Public Meeting.

The Commission approved a Conditional (1) year PCI Waiver to Doctors Community Hospital; Holy Cross Hospital; Shady Grove Adventist Hospital; and Southern Maryland Hospital Center.

Staff briefed the Commission on the Racial and Ethnic Disparity Conference.

DATA SYSTEMS AND ANALYSIS

(Transitions to *The Center for Information Services and Analysis*, July 1, 2006)

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 2006, the Cost and Quality Analysis division released seven publications, including five reports and two issue briefs, which are discussed in the paragraphs that follow. Two of the reports created by the division, *State Health Care Expenditures: Experience from 2004* and *Practitioner Utilization: Trends within Privately Insured Patients, 2003-2004*, are annual reports mandated in the legislation that created the Commission.

State Health Care Expenditures: Experience from 2004 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 estimates that total spending for health care received by state residents increased 6.8% in 2004 to $28.8 billion. The 2004 per capita rate of increase, 5.9%, is below the 7.2% increase in per capita spending reported for 2003. This is similar to the national pattern in per capita spending: from 7.2% in 2003 to 6.6% in 2004. The lower growth in 2004 continues a trend of declining growth in health care spending that began in 2002. Nevertheless, growth in health care spending was still slightly ahead of growth in personal income in Maryland in 2004. Analysis of expenditures by service type indicates that spending on hospital care (inpatient and outpatient) grew faster than spending for

any other services; hospital care accounted for almost half of the $1.9 billion increase in state health care spending in 2004. Analysis by payer-type shows that Medicare contributed disproportionately to the spending increase: Medicare spending in Maryland grew by over 12%, fastest of all payers in the state and faster than the national average for Medicare (10%).

Practitioner Utilization: Trends within Privately Insured Patients, 2003-2004, a mandated report based on analyses of the MCDB, was released in April. The purpose of this annual analysis is to provide an understanding of the factors underlying increases in expenditures for insured practitioner services. The 41-page report examines how payments to physicians and other health care professionals for the care of privately insured Maryland residents under age 65 changed from 2003 to 2004, including a comparison to 2004 Medicare reimbursement rates. Payment rates in Maryland increased by 1-2% over 2003 rates and were quite close, on average, to the typical Medicare rate. However, among those using practitioner services, the annual per user expenditure grew by 4% for non-HMO enrollees and by 1% for HMO enrollees. The rate changes account for nearly all of the per user spending increase among HMO enrollees, but most of the per user spending increase for non-HMO enrollees is due to increased utilization (more services and/or more intensive services). Per user spending for professional services in 2004 was about $878 and on par with national estimates. Per user expenditures differ by type of private coverage, age, and gender, and the count of significant diagnoses per user. The number of significant diagnoses is a strong predictor of expenditures for professional services. The half of users who had no significant diagnoses averaged $333 per user, compared with $3,020 for those with 3 or more significant diagnoses (8% of users).

The Maryland legislature mandated two other reports produced by the Division in this fiscal year. *Mail-Order Purchase of Maintenance Drugs: Impact on Consumers, Payers, and Retail Pharmacies* was required under SB885 (2005) and released in December. This study, produced with the Maryland Insurance Administration and in consultation with the Maryland Board of Pharmacy, finds the retail pharmacy protections that currently exist in Maryland law have contributed to a lower use of mail order in the state. Mail order accounts for about 14% of drug spending in the state ($600 million) versus 18% nationwide. Mail order is just 7% of drug payments under fully-insured plans in the state compared to 22% of payments in Maryland plans sponsored by self-insured employers, which are exempt from Maryland insurance law. The study estimates the impact on consumers, carriers, and retail pharmacies if the current protections under Maryland law were eliminated. Fully-insured Maryland consumers would save from $7 million to $16 million (under different scenarios) through reduced co-payments for use of mail order. Savings for carriers depend upon the discount they would receive for mail order prescriptions. Assuming a 5% discount, carriers would realize savings of $3 to $8 million; with a 10% discount, savings would approximately double to $7 to $16 million. The impact on retail pharmacy revenue is estimated to range from $88 million (1% of revenue) – if mail order share in fully-insured plans matches the share in the self-insured Maryland market – to a high of $210 million (3% of revenue) if all 90-day supply prescriptions are switched to mail order. The financial impact on retail pharmacies would be dampened, however, by the overall growth in sales of prescription drugs. Independent pharmacies would be somewhat less than their shares of

the current market would predict because consumers are currently more likely to fill maintenance medications at mass merchandisers and grocery stores.

The other study mandated by 2005 legislation (HB627), *Uncompensated Charity and Under-Compensated Care Provided in Maryland: What We Know and Estimates of the Cost of Subsidizing This Care,* was produced with the Health Services Cost Review Commission and released in February. Although the mandate was to study uncompensated and under-compensated care rendered by physicians who provide at least 25% of care in hospital settings, the study includes estimates for total hospital and community-based care because funding of only hospital care may encourage provision of care in higher-cost hospital settings. Maryland physicians provided about $115 million in uncompensated charity care in 2004, with about 32% of this provided in hospital settings. Although most surgical specialties would meet the 25% threshold (described above), many medical specialties, as well as family practice and general practitioners, would not. Additionally, some Medicaid services are significantly under-compensated: about 18% of all physician services provided through Medicaid were reimbursed at less than 50% of cost. The costs of funding both uncompensated charity care and under-compensated Medicaid services were estimated at three different funding levels, ranging from funding charity care at 80% of Medicare payment rates and Medicaid services at 100% of Medicare (requiring $181.1 million) to funding both at 50% of Medicare (requiring $67.9 million). Maryland would need to access multiple funding streams if an uncompensated charity care fund is established, even one limited to hospital-based physicians.

Medical Expenditure Panel Survey – Insurance Component: Maryland Sample Through 2003 was released in November. This report is a new product intended to supplement information contained in the Commission's *Health Insurance Coverage Report*, which is released biannually. Information provided in this report is based on an analysis of the MEPS-IC, an annual survey of business establishments (locations) conducted by the Agency for Healthcare Quality and Research to determine if health insurance is offered, the types of plans offered, and the number and types of employees who were eligible and enrolled. The report provides detailed information on the availability of health insurance by selected employer and workforce characteristics, premiums and employee contributions for individual and family coverage, and the volume and types of employees who lack access to health insurance at the work place. In 2003, approximately 89% of Maryland's private-sector employees worked in establishments that offered health insurance, a figure that is statistically similar to the U.S. rate of 87%. Approximately 54% of private-sector employees in Maryland were enrolled in health insurance plans offered by their employers, compared to about 30% who were unable to obtain coverage through their employer: 19% because they were ineligible and 11% because they worked for employers who did not offer coverage. Another 16% were eligible for their employers' health plans, but declined the coverage.

Two *Spotlight on Maryland* issue briefs – one related to state health care spending and the other based on an analysis of prescription drug claims in the MCDB – were released in May. *Maryland Employment in Health Care* examines growth in private employment in health care and related industries in Maryland and compares Maryland with several neighboring states. It is part of a series of reports that look at factors that contribute to growth in health care costs in

Maryland. This brief highlights how employment growth in the health sector may contribute to growth in health care costs if that employment growth is not balanced with simultaneous productivity gains. The key findings are:

- Health care and related industries account for about 13 percent of total employment in Maryland, about 1 percentage point higher than the US overall.
- Employment in health care industries increased by 7.8 percent in 2001-2004. Hospital employment increased faster at 8.6 percent.
- Health care constitutes a greater share of total employment in Maryland than in Virginia, is equal to the share in New Jersey, and is lower than the share in Pennsylvania.
- Relative to the neighboring states, Maryland has higher levels of high-level health professionals such as physicians, physician assistants, and nurses.

Patterns of Use and Spending for High Cost Drug Users, 2004: Non-Elderly Maryland Residents with Private Insurance focuses on the under 65-privately insured population with the highest drug spending. The top 25 percent of users are responsible for 80 percent of private drug spending in MHCC's prescription drug data. These users account for just over $1,500 in spending per patient compared to about $120 for non-high-cost users. High-cost users are older and more likely to suffer from multiple conditions for which they are being treated on a continuing basis: over 50% of high-cost users filled prescriptions in 6 or more therapeutic categories. Statins, for lowering cholesterol, proton pump inhibitors, and selective serotonin reuptake inhibitors (SSRIs) were the most commonly prescribed classes of drugs for high–cost users. Generic substitution and increased mail-order may have some benefit in slowing spending growth for high cost users. But newer, more comprehensive strategies that target individuals with high-cost, high-impact diseases may yield greater results. These programs emphasize integrating pharmacy and medical benefits in order to better manage total costs. Strategies focus on lowering overall costs by encouraging better prescription drug management and compliance; higher prescription drug spending is acceptable if use of pharmaceuticals can offset other more costly medical care such as emergency department visits or hospitalizations.

Maryland Trauma Physician Services Fund

Background

During the 2003 Legislative Session, the Maryland General Assembly adopted the Maryland Trauma Physician Services Fund to aid Maryland's trauma system by reimbursing trauma physicians[1] for uncompensated care losses and by raising Medicaid payments to 100 percent of the Medicare rate when a Medicaid patient receives trauma care at a designated center. The legislation also established a formula for reimbursing trauma centers for trauma-related on-call expenses for trauma surgeons, orthopedists, neurosurgeons, and anesthesiologists.[2] The

[1] COMAR 10.25.10 originally defined trauma physicians as trauma surgeons, anesthesiologists, orthopedic surgeons, neurosurgeons, critical care physicians, and emergency room physicians to conform with the statutory definition.

[2] On-call requirements under the Maryland Institute for Emergency Medical Services Systems (MIEMSS) standards for Maryland trauma centers require that physicians be available to respond within 30 minutes. Standby requirements state that the physician must be at the facility ready to respond. Level III trauma centers may operate with all trauma physicians on call, although a center is permitted to have physicians on standby. Level III centers

legislation directed the HSCRC to allow trauma center hospitals to include trauma-related standby expenses in HSCRC-approved hospital rates. In FY 2004 and FY 2005, the Trauma Fund reimbursed physicians and trauma centers for about $7 million in the trauma-related expenses. The MVA collected over $22 million in revenue during FY 2004 and FY 2005. By the end of FY 2005, the balance had grown to $15.5 million. When claims incurred, but not paid were netted against the Fund, the balance stood at $12.4 million at the end of FY 2005.[3]

A sizeable balance in the Fund developed for three reasons. First, the initial eligibility criteria were intentionally limited. Specialties that commonly provided trauma care were the only specialties eligible reimbursement for the uncompensated care and Medicaid under-payment from the Fund. Second, thresholds for on-call payments were designed to partially cover total on-call expenses. This is consistent with the language in the law which directs the MHCC to continue to provide incentives to trauma centers hospitals to cover trauma center costs. Lastly, MHCC overestimated the funds needed to raise Medicaid payments to 100 percent of Medicare.[4] In the last 3 years, payments to Medicaid to account for the difference between the Medicare and the Medicaid rates have totaled only about 25 percent of the original estimate. Beginning in 2006, the Medicaid program increased fees for a number of specialties and as a result the under-payments have declined, further reducing the Trauma Fund's obligations. Medicaid fees for emergency medicine and orthopedics are now about 100 percent of the Medicare fee in Maryland.

