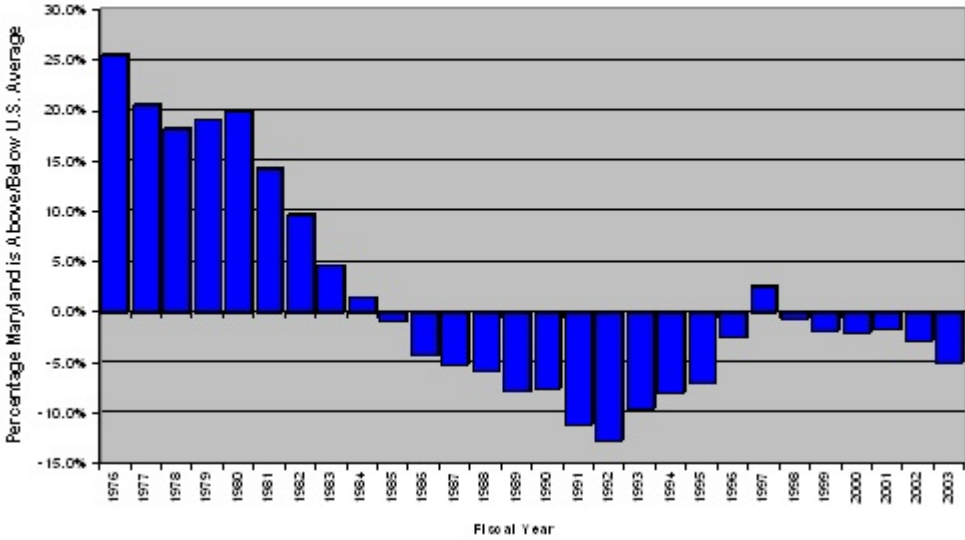


MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

Comparison - COST PER EIPA
MARYLAND vs. U.S. 1976-2003



REPORT TO THE GOVERNOR FISCAL YEAR 2005

ROBERT L. EHRLICH, JR.
GOVERNOR

STATE OF MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

Commissioners as of June 30, 2005

	<u>Appointed</u>	<u>Term Expires</u>
Joseph Antos, Ph.D.	July 1, 2004	June 30, 2008
Irvin W. Kues Chairman	July 1, 2003 (Appointed Chairman September 15, 2003)	June 30, 2007
Michael J. Eusebio	July 1, 2003	June 30, 2007
Trudy R. Hall, M.D., P.A.	July 1, 2002	June 30, 2006
Larry L. Grosser	July 1, 2001	June 30, 2005
Samuel Lin, M.D., Ph.D. Vice Chairman	July 1, 1997 July 1, 2001* (Appointed Vice Chairman May 5, 2004)	June 30, 2001 June 30, 2005
Kevin J. Sexton	July 1, 2003	June 30, 2007

*Reappointed

STATE OF MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION
ANNUAL REPORT TO THE GOVERNOR

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This Governor's Report reports on activities of the Health Services Cost Review Commission for the Fiscal Year 2005. Audited data throughout the report, however, are for the most recent fiscal year available, which is Fiscal Year 2004. Audited data for Fiscal Year 2005 will be available from the Commission in June 2006.

I. EXECUTIVE SUMMARY

Building on the significant change that began in Fiscal Year 2000, the Health Services Cost Review Commission ("HSCRC" or "Commission") continued work on the revised hospital rate setting system through Fiscal Year 2005, further refining changes to the system which had been in place for 25 years. The redesigned system has demonstrated its effectiveness in achieving the founding principles of the Maryland system - they are the principles of access, equity, public accountability, and solvency.

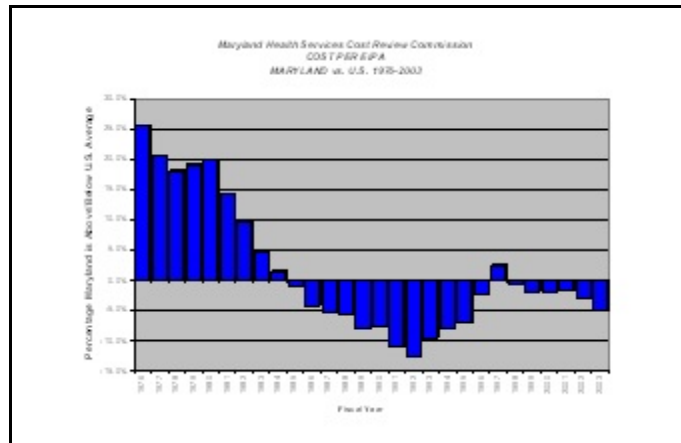
Maryland Hospital Cost Performance

The HSCRC's Fiscal Year 2004 Disclosure Statement reported that the average cost of a hospital stay in Maryland increased at a rate of 9%, from \$7,707 in Fiscal Year 2003 to \$8,403 in Fiscal Year 2004, above the national average of 5.9%. This development, which had been anticipated, reflects the realization of the effects of a policy implemented by the HSCRC two years ago to increase hospital rates and, as a result, revitalize and recapitalize a hospital industry that had seen its profitability become depressed and its ability to enter the capital markets to finance facility upgrade and replacement seriously impeded.

The ratesetting system has retained other unique benefits, such as keeping the mark-up, or the difference between hospital costs and charges, in Maryland hospitals the lowest in the nation at 20%, compared to the average mark-up of 152% for hospitals nationally, according to the most recent data from the American Hospital Association (AHA). In the absence of

ratesetting, hospitals outside of Maryland must artificially mark up their charges by 100-300 percent in an effort to compensate for shortfalls in uncompensated care, discounts to large managed care organizations (HMOs), and low reimbursement from Medicare and Medicaid. These marked-up charges make payment difficult for “self-pay” patients. This issue of charges to the “self-pay” patients remains under review by Congress. In Maryland, the payment system builds the cost of uncompensated care into the rates, and all payers in Maryland pay the same rates for hospital care (For details, please see section entitled “Uncompensated Care” below).

In 1976, the cost of an adjusted admission to a Maryland hospital was 26% above the national average. In 2003, the average cost per adjusted admission in Maryland was 6% below the U.S. average (See chart).



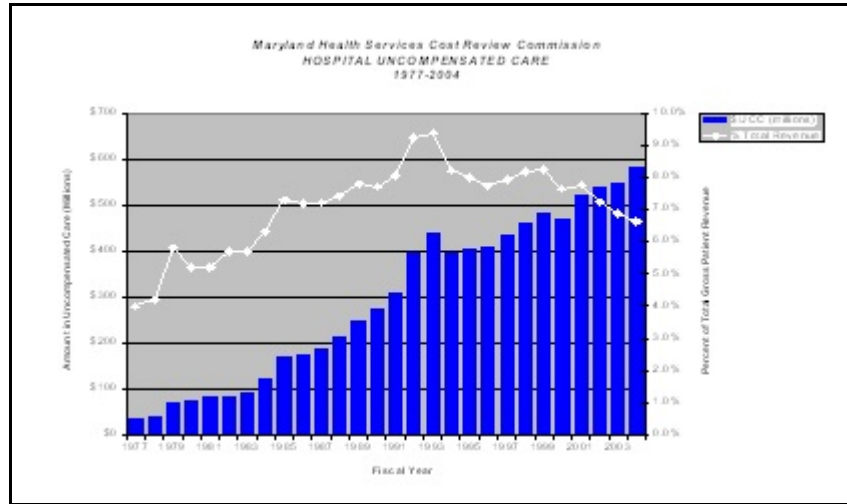
Additionally, from 1977 to 2003, Maryland experienced the second

lowest cumulative growth in cost per adjusted admission of any state in the nation.