Summary

During FY 2006, the MVA collected $12.5 million from the $5 surcharge on motor vehicle renewals. The Trauma Fund paid trauma physicians and trauma centers $7.2 million for providing uncompensated care, Medicaid under-compensated services, and trauma on-call expenses. The Fund also held $4.2 in claims that were incurred, but not paid until FY 2007. The balance in the Trauma Fund stood at about $20.8 million at the end of FY 2006 or $16.5 million if incurred, but not paid obligations, are netted against the Fund.

Disbursements from the Trauma Fund to trauma providers will increase significantly beginning in FY 2007. HB 1164 (Trauma Reimbursement and Grants), passed in the 2006 session of the Maryland General Assembly, increases the specialties that are eligible for uncompensated and Medicaid under-compensated care and raises the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers become eligible for uncompensated care reimbursement and elevated Medicaid payments. The legislation further directs the MHCC to award equipment grants totaling $3 million from the balance in the Trauma Fund at the end of FY 2006. These expansions will more closely align collections from the MVA with disbursements from the Fund. MHCC expects the trauma equipment grant program to reduce the

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must have trauma surgeons on standby status, but other physicians are permitted to be on call. Level I centers must have physicians in all MIEMSS-designated specialties on-site at all times.

[3] Physician practices and trauma centers submit applications for reimbursement biannually on January 31st and July 31st for the previous 6 month period. The 6 month reporting lag means that services provided in the last half of each fiscal year are paid in the following fiscal year. The MHCC nets these disbursements against the Fund balance to provide a complete picture of financial status.

[4] MHCC had access to limited data on Medicaid under-payments from only one trauma center in 2003.

balance in the Fund by $3 million as all eligible trauma centers report significant unfunded equipment needed related to trauma.

MHCC does not believe further changes in the distribution formula or eligibility criteria for the Trauma Fund are warranted in 2007. At least one year is needed to fully implement the changes enacted through HB 1164.

Data Base and Applications Development Division

Overview

The Data Base and Application Development Division is responsible for managing data collection efforts and health care provider surveys mandated by law. The Commission has authority to collect and manage information on health care professionals, hospitals, nursing homes, assisted living facilities, and adult day care centers. This division also acquires and manages external analytic databases used by the Commission, including the Maryland and District of Columbia hospital inpatient and emergency department data, state psychiatric hospital data, outpatient ambulatory surgery data, Medicare and private payer outpatient claims data, large private payer pharmacy data, and various CMS data systems 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

Data Requests

Data Staff continues to support the Certificate of Need Program (CON) and the State Health Plan objectives as well as fulfilling external data requests. This work includes: processing the Nursing Home Bed Need Methodology; creating obstetrics discharge tabulations, analysis of NICU discharges; and tabulations of patient acuity and payment source from the CMS Minimum Data Set. Staff completed a series of demographic tables describing Maryland nursing home residents and home health patients use to update the State Health Plan for Long Term Care Services, COMAR 10.24.08. Staff also converted the acute care methodology from a series of excel sheets into a SAS program, considerably reducing staff workload.

Data staff provided data processing support for several external entities including the DC planning agency, Doctors Community Hospital, Greater Baltimore HIV Health Services Planning Council for their comprehensive AIDS plan, and Ft. Washington Hospital, and an analysis detailing the racial makeup of Maryland's doctors undertaken for the Maryland General Assembly's Office of Policy Analysis. Data staff also provided data processing support for many internal projects including the Maryland Trauma Physician Fund, the Maryland Physician Data Base, processing the Medical Expenditure Panel Survey, the Minimum Data Set, analysis of Home Health data, and asthma analysis on the Medical Care Data Base. In addition, the Data staff provided technical review support on Request for Proposals (RFPs) for Hospice, Hospital and Nursing Home Report Cards and helped the Hospital staff identify items for close-out on the current hospital contract. Staff compiled a comprehensive application development requirements document that can be used for all proposals requiring application development.

The Data staff completed several mapping requests including 7 maps showing the "Locations of Adult Primary Percutaneous Coronary Intervention (PCI) Programs at Maryland Hospitals Without On-Site Cardiac Surgery and of Maryland and Washington, D.C. Hospitals With Adult Cardiac Surgery Programs (July 2006)" for the MBR-MWR PCI Hospitals project. These maps also showed the 30 minute rush hour drive times of selected hospitals in various Maryland regions.

The Data staff developed an MHCC data sources application which comprehensively lists data sources, descriptions, the location of the on the network, and allows access to each data dictionary. Staff developed an application which allows users with no programming background to run common tabulations and format data for the Hospital Discharge abstract. Staff also added the capability for tabulating diagnostic and procedure statistics in the application.

MHCC Website

Staff compiled web statistics and trends for a number of MHCC projects. New Electronic Health and National Provider Identifier sections were created for the website and numerous updates, project section overhauls and publications have been uploaded. Staff made all modifications necessary to accommodate the new DNS for our website and added a Late Breaking Reports section to the main page. Staff tested all web applications in preparation for the upgrade to the new version of ASP.NET and modified all applications after password security for the web server was heightened. Staff has been working on an overhaul of the MHCC website. Meetings were held with interested MHCC staff to discuss and come to agreement on objectives for the new design. Data staff have completed most of the overhaul and are now in the phase of optimizing the website for search engines.

Graphic Work

Staff provided graphic design support for various projects including logo development, color issues and conversions, formatting reports for web and print, creation of tables and graphs, report cover and bookmark creation, review of vendor graphic work, reviewing and writing printing specifications, methods for getting bookmarks and hyperlinks working in documents to be published on the web, and technical issues relating to downloading large reports.

Bed Need Inventory

The data staff converted a number of different sources of bed inventory data into 1 cohesive database, including conversion of the Excel Hospital Bed Projection application into SAS. This required scanning facility licenses from the Office of Health Care Quality, converting them to xml, and modifying the license information if discrepancies with the reported beds on the Long Term Survey were identified. The number of beds reported by MHCC is the potential bed occupancy of a facility based on the number of occupants that OHCQ has licensed for the facility and the number of occupants that MHCC has permitted the facility to have including waiver beds and de-licensed beds. This process identified discrepancies between MHCC data and OHCQ data that the staff will work with OHCQ to correct. This data is the basis of bed need projections which are required for planning aspects of the State Health Plan.

Long Term Care Survey
The annual, web-based, Maryland Long Term Care Survey collects facility level data from comprehensive care nursing homes, assisted living, chronic care, subacute, extended care and adult day care facilities throughout the State. Assisted Living facilities with ten beds or more participate in the survey. **In 2004,** MHCC surveyed 710 facilities. 690 out of 710 facilities completed the survey for an acceptance rate of 97.2% during the 3-month data collection phase of the survey. Facility license types included: 218 Comprehensive Care facilities; 330 Assisted Living facilities; 10 Comprehensive/Assisted Living facilities; 111 Adult Day Care Centers; 1 Extended Care facility; 13 chronic Care facilities; and 7 Subacute Care facilities. The data collected is used to update the web-based Assisted Living Profile, the Nursing Home Evaluation Guide, and to support State Health Plan work of the MHCC health planning staff. Staff produced 17 reports from the survey data including the Bed Trends Reports, the fiscal year Bed Days reports and the Bed Population ratio reports. Staff created Public Use data files from the survey data in order to allow internet users to download non-confidential data for research and other purposes.

Nursing Home Report Card
This past year staff converted nursing home deficiency data processing from using the Office of Health Care Quality data to using Oscar data downloaded from the CMS website. This data is unduplicated and clearly identifies survey and complaint inspections. The online nursing home application was overhauled to use data on-the-fly directly from the server instead of pre-populating the pages. The online nursing home data base is updated when new Minimum Data Set data is available, when CMS quality measures and resident data are updated, and when the MHCC Long Term Care Survey data is annually updated. Data staff worked with the Performance and Benefits division to modify the application to change emphasis from quality indicators to quality measures. Data staff also assisted the Performance staff with designing an ad, integrating a consumer survey into the consumer guide page, and scoring the Nursing Home Family Satisfaction Survey.

Assisted Living Profile
MHCC obtained assisted living facility deficiency data from the Office of Health Care Quality and developed an online profile of assisted living facilities. The application allows facilities to update their profile information online as well.

Home Health
Staff members assisted the Long Term Care staff in updating the State Health Plan for nursing homes and home health agencies. The home health agency methodology was rewritten to allow the use of Maryland's Minimum Data Set to identify home health agency candidates from Maryland nursing homes to help predict future need for home health agency services. Staff members assisted in preparing analyses for western Maryland and eastern shore to determine which home health agencies could be used for jurisdictions that are underserved.

Physician Database
The data staff took up organization and processing of the physician licensing data base in order to standardize the data over years and to construct a data base more suitable for analysis. The Board of Physicians has allowed paper submission of the license applications up until this year

and the data quality of the paper submissions is not as high as the data from the online application. The Board also changed the definition of some fields over time; to make this data consistent for trend analysis required. Staff created a 2003 public use file of physician data after consultation to determine a non-confidential subset of the data. We plan to continue to produce public use files for more recent years.

Maryland Subacute Care Survey
The Maryland Subacute Care Survey (MSACS) was established in March, 1995 to identify and distinguish programs and patient characteristics and increase the Commission's knowledge of emerging subacute care services. Information is now available to us from secondary data sources such as the Center for Medicaid and Medicare Services (CMS) Medpar file which can be used to monitor the utilization of subacute care facilities in a limited way. As a result, the MSACS has been discontinued as of December 31, 2005.