Uncompensated Care

The Commission’s annual Disclosure Report showed that the uncompensated care financed through the system again increased from Fiscal Year 2003 to Fiscal Year 2004 to a level of \$583 million. (See chart on Page 3). Uncompensated care financed through the system

decreased slightly from 6.9% in 2003 to 6.6% in 2004. As in years past, approximately 85% of the statewide uncompensated care expenditure originated in Maryland's metropolitan areas.



During FY 2004, the Department of Health and Mental Hygiene (DHMH) reduced funds for hospital payments by establishing day limits for adult Medicaid participants. The Medicaid day limits were to sunset by June 30, 2005. As a cost containment measure, however, DHMH decided to continue the imposition of day limits in State Medicaid reimbursement to acute care hospitals until June 30, 2006. This action causes an increase in uncompensated care for Maryland hospitals. Based on information currently available for CY 04 admissions, the savings to the Medicaid program is expected to exceed \$64 million (\$32 million in state funds, \$32 million in federal funds). Uncompensated care increases are funded in future year hospital rates; however, such an immediate reduction in Medicaid funding impacts short-term hospital cash flow. As a result, the HSCRC approved funding for 80% of the day limit impact to be built into hospital rates prospectively in order to mitigate the effect of Medicaid day limits. This increase in the uncompensated care provision is scheduled to remain in effect until June 2006, when the Medicaid day limit restrictions expire.

Financial Condition of Maryland Hospitals

In addition to its other statutory obligations, the Commission reviews yearly the financial performance of Maryland hospitals.

Over the years, the Commission and the hospital industry have monitored performance relative to certain targets as a means of assessing the overall financial condition of the Maryland hospital industry. In utilizing these targets, however, the Commission and the industry note that no one target, financial or operating, should be viewed as dominant. All targets should be evaluated in conjunction with each other before conclusions can be drawn as to the financial condition of the industry. As the Commission and Maryland hospitals continue the work to attain and balance these targeted levels, it is expected that improved levels of industry financial health will be realized.

For Fiscal Year 2004, Maryland acute hospitals experienced operating (regulated) and excess (total, including unregulated activities) margins of 4.5% and 2.3% respectively, up from 3.5% and 1.5% in Fiscal Year 2003. The current position is well within the range of the desired profitability HSCRC targets for operating and excess margins. These positive results reflect, in large part, Maryland hospitals' fulfillment of their pledge to control their expenses during this period in order to improve the level of profits.

The cost per equivalent inpatient admission for acute hospitals in Maryland was \$7,824, compared with the rest of the nation at \$8,233. Thus, Maryland was approximately 5% below the U.S. average. As a result, Maryland remained within the target of 3-6% below the national level for the cost per EIPA.

Medicare Waiver

Although the State remains in no immediate danger of losing the waiver, we continue to closely monitor our performance on the waiver test and continue to provide both positive and negative incentives to hospitals to improve Medicare utilization. Through the assistance of the Governor's office, and the leadership of the Maryland congressional delegation, the State was successful in November 1990 in modifying the language of Section 1814(b) of the Social Security Act, which determines the ability of Maryland to continue its all-payer hospital reimbursement system. The change in the law allows for a more equitable comparison between Maryland's performance and that of the nation by taking into account savings that have been achieved since January 1, 1981. Language was also incorporated into the waiver test that would allow Maryland three years to come back into compliance with the test if, in the unlikely event, Maryland were ever to fail the rate of increase test. The most recent waiver test information indicates that payment per admission for Medicare patients nationally increased 259% from January 1, 1981, through June 30, 2004, compared to a 222% increase in Maryland over the same time period. As evidenced by the changes to the rate setting system implemented during the current Redesign effort, the Commission will continue to take whatever steps are necessary to assure continuation of our all-payer system.