Maryland Assessment Tool for Community Health (MATCH)
The purpose of the MATCH project is to design, develop, test and implement a web-based data-mart analysis portal that will allow the public to easily perform statistical queries of select Maryland Department of Health datasets and obtain immediate hypercube data results. The vision is to build a maintainable, scalable website within the Department where internet users can build, run and download aggregate data queries from the Department's health agency data sources. MHCC will participate in this project using the non-confidential portions of private claims from the Medical Care Data Base, the Maryland Inpatient Discharge Abstract, and the Maryland Ambulatory Care (ED) data set. One data set for public use and one for DHMH staff or "private" use will be developed. The public application will use SAS Intranet software. The Web-enabled SAS intranet web application will enable users to perform simple analyses of the SAS-based data without having SAS programming knowledge. SAS Business Intelligence software will be used to construct the private site and will perform more complex data analysis than the SAS Intranet application and allows staff to manipulate SAS datasets via Excel.

Web Applications

Accomplishments

Physician Pricing
Using the Medical Care Data Base, staff developed a web application which allows internet users to view payment ranges for procedures provided by Maryland providers by county and medical specialty. This database is useful for Maryland residents who are considering procedures and would like to compare costs. The application is currently under review by members of the Medical and Chirurgical Association and is scheduled for public release in January 2007.

Publication Sharing Application
Staff developed a document sharing online application for use by the Electronic Health Task Force. The application allows secure sharing of documents and allows specific people to have edit access to the documents and the ability to upload their edited versions for continued review.

Assessment Database
Major changes were made to the Assessment program to allow for the adjusted calculation of hospital assessments based on a prior year adjustment of assessment fees. This resulted in debits or credits given to hospitals on this year's assessment and also required modification of supporting reports to show these adjustments. Staff updated the Assessment web site to view details of archived information and developed an email generator for the application to send bulk email notices to insurance companies and nursing homes. Staff assisted in the 2002 audit of the assessment database.

Ambulatory Surgery
Data staff worked with ambulatory surgery staff to review and modify specifications for development for this year's survey by an outside vendor. Staff consequently helped with survey testing, data review and validation, and communications with the software developer.

Certificate of Need (CON) Hospital Application
An electronic version of the CON Hospital Application was developed and is currently under testing and review by the CON staff. This will enable hospitals to complete applications online and reduce the staff time required to verify all elements required for application as well as enable tracking of application status quickly. Additionally, this application creates a database of CON documents which enables CON staff to review applications quickly.

Hospital Guide
Data staff supported the Hospital Guide vendor by setting up testing areas on the web server and allowing permissions for the vendor to update the Guide on our web server. Data staff supported the Performance and Benefits staff by compiling web statistics for the guide.

Dental Renewal Application
Staff developed an online Dental License Renewal application. The application was deployed and Dental Online licensing ended on June 30, 2006. 3,262 or 75% of applicants chose to complete the online application in its first year instead of using the optional paper submission. 2,936 or 91% of online applicants used a credit card to pay the renewal fee. Out of 643 responses to the User Evaluation Survey, 608 applicants experienced no or few technical difficulties.

Pharmacy Licensing
Data staff began work with the Board of Pharmacy to review new screens for development of the Pharmacy licensing application.

Physician Licensing
Staff continued to provide support to the Board of Physicians licensing application. Staff completed renewal modifications for this year including development of a credit card interface that also works with Mac users, and development of improved menu navigation. This year there were 10,670 (77% of database on file) renewals and a fee collection of $5,501,651 of which 85% was collected from credit cards.

Network and Operating Systems Division

Overview

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

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

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

Accomplishments

During FY 2006, the Commission's LAN was available to staff more than 99% of the time.

This year the network staff completed the upgrade of the LAN to maintain high availability and response time. The transition to a new domain structure has been completed and the email, file, and database servers have been upgraded as planned.

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.

Health Information Technology

Overview

MHCC has a broad statutory mandate to promote the use of information technology statewide, to improve patient safety, quality of care, and administrative efficiencies, and has positioned itself at the forefront of developing a framework for State policy to guide the expanding adoption and use of health information technology to enable electronic health information exchange. Accordingly, MHCC has responded to the national goal that every American have an electronic health record within ten years – a challenge posed by President Bush in his 2004 State of the Union address – and the resulting acceleration in the development of health information

technology (HIT) by establishing a policy development unit in its Center for Health Information Technology.

Provider adoption of HIT is widely viewed as a necessary component of a national strategy to improve the quality and reduce the cost of health care. A predominantly paper-based administrative and clinical health care system has resulted in preventable medical errors, variability in the quality of care, a fragmented health care delivery system, and high administrative costs. Key health care reform initiatives -- such as pay-for-performance, patient-centered health care, evidence-based medicine, and patient safety programs -- cannot effectively address these problems in the absence of a robust and interoperable system that enables health information exchange.

Connecting consumers, providers, and payers to an information network for the voluntary exchange of a patient's health information would have far-reaching benefits for Marylanders, enabling patients to actively participate in their care without fear of lost or incomplete records, unnecessary repetition of tests, or having to recall complex histories. Payers would benefit through the economic efficiencies resulting from fewer errors and a reduction in the duplication of services. Providers would benefit from their enhanced access to a patient's complete problem lists, procedure histories, allergies, and medication histories at the point of service, and would also have access to best practices information to support their medical decisions.

However, the wider adoption of HIT will depend on the public's acceptance of information technology to positively transform the nation's health care system. Making full use of HIT holds the greatest potential benefits for consumers, although payers and providers will be the largest users of health information. However, for HIT to gain acceptance, and for its adoption to increase, consumers will need to trust that their electronic health information is maintained in a secure manner with appropriate safeguards for its privacy and confidentiality. Consumer fears regarding authorization, access, use, and disclosure of their most private and sensitive information will hinder the expanded adoption and use of HIT.

Much of the impetus and expertise in this rapidly-evolving area continues to come from pioneering private sector entities, which have engaged health care providers and government agencies at all levels. These include the Markle Foundation's Connecting for Health, the Health Information Management Systems Society (HIMSS), the American Health Information Management Association (AHIMA), and the eHealth Initiative. These entities have developed and made available on their websites comprehensive policy and implementation tools to guide the adoption and use of electronic health information exchange. Staff has also spent considerable time becoming involved in HIT initiatives at the federal level, directed by the Department of Health and Human Services and the Office of the National Coordinator for Health Information Technology, and guided by the American Health Information Community, a high-level public-private advisory body.

Accomplishments

Support for the Task Force to Study Electronic Health Records

Center for Health IT staff provides executive and administrative support for the Task Force to Study Electronic Health Records (Task Force), established by the General Assembly in 2005 to study the current use, and potential expansion, of electronic health records across the state. Its 26 members include representatives of the Maryland Senate and the House of Delegates, the Office of the Attorney General, the Johns Hopkins and the University of Maryland Schools of Medicine, and the federal Veterans Administration, as well as twenty members appointed by the Governor to represent a broad range of provider and consumer interests, as specified in the enabling legislation. The Task Force is divided into three workgroups, focused on different aspects of the required study, including the management of infrastructure needed to support electronic health information exchange, categories of electronic patient information, and computerized prescribing.

Establishment of Health Information Technology Steering Committee

The Commission was instrumental in the formation of a Health Information Technology Steering Committee, to act as an advisory group to staff on health information technology initiatives. The Steering Committee consists of 27 members, more than half of whom are also members of the Task Force. The Steering Committee will provide guidance during the planning and implementation of a statewide health information exchange for Maryland.

Establishment of a Funding Mechanism for HIT Planning Projects

One of the first initiatives undertaken by the Center for Health Information Technology was a cooperative effort with the Health Services Cost Review Commission (HSCRC) to design and operationalize a process for developing a long-term, sustainable model for the effective, efficient, and secure exchange of health information across the spectrum of health care stakeholders, by identifying and funding the most promising pilot projects for such an exchange. As FY 2006 ended, each Commission was finalizing draft regulations to establish an interrelated process whereby MHCC will receive and evaluate applications for HIT projects, and recommend them for funding by HSCRC through small assessments on hospital rates.

Initiation of a Study of Privacy and Security Policies Related to Electronic Health Information Exchange Across Health Care Business Sectors

As the fiscal year ended, staff had developed a process through which to assess how organizational business policies and practices, as well as state laws regarding privacy and security, could affect the regional and statewide exchange of electronic health information. Advisory groups representing a broad spectrum of health care business sectors will convene to examine ways in which differences between federal and State privacy laws, and variations in the business practices between sectors, may affect the interoperability of systems wishing to share electronic patient information. The work of these groups will inform a subsequent effort to find ways to foster interoperability while still protecting the privacy and security of electronic health information, and will augment findings of a parallel, federally-funded effort unfolding in thirty-four states. Staff also formed an advisory group of attorneys to work on this project; the group's major focus will be to examine the differences between federal and State rules governing the privacy and permitted disclosures of protected health information, and the legal implications of a

wider use of electronic health records on the confidentiality and security of this sensitive information.

Health Information Exchange

Overview

The Annotated Code of Maryland, Title 10, Subtitle 25, grants the Commission the authority to promote the adoption of electronic data interchange (EDI or electronic health information exchange) in Maryland, including certification of electronic health networks (networks). The Commission's electronic health information exchange strategy is intended to promote increased quality in the electronic environment, reduce administrative costs, and promote the adoption of electronic health care transactions throughout Maryland. COMAR 10.25.07 establishes a certification process for networks 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 only from those networks certified by MHCC using EHNAC's standards. In addition, COMAR 10.25.09 requires payers to report annually on their volume of paper and electronic health care transaction data. This data is used to measure electronic health care transaction activity among payers and providers.

Stakeholders are exploring ways in which electronic health care transactions can be used to support clinical information. Efforts are underway nationally to develop an infrastructure to support the exchange of clinical information in a uniform and standard format, which can be understood by all trading partner technology. Exchanging clinical information has the potential to improve the quality, safety and efficiency of health care, and transforming the way health care services are delivered. The emerging infrastructure will enable electronic health records (EHRs) to be portable and available at anytime and at any place care is provided. Preliminary national estimates ranges from about 11-25 percent of physicians have an EHR system.

Over the next year the Commission plans to identify sound policies relating to widespread EHR adoption, and to expand the use of administrative and clinical transactions. The Commission also plans to explore a statewide EHR data collection initiative to measure the usefulness of electronic health information exchange, and modify its network certification policies to reflect the exchange of clinical information.

Accomplishments

Health Information Exchange Promotion

Payer and practitioner interest in expanding the use of electronic health information exchange continued to grow during the past fiscal year. Staff developed a series of resource guides aimed at increasing provider understanding of the efficiencies generated by electronic health information exchange. The *2006 Health Information Exchange Review* shows an increase in practitioner and hospital electronic claim submissions of about 4 percent, as well as approximately a 14 percent increase in the utilization of other administrative transactions, including eligibility, claim status, and enrollment in a health plan. The dental provider community has traditionally lagged behind the medical community in adopting health

information exchange. Dental electronic health information exchange activities included release of the *2005 Dental EDI Review*, a report that for the first time highlighted the use of electronic administrative transactions between payers and dental providers.

Over the last several years, the Commission has developed educational tools and provided consultative support to the provider community to facilitate implementation of the Administrative Simplification requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA). Last year, staff developed resource materials to assist providers with implementation of the National Provider Identifier (NPI), a standard identifier which will be required on all HIPAA standard electronic health care transactions as of May 23, 2007. These materials are posted on the Commission website, and have been widely distributed within the provider community.

Networks that transmit electronic transactions between health care entities are essential components of electronic health information exchange. The MHCC network certification program insures that networks doing business in the state meet industry "best practices" and critical privacy, security, and performance standards. Last year, MHCC's network certification program was expanded to include networks that transmit electronic prescription information; two e-prescribing networks are in MHCC network candidacy status. Despite several mergers and acquisitions of networks throughout 2006, the number of MHCC-certified networks continues to grow, currently twenty networks are certified, and ten networks are in candidacy status.

PERFORMANCE AND BENEFITS

(Transitions to *The Center for Long Term Care and Community Based Services and The Center for Health Care Financing and Health Policy*, July 1, 2006)

Benefits Analysis Division

(Transitions to *Small Group Market Division* under *The Center for Health Care Financing and Health Policy*, July 1, 2006)

Overview

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

As of July 1, 1994, carriers participating in the small employer market can only offer a policy incorporating the CSHBP on a guaranteed issue, guaranteed renewal basis. Medical underwriting was phased out as of January 1, 1995. Riders can be issued to improve the benefits, but not to diminish them. The insurance reform required community rating adjusted only for age and geography. Rating bands were established and are currently set at +/- forty percent. Since its inception, this health insurance reform initiative has provided small businesses in Maryland with access to a comprehensive health insurance benefits package on a guaranteed issue, guaranteed renewal basis, without rating based on health status.

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

Accomplishments

Comprehensive Standard Health Benefit Plan

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

Limited Benefit Plan

As the result of public meetings, the Commission developed the Limited Health Benefit Plan (LBP), which participating carriers began offering to certain small employers on July 1, 2005. Along with conducting meetings with interested parties and holding a public hearing, staff worked with Mercer Human Resource Consulting (Mercer), its consulting actuary, as well as CareFirst BlueCross BlueShield (CareFirst) and United HealthCare, to develop alternative proposals that meet the statutory requirement of pricing the LBP at 70% of the cost of the CSHBP as of January 1, 2004. The process resulted in the development of two proposed options: a credit fund plan and a capped benefit plan. In March 2005, the Commission approved the final regulations for both options to be implemented effective July 1, 2005. CareFirst and United, the two carriers required to participate in the LBP, began offering the capped benefit plan on July 1, 2005. The Commission is required to submit a report to the General Assembly by January 1, 2008.

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

Accomplishments

In FY 2006, Mercer prepared its eighth study of the impact of mandated services. Commission staff submitted this report, along with a transmittal letter summarizing the key findings in the report and outlining the issues posed by each proposed mandate, to the General Assembly in January 2006. A complete copy of the mandated services report entitled, *Annual Mandated Health Insurance Services Evaluation, January 19, 2006,* is available on the Commission's website. The first part of the report contains actuarial estimates of the annual cost impact of Maryland's existing required health insurance services for four types of contracts: group insurance plans; individual insurance plans; the CSHBP for small groups; and the Maryland state employee benefit plan. The second part of the report, in preparation for the 2006 legislative session, includes an evaluation of the financial, medical, and social impact of three mandates, at the request of three legislators. The next comparative study is due January 1, 2008.

Facility Quality and Performance Division

(Phases out July 1, 2006)

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

(Transitions to *The Long Term Care Quality Initiative Division*, July 1, 2006)

Overview

As part of the restructuring of the Maryland Health Care Commission scheduled for implementation in July 2006, the Performance and Benefits section was reconfigured into the Center for Long-term and Community-Based Services and the Center for Health Care Financing and Health Policy. The focus of the Center for Long-term and Community-Based Services will include the full array of long-term care services and supports. Long term care is experiencing a period of transition in Maryland and in the nation. LTC trends include a community-based approach to services, incorporation of consumer directed care models, design of systems for optimal individual independence and access, and enhancement of informed consumer choice. The center composition and scope of work as well as the creation of the advisory committee described below are designed to provide leadership in identifying and addressing issues of importance for Long Term Care in Maryland in this changing environment.

Long Term Care Planning Act

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

Determine the types of services and programs that people aged 65 and older and individuals with disabilities will need in 2010, 2020, 2030; and,

Identify how the State should begin planning for needed services and programs.

The Act specifies that the study review:

1) Population projections for ages 65 and older and individuals with disabilities for 2010, 2020, 2030

2) Services and programs operated by the State, including housing, transportation, medical needs and food subsidies to identify:

   a. problems with delivery of existing services

   b. the need for additional services or programs

3) The adequacy of current services and programs provided by county and region and identify any gaps in services

4) The effect that growth in age 65 and older population will have on current services and programs and the areas of the state most affected.

5) The types of services and programs most needed to support individuals with disabilities and 65 or older in 2010, 2020, 2030

6) Affordability of types of services and programs needed for individuals who may not qualify for state, federal, or local assistance

7) Cost to the State to provide the services

Accomplishments

Discussions with UMBC, Center for Health Program Development and Management were held to develop the details needed to complete the study required by the Long Term Care Planning

Act of 2006. A Memorandum of Understanding is expected to be completed between the Commission and UMBC after July1, 2006. UMBC will provide project management, acquire data/reports to produce specified analyses required by the legislation; draw conclusions from analyses; generate recommendations for consideration; and assist in producing the final report for the approval of the Commission. A consultant able to provide a futurist perspective in articulating the continuum of services and supports and guide long range planning (for the years 2015-2030) will complete the study team.

Performance Guide

The Commission contracted with the University of Maryland Baltimore County (UMBC), Center for Health Program Development and Management to conduct focus groups on the usefulness of the performance guides to Maryland citizens. The purposes of the focus groups were to gain a better understanding of the experience of Marylanders in finding and using information to make important health care decisions and to gather ideas about how MHCC staff might improve their approach to providing consumers with useful information. Three focus group sessions: one for Hospitals & Ambulatory Surgery facilities, one for HMO/POS plans, and one for Long Term Care services were completed in April 2006. The final report, *Maryland Health Care Commission Consumer Guide Evaluation Project*, was completed in May 2006.

Focus group participants reported using various sources of information to make decisions about health care facilities. Participants' own experience as well as the recommendations from other people (personal physician, other healthcare staff, friends, family, and co-workers) were valued as sources of information for healthcare decision making. Other sources were information from governmental sources, specific facilities, health plans, and published materials. Participants also reported the reputation of a facility or provider to be a factor in their decision making.

The information available to consumers for decision making was viewed as either too little or too much. In the case of a large volume of information, consumers wanted tools to help them organize the information. Often, the time needed to absorb and understand one's choices was felt to be insufficient by participants in the focus groups. Participants also made any suggestions for creating greater awareness of the guides among the general public.

Several MHCC initiatives have identified components of the Nursing Home Performance Evaluation Guide needing redesign to enhance effectiveness and usage. The initiatives included a structured internal staff review of the Nursing Home Performance Guide and Guide to Assisted Living and translating three major sources of guide user feedback (focus group feedback, recommendations from a study to assess user preferences and understanding of the Guides (Lewin), and written suggestions from users of the guide collected over time) into a design document. Implementation of the redesign components is scheduled to be completed in the latter part of calendar year 2006.

The Commission continually updates Guide data as it becomes available; data is current through June 2006. The Guide offers information about 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. The site features fourteen quality measures that are also reported on the CMS Nursing Home Compare Website as well as eleven additional quality indicators. 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 information may be accessed by name or geographical area, including county and zip code. The Guide also has an advanced search capability that allows Marylanders to search by facility characteristics and specific services.

During the year the Commission also considered changes to the Guide content to enhance the reporting of quality measures: healthcare associated infection (HAI), report of satisfaction, (described in more detail below) information about staff credentials, training and experience, and laws governing nursing facilities were some measures recommended by focus groups.

During the previous fiscal year, the Commission piloted a family survey to measure satisfaction related to quality of care received in Maryland nursing home facilities.

Market Decisions, LLC and the Institute for Health, Health Care Policy and Aging Research at Rutgers University conducted the pilot survey. The survey was mailed to families in September 2005; responses received through November 28, 2005 were included in the results. The survey tool consisted of fifty (50) satisfaction questions covering six (6) domains of care: administrative and patient care staff, environment, resident activities, personal care services, food, and resident personal rights. The Statewide results were published on the Commission website in May 2006.

Following completion of the 2005 pilot data collection, Commission staff reviewed the questions in the pilot survey and considered the comments on the questionnaire from family members, as well as comments made by other consumers and by the contractors on the 2005 survey. The Commission has considered survey instruments being used or developed elsewhere and consulted with representatives from the Agency for HealthCare Research and Quality (AHRQ); the Center for Medicare and Medicaid Services (CMS); and AHRQ's partners in the Nursing Home CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey development process. The Commission has also consulted with representatives of the Health Facilities Association of Maryland and Mid-Atlantic LifeSpan to incorporate the perspective of providers. The goal of soliciting the wide range of feedback is to revise the survey questions so that results of future surveys will be both reliable and valuable to Maryland consumers.

Commission staff anticipates that, before the end of 2006, the Commission will release a request for proposals that will result in its selection of a contractor to conduct the next Nursing Home Family Satisfaction Survey, using the revised and improved questionnaire. After completion of the survey and analysis of results, the Commission intends to publish both statewide and facility-specific results.

Obtaining the experience of care the residents of nursing facilities is also under consideration. MHCC is collaborating with the federal Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (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.