Redesign of the Rate Setting System

Over the years, the Commission's rate-setting methodologies had been changed to respond to unique hospital situations, to make the system more equitable, and to incorporate more sophisticated measurement tools. These improvements in the Commission methodology are accomplished through a workgroup consisting of representatives from Maryland's hospitals, payers, and business communities. The workgroup functions to maintain access to care, the

system of financing social costs, and the appropriate level of equity and fairness, while keeping Maryland's cost performance in line with the nation.

Maryland's rate-setting system continues to meet the challenges of a changing marketplace while preserving the guiding principles that have helped make Maryland the nation's leader in effectively containing hospital costs.

Transition to APR-DRGs

In June 2004, the Commission initiated a change in policy to improve its measurement of hospital efficiency. Many HSCRC methodologies include adjustments for differences in patient severity (also known as case mix) across hospitals to recognize the additional resources required to treat complex cases. Previously, case mix was measured by using the Center for Medicare and Medicaid Services (CMS) diagnosis related groups (DRGs). However, substantial variation in the costs of treating patients may occur within each DRG. To properly direct resources within the hospital system, the Commission has begun to measure case mix with a severity-adjusted classification system from 3M Health Information Systems. This classification system, or grouper, is the APR-DRG system. Under this grouper, discharges within each DRG are further divided into four severity levels to better measure differences in average patient acuity across hospitals. While the move to this new system will be phased in over time, implementation began on July 1, 2005 (FY 2006). This transition makes Maryland a leader in better measuring hospital revenue usage.

Other Projects

HSCRC Quality Initiative

In October 2003, the Commission established the HSCRC Quality Project to identify issues and lay the groundwork for quality based reimbursement for Maryland hospitals. An

Initiation Work Group, under the leadership of Dr. Trudy Ruth Hall, a Commissioner and practicing physician, has begun work on HSCRC's Quality Initiative design, measures and methodology. The Initiation Work Group is comprised of representatives from the hospital industry, payer groups, academia and research, and federal agencies and will develop recommendations for the HSCRC which will make final decisions regarding the design and incentives. The HSCRC anticipates that the Quality Initiative will be introduced to Maryland hospitals as a pilot program involving a few hospitals and selected measures. After analysis of pilot results and any indicated program refinement, the HSCRC will schedule full Quality Initiative implementation. In the future, an Evaluation Work Group will conduct periodic program assessments to determine if the Initiative is meeting its goals, and recommend ways to continuously update and improve the HSCRC Quality Initiative.

The Maryland healthcare system, under the authority of the HSCRC and the Maryland Health Care Commission (MHCC), continually strives to improve access to appropriate high quality care at reasonable cost. This Initiative, when fully implemented, will represent one of the broadest quality-based reimbursement systems in the nation. The Commission recognizes that the delivery of health care necessarily involves the multiple goals of access to appropriate health care, reasonable cost, and quality.

Patient Safety

During the 2001 Legislative Session, the General Assembly passed the "Patients' Safety Act of 2001" charging the Maryland Health Care Commission, in consultation with the Department of Health and Mental Hygiene, with studying the feasibility of developing a system for reducing incidences of preventable adverse medical events in Maryland including, but not limited to, a system of reporting such incidences. The MHCC subsequently recommended that

one approach to improving patient safety in Maryland was to establish the Maryland Patient Safety Center (MPSC).

In early 2004, the MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) to operate the MPSC. In 2004, the HSCRC received a request as a joint collaboration for financial support of the MPSC through HSCRC rates for the first three years of the project. In the request, the MPSC budget is projected to be \$1.5 million in Year 1, \$1.6 million in Year 2, and \$1.6 million in Year 3. Delmarva, the MHA, and Maryland hospitals had agreed to contribute \$200,000 each to the project for a total infusion of \$600,000 each year.

During its July 2004 meeting, the Commission concurred with the assessment presented in the request of the potential value of the Maryland Patient Safety Center as one component of a broad patient safety initiative in improving the quality of care by reducing adverse health events at Maryland hospitals and nursing homes. The Commission was further intrigued by the future potential for savings in health care costs and health insurance premiums and believes that a successful MPSC will likely lead to hospital cost savings in the future. Reduced errors should result in reduced mortality rates, length of stays, patient acuity, and malpractice insurance costs. This initiative provides a unique opportunity to improve both health care outcomes and, at the same time, reduce costs in the system.

The Commission, therefore, approved recommendations that, in effect, make payers a partner in the initiation of the MPSC by providing funding through hospital rates as “seed” money for the first three years of the project. The Commission believes it is reasonable to expect payers, through hospital rates, to maintain a financial stake in the project since they too

will benefit from long-term cost savings. As a result, the Commission will increase rates to cover 50% of the reasonable budgeted costs of the MPSC for the first three years of the project.

Community Benefit Report

In June 2004, the Commission released its first ever Maryland Hospital Community Benefit Report (CBR), which summarized community benefits reported by individual Maryland hospitals. For FY 2004, Maryland hospitals reported providing a total of over \$580 million in benefits to their communities. Of this, \$252 million was provided in medical education activities, nearly \$150 million in charity care, \$73 million for mission driven health services, \$43 million in community services, \$13 million for donations, \$9 million in community building efforts, \$6 million in foundation community benefit initiatives, \$3.7 million in research efforts, and nearly \$28 million in other Mission Driven Services (or areas which are difficult to neatly account for in any one community benefit service category).

The HSCRC views the CBR as an opportunity for each Maryland hospital to critically examine, evaluate, and report the nature, impact, long term sustainability, and success of community benefit activities. The Commission also views the CBR as a work-in-progress, in part to its start-up nature in first years, but evolving in future years to both keep pace with the changing environment of community benefits and to improve the report's effectiveness as a public policy tool. Given other states' and organizations' experience, it is expected that Maryland's initiative will take several years to mature. For this first CBR, Maryland hospitals and the Commission worked collaboratively with one another and many interested parties, including local health departments and other state and national organizations. The HSCRC commits to continuing this work to further improve the report and to refine definitions as needed.

Commissioners

In July 2003, Mr. Irvin Kues was named to the Commission and was subsequently named Chairman in September 2003. Dr. Samuel Lin was also reappointed to serve a four-year term beginning July 1, 2001, and named Vice-Chairman in May 2004. Additionally, Commissioners Mike Eusebio and Kevin Sexton were appointed to serve four year terms beginning July 2003.

The Commission thanks the Governor's office for the support given us throughout the year. We look forward to working with you and continuing our efforts to improve the hospital rate system and meet our policy objectives in the upcoming fiscal year.

II. REVIEW OF RATE REGULATION ACTIVITIES

A. Closed Docket Proceedings

Disposition of those applications acted upon by the Commission in Fiscal Year 2005 is summarized below. Copies of the applications, staff recommendations, as well as the complete file in these proceedings may be obtained by contacting the Commission's offices.

CATEGORY OF RATE APPLICATION	NUMBER OF APPLICATIONS	DESCRIPTION OF TYPE OF APPLICATION
Full Rate Applications	2	Two requests for approval of an increase to all rates Approved:2
Partial Rate Applications	19	Nine requests for approval of a rate for a new service Approved:9

		Five requests to change a rate from an inpatient only “Rebundled” service, performed by an off-site provider, to a rate for an inpatient and outpatient service provided by the hospital Approved:5
		Two request for capital project funding Approved:2
		One request to combine a hospital’s Pediatric-Acute rate with its Medical/Surgical -Acute rate Approved:1
		One request to combine a hospital’s Definitive Observation-Acute rate with its Medical/Surgical-Acute rate Approved:1
Partial Rate Applications (Continued)		One request to combine a hospital’s Pediatric-Acute and Definitive Observation-Acute rate with its Medical/Surgical-Acute rate Approved:1
Applications for an Alternative method of Rate Determination*	10	Two requests for approval to participate in global fixed price alternative payment arrangements** Approved:2
		Seven requests for approval to participate in capitation alternative payment arrangements**** Approved:7