ARHQ and CMS representatives invited Maryland to participate in development and testing of surveys and tool kits for Assisted Living, Home Health, and Community Services. These initiatives are in various stages of development; meetings among AHRQ, CMS, and MHCC staff will continue.

Maryland Department of Disabilities (MDOD) Quality & Self-Directed Services Steering Committee

The Division Chief served on this Steering Committee which represents a statewide effort to define quality indicators and population outcomes for LTC community programs & waivers for adults with disabilities. The programs are all focused toward transitioning from or preventing institutional placement. Three meetings were held in the Spring of 2006 to: 1) Develop draft definitions for quality, quality indicators, and outcome measures for Maryland's long-term care service programs; and 2) apply a specific framework and methodology to develop outcomes (population results) and performance measures. Following the completion of the tasks assigned to the committee community forums and town meetings were to be scheduled by the Department of Disabilities to gather feedback.

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

In 2006, the Commission convened an advisory committee to replace the previous steering committee that assisted in development of the Nursing Home Performance Guide. The LTC Advisory Committee is intended to be a resource to the Commission as it addresses the various policy and public reporting issues related to LTC, including the Quality Initiative, the State Plan, and the LTC study mandated by HB 1342. The advisory committee has broad consumer and advocacy representation consisting of twenty individuals representing Long-Term Care and Community-Based service agencies, advocacy groups, state agencies providing or funding LTC services, and consumers. The first meeting is planned for August 2006 with monthly meetings anticipated thereafter.

Hospital Performance Evaluation System

(Transitions to *The Hospital Quality Initiative Division* under *The Center for Hospital Services*, July 1, 2006)

Overview

Chapter 657 (HB 705) of the Acts of 1999 required the Commission to develop a performance evaluation system for hospitals. In order to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Maryland Hospital Performance Evaluation Guide (Guide), and (2) design and execute a Marylander-oriented website for the Guide, the Commission contracted with the Delmarva Foundation, in partnership with ABT Associates. The Commission released its initial version of the Hospital Performance Evaluation Guide on January 31, 2002. In May 2003, an updated edition of the Guide was released which included quality of care measures. In January 2005, the Commission introduced the addition of six new acute myocardial infarction (AMI) treatment measures to the Guide. Obstetrics data was presented in May 2005.

The Commission's most recent Guide enhancements were released during a press conference on June 29, 2006. In addition to the modernized appearance and ease of navigation through four "portals" (hospital, patient, practitioner, hospital leader), the newest Guide reported information

concerning the first generation of process improvement measures on healthcare associated infections (activities associated with prevention of infections following hip, knee, and colon surgery). Trend information on quality measures was also updated. Another new feature included pricing information on the 15 most "All Patient Refined Diagnosis Related Group" (APR-DRGs) as reported by Maryland hospitals to the Health Services Cost Review Commission (HSCRC) for admissions during July – March 2006. For each acute care hospital in Maryland, information was provided regarding the number of cases in the APR-DRG, the average charge per case, and the average charge per day. In addition, through its website survey element, Marylanders were offered an opportunity to provide comments and suggestions regarding the revised Guide.

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

Accomplishments

Since the inception of the Hospital Guide, the Commission's goals have been to: (1) improve the performance and quality of the Guide; (2) enhance informed, value-based decision making; and (3) demonstrate accountability to Maryland residents.

The Commission continued to work with the Maryland Patient Safety Center to reduce and eliminate both blood stream infection rates and ventilator associates pneumonia for ICU patients. In connection with health care-associated infections, during its 2006 session, the Maryland General Assembly enacted legislation requiring the Maryland Health Care Commission to include Health Care-Associated Infection information in its existing Hospital Performance Evaluation Guide. Consequently, the Commission began taking steps to develop a Health Care-Acquired Infections Technical Advisory Committee.

In connection with the website's portal development, the Commission tasked a usability study on the existing website which found the audience frequently could not find information that addressed their needs and questions. As a subcontractor of the Delmarva Foundation, *i-Squared* (formerly Techwrite – a business process management firm with a focus on content), worked with the Commission to design the portal information strategy.

The Hospital Performance Evaluation Guide Steering Committee (now known as the Hospital Performance Evaluation Guide Advisory Committee) met several times to discuss redesign issues including: (1) the use of different symbols; (2) key quality measures [i.e., Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia (PN)],) (3) navigational tutorials, (4) comparison reports, and (5) pricing information.

To ensure that the Hospital Performance Evaluation Guide was useful to all Marylanders, particularly to patients and family members, the Commission contracted with the Center for Health Program Development and Management at the University of Maryland Baltimore County to conduct three focus groups. The hospital focus group session occurred on April 18, 2006. During the session, the Commission gathered ideas and perspectives based on the actual experiences of the group regarding hospital interactions as well as suggestions regarding the Commission's Hospital Performance Evaluation Guide. The Commission summarized these ideas and will utilize them in improving its approach for enhancing future Guides.

The Commission recognizes the importance of working with hospitals in Maryland so that it can provide quality and valuable information to Marylanders. In conjunction with this, the Commission provided a preview of its enhanced edition of the Guide to hospital representatives at a meeting hosted by the Maryland Hospital Association (MHA) on June 20, 2006. The preview included a tour of the revised Guide (conducted by staff from the Delmarva Foundation), and a preview of the new and updated data and information that would be available to Marylanders during the June 2006 release.

In conjunction with the Delmarva Foundation, the Commission revised its Bookmark and developed a Point of Purchase Display describing the content and online location of the Hospital Performance Evaluation Guide. These promotional materials were distributed to Maryland acute care hospitals, primary care physicians, county health departments, public libraries, academic libraries, shopping malls, and various state agencies.

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

(Transitions to *Health Plan Quality and Performance Division* under *The Center for Health Care Financing and Health Policy*, July 1, 2006)

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 65 percent of their enrollees covered through the Medicare and Medicaid programs are not required to submit HEDIS reports to the Commission.

Accomplishments

2005 Report Series

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

Division staff worked in partnership with contractor staff having special expertise in health quality measurement to develop the ninth series of annual HMO reports. The four report series had sequenced releases during the fiscal period. Beginning in autumn 2005, two publications—*Measuring the Quality of Maryland HMOs and POS Plans: 2005 Consumer Guide* and *2005 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland*—were completed and released.

The *Comprehensive Report* targeted audiences, such as health benefit plan managers, who seek information-rich content. This report assembled the collective results reported by plans in 2005 to form a statistical compendium of HEDIS (clinical) and CAHPS (survey) data. Results for the seven plans required to submit their performance data were benchmarked against the state average. The state average reflects the simple average of the combined seven performances for each clinical and survey measure. Measurement areas span from frequency of utilization to rates of recommended preventive and chronic care services.

The *2005 Consumer Guide,* a consumer-oriented comparative report, was derived from these collective data and presented a sub-set of the measures of interest to a more general audience. This report was designed for individuals who are deciding which health plan to join or for employers who are choosing which HMO to offer their employees**.** HMOs are compared on

members' satisfaction with their plan and the health care that they receive and on the degree to which health care services are provided to members that should receive them.

In January 2006, the third publication, *Maryland Commercial HMOs and POS Plans: Report to Policy Makers* was released. The release of the publication is timed to coincide with the convening of the general assembly, the primary audience for the report.

The *Policy Makers Report* extended the analysis of the results by providing a snapshot of how Maryland commercial HMOs and their affiliated point of service products compared to the average performance of their counterparts in the Mid-Atlantic region and the nation. In addition, the report showed how the overall performance of Maryland commercial HMOs changed over time. Analysis of the five-year results (2001—2005) revealed an overall trend of statistically significant improvements in clinical and member satisfaction results. The most marked improvements were in diabetes care.

Completing the 2005 HMO report series, the forth and final report, *Measuring the Quality of Maryland HMOs and POS Plans: 2006 State Employee Guide*, was provided to 50,000 active state employees during the spring 2006. This report mirrored the *Consumer Guide* but limited the plan results to only those plans available to state employees. Procedural information specific to state employees was also presented to assist in their understanding of how to obtain authorizations for behavioral health care and to learn of the additional resources developed by other state agencies.

Upon their release, the reports were sent to businesses, HMOs, libraries, policy makers, and academic health care programs, with distribution continuing throughout the fiscal year. Outreach activities by staff generated an equal amount of paper distribution of the *Consumer Guide* as compared to the previous year. 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 the full set of reports for their reference sections, as well as repositories received them for their state publication archives.

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

2006 Report Series

Administration of the 2006 survey of HMO and POS members was completed in the spring 2006 using the CAHPS 3.0H survey tool making this the eighth year this instrument has been used to collect member opinions. The data collected for this report series followed the most recent survey protocol that required a sample composed of 1,100 adult members from each of the seven HMOs submitting performance data during calendar year 2006. Because six plans have relatively large point of service memberships, the sample of members surveyed for those plans included both HMO and POS members. This allowed plans to more accurately assess how delivery occurs within their health systems. 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.

Over the course of the first half of 2006, the seven HMOs reporting in this calendar year underwent an audit of their HEDIS processes, information systems, and rates submitted to the Commission in June. Division staff directed activities conducted by HealthcareDat.com, LLC, an NCQA-certified (National Committee for Quality Assurance) auditing firm. In addition, Division staff participated in all document reviews, onsite interviews, and communications with NCQA's policy body regarding various matters that affected the data collection process.

2007 Report Series

To examine potential opportunities for improving the effectiveness of health plan quality reporting, a voluntary project was initiated early in 2006. This voluntary endeavor seeks to test the administrative feasibility of performance reporting by preferred provider organizations (PPOs). Staff hosted a series of conference calls during the first half of 2006 with quality improvement directors from insurers currently collecting HEDIS data for their HMO product line: Aetna, CareFirst, CIGNA, Coventry, Kaiser, and United Healthcare. The objectives of these discussions were to:

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

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

Federal reporting requirements in 2007:

- FEHBP FFS carriers will collect and submit to OPM results for 5 measures in 2007: breast cancer screening, cholesterol management for patients with cardiovascular conditions, CDC HbA1c testing, CDC retinal eye exam, CDC LDL-C screening
- MA PPO plans will collect and submit results in 2007 to CMS for selected HEDIS measures in Effectiveness of Care, Access to Care, Health Plan Stability, Use of Services, and Health Plan Descriptive Information.

HEALTH RESOURCES

(Transitions to *The Center for Hospital Services*, July 1, 2006)

Acute and Ambulatory Care Services Division

Overview

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

Accomplishments

State Health Plan

Amendments to the Acute Inpatient Services Chapter of the State Health Plan were adopted as proposed permanent regulations at the November, 2005 meeting of the Commission. This proposed Supplement 5 to the COMAR 10.24.10 was intended to delete obsolete standards and outdated material and make technical corrections, consistent with recommendations formulated

by the CON Task Force, which completed its work in November, 2005. Notice of this action was published in the January 6, 2006 *Maryland Register*.

The public comment period closed on February 7, 2006. In response to the proposed changes, comments were received from Adventist HealthCare, Holy Cross Hospital, MedStar Health, and Suburban Hospital.

The Commission adopted Supplement 5 as final rule changes on March 15, 2006 and they went into effect on April 24, 2006.

An Acute Care Work Group to assist MHCC in development of more comprehensive amendments to the Acute Inpatient Services chapter of the SHP was established in the late summer of 2006 and began meeting in the fall of 2007. It is anticipated that this group will finish its work in the spring of 2007 and a more fully updated version of COMAR 10.24.10 will be brought to the Commission for consideration, including updated bed need projections, at that time. Following completion of this effort, work will begin on amending COMAR 10.24.12, the State Health Plan chapter for Ambulatory Surgical Services.

Annual Acute General Hospital Bed Licensure

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

For FY 2006, for the first time in several years, there was no substantive change in licensed acute care hospital bed capacity in Maryland. The number of licensed acute inpatient beds increased from 10,321 in FY 2005 to 10,323 in FY 2006. The Commission also asked hospitals to report their physical acute care bed capacity for FY 2006, i.e., the maximum number of acute care beds they could "physically" set up and staff, on short notice. They reported a total of 11,290 beds, 967 beds above the total acute care beds licensed for FY 2006.

On June 1, 2006, the application forms with the new bed licensure numbers for FY 2007 were sent to all hospitals. Along with the allocation of their licensed capacity, hospitals are asked to provide information to the Commission on changes in the capacity of other hospital inpatient services. This annual survey, performed in conjunction with the licensure update process, collects information on the inventory of emergency department treatment space, obstetric service facilities, and surgical service capacity.

In contrast to FY 2006, in FY 2007, the acute care hospital bed licensure update produced results more in line with the experience of recent years. The total inventory of licensed acute care beds in Maryland increased approximately one percent, to 10,426 total beds.

Ambulatory Surgery Provider Directory
The eighth edition of the Commission's *Ambulatory Surgery Provider Directory, September 2005* was released at the Commission's September meeting. The *Directory* provides CY 2004 information on freestanding and hospital-based ambulatory surgery providers in Maryland, such as inventory and utilization data, surgical specialties, and contact information. Copies of this report are posted on the Commission's website.

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.

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

Specialized Health Care Services Division

(Transitions to *Specialty Services Policy and Planning Division*, July 1, 2006)

Overview

This division is responsible for health planning and policy functions related to cardiac surgery and percutaneous coronary intervention, organ transplant, neonatal intensive care, acute inpatient rehabilitation (including brain injury, spinal cord, and pediatric programs), and burn intensive

care services. This level of health care is provided to segments of the population that are severely ill or injured, require advanced diagnostic and therapeutic services, and are at high risk for poor outcomes. The cost of staffing and equipping specialized health care services is very high. The main function of the division is to develop a State Health Plan that includes the methodologies, policies, and standards for reviewing applications for a Certificate of Need (CON). The division assists in the collection of data to monitor and assess changes in health care access, quality, and cost; identify and analyze policy options; evaluate alternative approaches to regulation; and improve public knowledge about health care issues. The Commission coordinates the exercise of its functions with other State agencies.

Accomplishments

State Health Plan Provisions for Primary PCI Waiver

The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17) requires that hospitals providing PCI services have cardiac surgical services on-site ; however, the Commission may waive its policy if the exemption meets specific conditions. Beginning in 1996, the Commission approved and extended an exemption for the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) clinical trial, an innovative project designed to study the use of primary (emergency) angioplasty in treating certain patients experiencing acute myocardial infarction. This study compared primary PCI and thrombolytic therapy at hospitals without on-site cardiac surgery; data from the study made an important contribution to the knowledge base concerning whether primary angioplasty services can be provided safely by hospitals without cardiac surgical services on-site. The C-PORT trial ended in 1999, and the Commission extended the C-PORT exemption to an ongoing primary angioplasty registry until COMAR 10.24.17 was amended to include the recommendations of the Advisory Committee on Outcome Assessment in Cardiovascular Care on interventional cardiology services. The amended regulations became effective in March 2004.

Under COMAR 10.24.17.05D(1), the Commission may issue a waiver that permits hospitals without on-site cardiac surgery, upon demonstrating the ability to comply with the requirements for primary PCI programs, to provide primary PCI services. Beginning with the hospitals that participated in the Atlantic C-PORT Primary PCI Registry, the Commission initiated its waiver process by publishing the schedule for submitting an application to request a primary PCI waiver in the *Maryland Register* on October 28, 2005. The hospitals' transition from the C-PORT registry to the Commission's waiver registry occurred in January 2006. The Commission granted interim primary PCI waivers to the 12 participating hospitals for the period from January 1, 2006, through July 31, 2006: Anne Arundel Medical Center, Baltimore Washington Medical Center, Doctors Community Hospital, Franklin Square Hospital Center, Holy Cross Hospital, Howard County General Hospital, Johns Hopkins Bayview Medical Center, Mercy Medical Center, St. Agnes Hospital, Shady Grove Adventist Hospital, Southern Maryland Hospital Center, and Suburban Hospital. After a review of the hospitals' applications, data submitted to the C-PORT registry, and data from the Quality Improvement Organization (QIO) Clinical Warehouse, the Commission granted conditional waivers to 11 hospitals in May and June. Suburban Hospital, which received a CON in July 2005 to provide cardiac surgery, initiated its cardiac surgery program on May 9, 2006; the hospital was required to submit data for all primary PCI patients treated prior to initiation of the cardiac surgery program.

State Health Plan Provisions for Non-Primary PCI Waiver

COMAR 10.24.17 also includes provisions for the Commission to consider a request for a waiver from its policies for a well-designed, peer-reviewed research proposal. On January 29, 2005, Thomas Aversano, M.D., Associate Professor of Medicine at the Johns Hopkins Medical Institutions, and colleagues sent to the Commission a proposal to study elective angioplasty at hospitals without on-site cardiac surgery. As required by Policy 5.3.2 of COMAR 10.24.17, the Commission appointed a Research Proposal Review Committee to provide advice to the Commission on research proposals that require a waiver under the State Health Plan. On August 16, 2005, Thomas J. Ryan, M.D., MACC, Chairman of the Research Proposal Review Committee, transmitted the committee's final report to Rex W. Cowdry, M.D., Executive Director. COMAR 10.24.17.05D(2)(b) requires the Commission's Executive Director to consider the advice of the Research Proposal Review Committee in preparing a recommendation to the Commission to issue or deny issuance of a waiver. On August 30th, Dr. Aversano and colleagues requested that their proposal be withdrawn from consideration by the Commission. At that time, the investigators also notified the Commission of their intention to submit a revised proposal. The Commission released the *Report of the Research Proposal Review Committee* in September 2005. On March 29, 2006, Dr. Aversano and colleagues resubmitted the C-PORT elective angioplasty project, noting that the proposal had undergone extensive revision based on comments by the Commission's Research Proposal Review Committee and others. The project is a randomized comparison of outcomes after PCI performed at hospitals with and hospitals without cardiac surgery on-site (SOS). The study intends to test the hypothesis that outcomes of non-primary PCI performed at hospitals without SOS are not inferior to outcomes of PCI performed at hospitals with SOS. The Research Proposal Review Committee will serve as the scientific review panel for the revised proposal and begin its review in August 2006.

State Health Plan on Neonatal Intensive Care Services

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

Long Term Care and Mental Health Services Division

(Transitions to *Long Term Care Policy and Planning* under *The Center for Long Term Care and Community Based Services*)

Overview

This program is responsible for health planning functions related to community-based and institutional long term care services. This includes monitoring changes in demographics,

medical technology, financing and reimbursement, and their impact on current and projected utilization of long term care services in Maryland; assessing the current health care delivery system in Maryland; determining where there may be gaps in the continuum of care; and promoting the development of needed services in response to identified needs, assuring access to a full continuum of long-term care services. The Commission coordinates its long term care 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 September 30, 2005 *Maryland Register* to update Chronic Hospital Occupancy for 2004. This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital (formerly Deaton); and Gladys Spellman Specialty Hospital and Nursing Center. The state operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center.

Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland Fiscal Year 2003
The Commission's *2003 Nursing Home Occupancy Rates and Utilization by Payment Source* is based on data that were obtained from the 2003 Maryland Long Term Care Survey, 2003 Medicaid Cost Reports, and the Commission's nursing home bed inventory.

Following an introduction, the second chapter of the report presented data on Nursing Home Occupancy for FY 2003, followed by data on Nursing Home Utilization by Payment Source for FY 2003. This is followed by chapters analyzing trends in nursing home operating occupancy (1996-2003) and trends in nursing home utilization by payment source (1996-2003). Data on facility-specific licensed and operating occupancy and utilization rates were presented in final section of the report. Occupancy rates were presented in two ways: those *including* temporarily delicensed beds (licensed bed capacity) and those *excluding* temporarily delicensed beds (operating bed capacity). The report was released in December of 2005 and is also available on the Commission's website.

Medicaid Patient Days and Nursing Home Occupancy Update
As required under COMAR 10.24.08, a notice was published in the December 23, 2005 *Maryland Register* to update the Percent of Total Patient Days Paid by Maryland Medical Assistance Program by Jurisdiction and Region for fiscal year 2003. In the same issue of the *Maryland Register*, the Commission also published an updated notice for nursing home operating occupancy for FY 2003.

Home Health Agency Data
Staff continues to analyze home health agency utilization data based on information submitted to the Commission. Based on data reported on the Home Health Agency Annual Reports, the Commission published, in November 2005, *Maryland Home Health Agency Statistical Profiles* for Fiscal Years 2002 and 2003.

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. Building on this database, the Commission now uses the MDS data to project need for nursing home beds, and analysis of data related to planning for long term care services in Maryland.

Hospice Data Collection
The Commission was charged with collection of its own hospice data without relying on other sources, as a result of SB 732 (2003). In order to complete this task, staff conducted site visits of several hospice programs. A draft survey was developed and reviewed with representatives of the Hospice Network of Maryland. The Commission procured a contract with Perforum (now OCS), which has developed data collection tools for the National Hospice and Palliative Care Organization, to develop an online hospice survey. All hospices in Maryland submitted data online for 2003, 2004 and 2005 and public use data sets were developed.

An Analysis of Future Need for Nursing Home Beds in Maryland: 2010
In preparation for the development of the Nursing Home section of the State Health Plan, the Commission developed a report entitled, *An Analysis of Future Need for Nursing Home Beds in Maryland: 2010.* The report assists the Commission by (1) providing background information on nursing home services in Maryland; (2) identifying key issues involved in projecting the future need for nursing home beds; (3) examining the impact of alternative policy assumptions on future nursing home bed need; and (4) providing a framework for the Commission to obtain

public comments on key policy issues prior to updating the State Health Plan. This Report was released by the Commission in November 2005 and is also available on the Commission's website.

Work Groups: Nursing Home, Home Health Agency, Hospice

In further State Health Plan preparation work, staff convened Work Groups to assist in the development of the components of the State Health Plan. Background papers including analysis of relevant trend data and related issues were developed for discussion purposes by each of the Work Groups. The Nursing Home Work Group met during March and April, 2006. Its membership included representatives of: nursing homes; the Health Facilities Association of Maryland; Lifespan; Medicaid; the Office of Health Care Quality; the Maryland Department of Aging's Ombudsman; and researchers in long term care. The Home Health Agency Work Group met during March and April 2006. Members included representatives of: home health agencies; the Centers for Medicare and Medicaid Services (CMS); the Medicaid Office of Nursing and Community Programs; the Office of Health Care Quality; the Maryland National Capital Homecare Association; and the National Association for Home Care and Hospice. The Hospice Work Group met during April and May of 2006. Membership included: hospice providers; the Hospice Network of Maryland; Director of Palliative Care, University of Maryland; Johns Hopkins School of Medicine; Medicaid; Centers for Medicare and Medicaid Services (CMS); and the Office of Health Care Quality. Input from these Work Groups helped the staff in the development of the State Health Plan, COMAR 10.24.08.

Repeal of Subacute Care Regulations COMAR 10.24.05

The Subacute Care Regulations (COMAR 10.24.05) were adopted in March 1995 in order to create a "subacute care bed pool" from which a limited number of nursing home beds would be made available for acute care hospitals to develop hospital-based skilled nursing facilities. A major focus of these regulations was to undertake a comprehensive approach to examining the various types of subacute care providers. The regulation permitted sunset when three conditions were met:

(1) A final report has been issued by the Commission in accordance with Regulation .08 of this chapter;
(2) Criteria and standards to guide future development of subacute care found in Regulations .05 and .06 of this chapter, with revisions as needed, have been incorporated into COMAR 10.24.08; and
(3) Appropriate provision for collection of data needed by the Commission on an ongoing basis has been made under the auspices of COMAR 10.24.02, 10.24.03, or other appropriate regulations.

A final report was issued by the Commission, "Emerging Trends in Selected Post-Acute Care Settings in Maryland" and was released in July 2003. Criteria and standards regarding the development of short-stay, hospital-based skilled nursing facilities have been incorporated into COMAR 10.24.08. Data collection will continue using the Hospital Discharge Abstract (COMR 10.24.02), the Maryland Long Term Care Survey (COMAR 10.24.03), and the federal minimum data set.

Action was taken by the Commission on December 15, 2005 to repeal these regulations. Notice of this action was published in the January 20, 2006 issue of the *Maryland Register*. Following a 30-day public comment period, the Commission took final action on these regulations at its March 15, 2006 meeting. The repeal was effective April 24, 2006.

Nursing Home Conversion Regulations
House Bill 1047, passed during the 2005 legislative session, proposes grant funding through the Office of Planning and Capital Financing to county, municipal, or nonprofit nursing homes to permit them to convert to other uses. Staff of the Commission met with staff of Medicaid and the Office of Planning and Capital Financing to begin to develop regulations to implement this legislation.

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 agencies, hospice, and nursing homes. Staff made a presentation to the Maryland National Capital Homecare Association on September 12, 2005 as part of its Annual Fall Convention.

In January 2006, staff prepared background materials for a presentation done by the Executive Director for Maryland Hospice Day in Annapolis. Staff presented information on the 2004 public use data set, the hospice section of the State Health Plan, changes made for the 2005 Maryland Hospice Survey.

In January 2006, staff met with the Tri-County Health Planning Committee via teleconference. The Tri-County Health Planning Committee is composed of agencies from Somerset, Wicomico, and Worcester Counties. The presentation included a review of the report entitled *An Analysis of Future Need for Nursing Home Beds in Maryland: 2010*. Discussion focused on policy issues in long term care and the assumptions made in projecting future nursing home bed need.

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

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

In-Home Health Services Forum
This group was convened by OHCQ in order to review the regulations governing the various in-home services including, but not limited to, home health agencies; residential services agencies;

nurse staffing agencies; and nursing referral service agencies. This group met during 2005 and 2006. Division staff participated in this Forum as well as with the Regulations and Structural Requirements Workgroup.

Certificate of Need (CON) Division

Overview

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

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

In Fiscal Year 2006, the Commission adopted *Principles to Guide the CON Program* recommended by a CON Task Force formed by the Commission. Those guiding principles are as follows:

Maryland's CON program should:

- Respond to its residents' needs for health care services, including hospital, long term care, ambulatory surgery, and specialized services;
- Promote the quality and safety of these services;
- Promote improved access to these services, including addressing the needs of underserved populations and both the ethnic and racial disparities in health care which presently exist; and
- Promote the affordability of health care available to Maryland residents.

CON should apply in situations where market forces are likely to result in:

- Significantly higher or unnecessary costs to the system;
- Decreased access to care by vulnerable populations or less populous regions of the state; or
- A diminution of the quality or safety of patient care.

The CON program should be:

- Procedurally clear, consistent, and timely;
- Flexible enough to accommodate unique situations, whether of provider mission, geography and demographics, or technological advances; and
- Specific to Maryland's unique policy and regulatory framework.

The State Health Plan standards, review criteria, and associated data used to conduct CON reviews should be kept current, and regularly updated.

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

Accomplishments

Certificate of Need Applications, Exemptions, and Modifications

During FY 2006, the Commission reviewed twenty (20) CON applications, approving eighteen (18) and denying two (2). It approved two (2) CON exemptions and modifications to six (6) previously approved projects. Three CON applications in review were withdrawn by applicants and one CON application filing was returned by MHCC for failing to comply with docketing rules.

Three of the larger hospital expansion and renovation projects reviewed and approved in FY 2006 were modified during the course of review in response to staff or Commission Reviewer's recommendations. Anne Arundel Medical Center reduced its proposed expansion by 19 beds and $2.4 million. Baltimore Washington Medical Center reduced its proposed expansion by 10 beds. Peninsula Regional Medical Center reduced its proposed expansion by 26 beds. A smaller hospital project, that proposed by Carroll Hospital Center, was modified in the course of its review to reduce the requested number of additional operating rooms, reducing the cost of the project by just under $100,000.

A clear cycle of substantial investment in replacing, expanding, and renovating hospital physical plants began in Maryland in the 2002-2003 period and continues today. 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, MHCC had thirteen major hospital capital projects under review, whose capital costs totaled $1.58 billion.

In FY 2006, the Commission approved new hospital CON projects totaling over $813 million in estimated project cost and also authorized additional spending of $232.6 million for previously approved hospital capital projects. The fiscal year saw eight hospital "pledge" projects, projects exceeding the capital spending threshold defining reviewability but not otherwise including elements requiring CON review, totaling an additional $76 million. As of July 1, 2006, MHCC had a total of six docketed hospital capital projects awaiting a decision, with an aggregate estimated capital cost of approximately $1.05 billion.

Approved CONs

Suburban Hospital (Bethesda/Montgomery Co.)
Introduce cardiac surgery and elective angioplasty
Approved with conditions - $18,617,820

St. Joseph Nursing Home (Catonsville/Baltimore Co.)
Expansion and renovation
Approved with conditions - $4,373,043

Washington Adventist Hospital (Takoma Park/Montgomery Co.)
Establish a freestanding ambulatory surgery center – 4 operating rooms
Approved with conditions - $3,896,903

Children's Outpatient Ctr. at Montgomery County (Rockville/Montgomery Co.)
Establish a freestanding ambulatory surgery center by adding a second operating room
Unconditional approval - $1,056,375

Clifton T. Perkins Hospital Center (Jessup/Howard Co.)
Expansion and renovation – Add 48 beds
Unconditional approval - $11,624,000

Sinai Hospital (Baltimore City)
Expansion and renovation – Add 4 operating rooms
Unconditional approval - $15,120,051

Johns Hopkins Bayview Medical Center (Baltimore City)
Expansion and renovation – Add 4 operating rooms
Unconditional approval - $9,826,416

Lorien LifeCenter – Baltimore County (Timonium/Baltimore Co.)
Add 15 beds (delicensed at an existing facility) to the approved capacity of an approved but unbuilt nursing home

Approved with conditions - $248,550

Peninsula Regional Medical Center (Salisbury/Wicomico Co.)
Expansion and renovation – Add 26 beds and 12 emergency department treatment spaces
Approved with conditions - $111,584,948

Lorien LifeCenter – Ellicott City (Ellicott City/Howard Co.)
Change in site for an approved new nursing home
Approved with conditions - $5,777,000

Anne Arundel Medical Center (Annapolis/Anne Arundel Co.)
Expansion and renovation – Add 19 beds, 8 operating rooms, and 19 emergency department treatment spaces
Approved with conditions - $207,838,650

Howard County General Hospital (Columbia/Howard Co.)
Expansion and renovation – Add 67 beds
Unconditional approval - $72,860,000

Baltimore Washington Medical Center (Glen Burnie/Anne Arundel Co.)
Expansion and renovation – Add 50 beds and 17 emergency department treatment spaces
Introduce obstetric services
Approved with conditions - $124,579,857

Western Maryland Health System (Cumberland/Allegany Co.)
Replace and relocate Cumberland Memorial Hospital and Medical Center and Sacred Heart Hospital
Approved with conditions - $323,893,863

Carroll Hospital Center (Westminster/Carroll Co.)
Expansion and renovation – Add 3 operating rooms
Unconditional approval - $28,750,000

Alice Byrd Tawes Nursing Home (Crisfield/Somerset Co.)
Replace existing nursing home
Unconditional approval - $14,218,618

Surgery Center of Potomac (Rockville/Montgomery Co.)
Establish a freestanding ambulatory surgery center by adding a second operating room
Unconditional approval - $86,550

Ruxton Surgery Center (Towson, Baltimore Co.)
Establish a freestanding ambulatory surgery center by adding a second operating room
Unconditional approval - $98,769

Denied CONs

Holy Cross Hospital (Silver Spring/Montgomery Co.)
Introduce cardiac surgery and elective angioplasty
$3,264,000

Southern Maryland Hospital Center (Clinton/Prince George's Co.)
Introduce cardiac surgery and elective angioplasty
$5,728,000

Approved CON Exemptions

Civista Medical Center (La Plata/Charles Co.)
Close hospital-based extended care facility
$0

LifeBridge Health
Transfer 5 nursing home beds from Jewish Convalescent Center to Northwest Hospital Center
$100,000

CON-Approved Projects Modified

Union Hospital (Elkton/Cecil Co.)
Change in physical plant design and $2,459,321 (12.0%) increase in approved cost

Frederick Memorial Hospital (Frederick/Frederick Co.)
Change in financing plan

Lorien LifeCenter – Ellicott City (Ellicott City/Howard Co.)
Change in physical plant design

Upper Chesapeake Medical Center (Bel Air/Harford Co.)
Change in physical plant design and $5,875,551 (18.7%) increase in approved cost

Children's Outpatient Ctr. at Montgomery County (Rockville/Montgomery Co.)
Change in physical plant design and $256,075 (19.5%) increase in approved cost

Johns Hopkins Hospital (Baltimore City)
Change in physical plant design and $224,152,155 (38.8%) increase in approved cost

CON Applications Withdrawn

Doctors Community Hospital (Lanham/Prince George's Co.)
Expansion and renovation
$12,549,000

Washington Adventist Hospital (Takoma Park/Montgomery Co.)
Expansion and renovation – add 16 emergency department treatment spaces
$132,946,619

Knollwood Manor (Millersville, Anne Arundel Co.)
Replace nursing home
$21,054,898

CON Applications Returned

Chesapeake Rehabilitation Hospital (Salisbury/Wicomico Co.)

Convert medical rehabilitation hospital beds to nursing home beds
$0

Determinations of Non-Coverage and Other Actions

In FY 2006, the Commission issued 161 determinations as to whether a proposed project or action by a person or existing health care facility required CON approval. The majority of these actions were made in accordance with statutory and regulatory provisions outlining; 1) The scope of CON coverage; 2) The types of projects or actions that, while similar in their general nature to projects that require CON review and approval, can be implemented outside of the CON regulatory process; and 3) The notification requirements and attestations which must be met to obtain the Commission's determination that CON is not required. These determinations are profiled on the following page. Chief among these types of determinations are those involving establishment of single operating room ambulatory surgical facilities, acquisitions of health care facilities, hospital capital expenditures for which the hospital is taking "the pledge," temporary delicensure of beds (for up to one year), primarily nursing home beds, and small increases in the bed capacity of facilities, primarily nursing homes, which are allowed increases of 10% of bed capacity or ten beds, whichever is less every two years so long as the facility maintains operation of all of its bed capacity without changes during that period of time.

Capital projects with costs below the threshold of reviewability	**18**
Hospital "pledge" projects [1] (8 received determination of non-coverage/1 denied)	**9**
Acquisitions of health care facilities	**23**
Hospitals	**3**
Nursing Homes	**10**
Ambulatory surgery centers	**6**
Other	**4**
Establishment of new ambulatory surgery center (no more than one sterile operating room)	**30**
Montgomery (6), Baltimore County (4), Anne Arundel (3), Frederick (3), Howard (3), Baltimore City (2), Charles (2), Harford (2), Calvert (1), Carroll (1), Prince George's (1), Washington (1), Worcester (1)	
Changes in ambulatory surgery center facilities or operation (e.g., addition of non-sterile procedure rooms, surgical staff, surgical specialties, ownership structure)	**7**
Temporary delicensure of beds (402 total beds)	**24**
Restoration of temporarily delicensed beds (400 total beds)	**26**
Acquisition of temporarily delicensed beds by another facility (49 total beds)	**1**
Establish program	**3**
Close program	**1**
Add "waiver" beds [2] (22 total beds)	**3**
Addition of CCF beds by continuing care retirement communities [3] (23 total beds)	**6**
Pre-licensure and/or first use approval for completed CON-approved projects	**6**

Abandonment of beds (59 beds)	**4**
TOTAL	**161**

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

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

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

Other Activity Bearing on the CON Program

In FY 2006, a Certificate of Need Task Force, appointed by Commission President Steven J. Salamon and chaired by Commissioner Robert E. Nicolay, completed its report and recommendations to the Commission. Its objectives were 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.

The Maryland Health Care Commission adopted the recommendations of the Task Force with one exception, a recommendation to propose elimination of home health agencies as a regulated category of health service under the CON program.

The Commission was successful in obtaining amendments to the CON statute that it supported, based on CON Task Force recommendations. Chief among these amendments was an increase in the capital spending level defining reviewability to $10 million for hospitals and $5 million for all other types of health care facilities.

The Commission also promulgated regulatory amendments to COMAR 10.24.01, based on the CON Task Force recommendations. These amendments streamline the process by which applications can be modified during the course of review, in response to recommendations of Commission reviewers or staff, and continue forward in the review process to a decision. They also bring the regulations in conformance with the statutory amendments produced by the 2006 General Assembly Session.

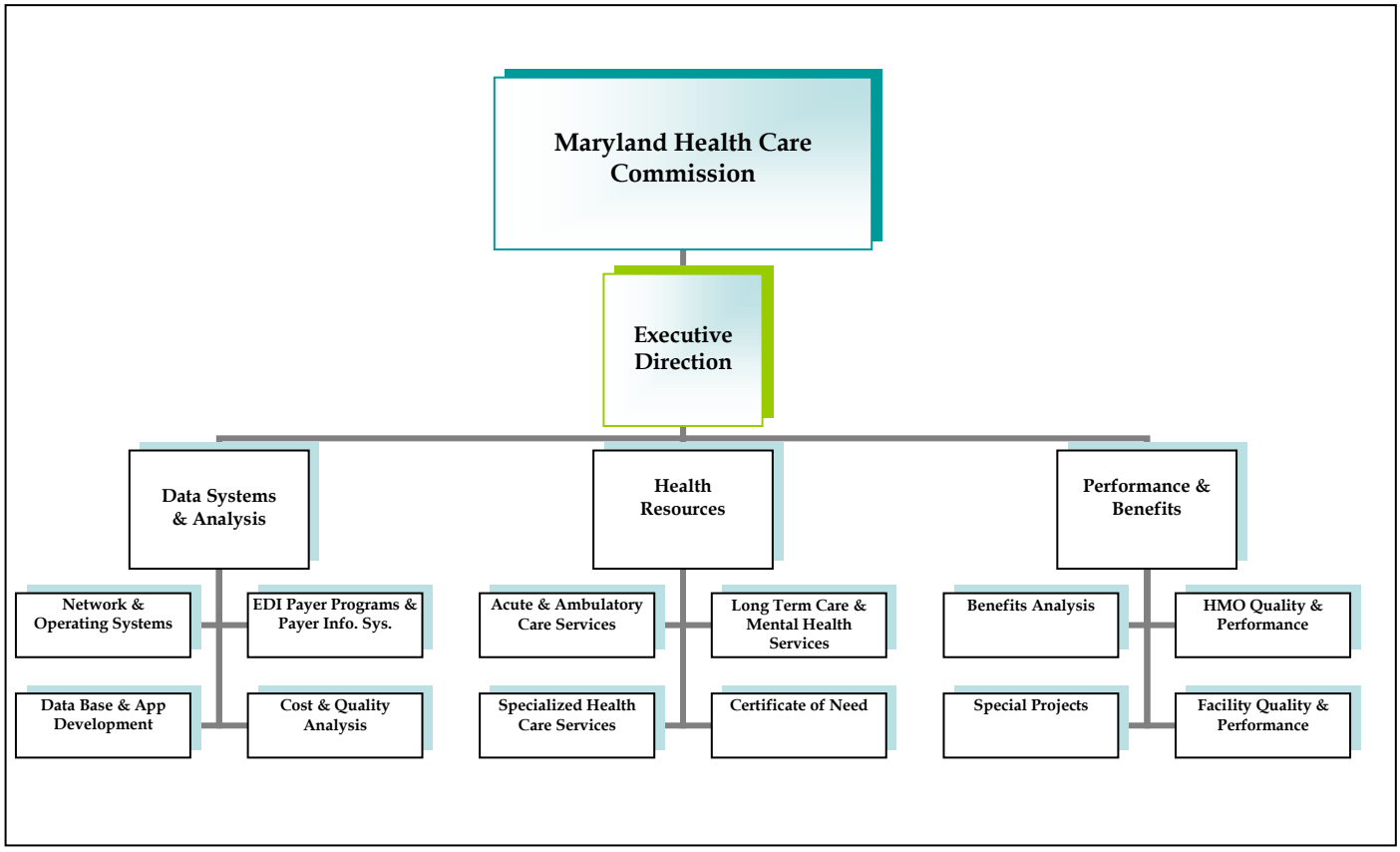
APPENDICES

Appendix A

Commission Revenues and Expenditures
Fiscal 2002 through 2006

	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Beginning Balance	$1,775,743	$2,044,110	$3,132,588	$4,587,487	$3,533,471
Revenues	7,684,073	8,628,138	9,025,574	7,694,715	8,764,702
Subtotal	**$9,459,816**	**$10,672,248**	**$12,169,985**	**$12,282,202**	**$12,298,173**
Direct Costs	$7,415,706	$7,539,660	$7,570,675	$7,557,620	$7,509,831
Indirect Costs				1,191,111	1,204,992
Subtotal	**$7,415,706**	**$7,539,660**	**$7,570,675**	**$8,748,731**	**$8,714,823**
Ending Balance	**$2,044,110**	**$3,132,588**	**$4,587,487**	**$3,533,471**	**$3,583,350**
Ending Balance as a % of Total Costs	28%	42%	61%	40%	41%

Appendix B – Maryland Health Care Commission current organizational chart



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