		<p>One request for special approval to allow a discount to one payer for specified services</p> <p style="text-align: right;">Approved: 1</p>
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***Alternative Method of Rate Determination - COMAR 10.37.10.06**

Under its law, Health-General Article, §19-219, the Commission may promote and approve alternative payment methodologies that are consistent with the fundamental principles inherent in its legislative mandate. This regulation effectuates the statutory authority granted and sets forth the process, reporting requirements, and penalties associated with alternative rate setting.

** Global Fixed Price Arrangement - is an arrangement that fixes a price to be charged to a payer for the combined physician and hospital services for patients who receive a specific service, e. g. transplants or cardiology services.

*** Fixed Price Case Rate Arrangement - is an arrangement that fixes the price to be charged to a payer for hospital services for cases in a particular DRG (diagnoses related group).

**** Capitation Arrangement - is an arrangement in which a fixed monthly payment is made by a payer to cover the costs of all or a specific segment of the health care services for a designated population.

B. Annual Unit Rate and Charge per Case Target Updates

During Fiscal Year 2005, forty-five (45) acute care hospitals and one (1) chronic specialty hospitals participated in the Charge per Case Target rate setting methodology. Effective July 1, 2004, these hospitals were granted, on average, a 4.8% update to the Charge per Case Target, as well as inpatient unit rates. An update factor of 3.8% was applied to all outpatient unit rates.

In recognition of the fact that some hospitals charged above or below predetermined system averages, the update factor was scaled, providing for a range of 4.1% to 5.5%. The scaling was applied in a revenue neutral fashion, thus maintaining the aggregate system wide 4.8% update. Garrett County Memorial Hospital, does not participate in the Charge per Case methodology. Its unit rates are developed in accordance with the Total Patient Revenue (“TPR”) unit rate setting methodology. A hospital must be a sole community provider with a defined population service area, with little or no competition from other acute care hospitals to participate in this method of setting rates. Further, its costs are considered to be 100% fixed.

C. Full Rate Reviews

A full rate review is an extensive analysis of a hospital's unit rate structure, Charge per Case Target, and underlying costs relative to the averages of its peer group. A hospital may file an application for a full review, or the Commission may initiate the review. These reviews are extremely technical, incorporating multiple Commission policies, and must be completed in the specific time frame established by law and regulation. Typically, a hospital files a full rate application to increase its revenue structure. The hospital must submit a detailed description of its request with supporting calculations documenting its efficiency relative to its peer group. Additionally, the hospital requesting the full rate review may attempt to demonstrate why the annual update factor is insufficient to meet its individual financial requirements.

During fiscal year 2005, two hospitals filed and received a full rate review. The following table summarizes the results.

FULL RATE REVIEWS – FISCAL YEAR 2005

HOSPITAL	EFFECTIVE DATE	OVERALL RATE CHANGE
Dorchester General Hospital	November 1, 2004	1.95%
Memorial Hospital of Easton	November 1, 2004	-.17%

D. Spend Down Hospitals

Every hospital's costs and charges are monitored for monthly compliance. Two times each year, all acute care hospitals are subject to the Reasonableness of Charges calculation. Any hospital with charges exceeding its peer group average by three percent (3%) or more is identified as a high cost hospital and must negotiate a Spend Down Agreement with the Commission. These agreements are specific to each hospital and detail the reductions the

hospital must make over a specified time period, usually two years. During fiscal year 2005, the following five (5) hospitals had Charge per Case reductions as a result of their high cost designation.

SPEND DOWN HOSPITALS – FISCAL YEAR 2005

HOSPITAL	EFFECTIVE DATE	REDUCTION
Doctors' Community Hospital	July 1, 2004	.52%
McCready Memorial Hospital	July 1, 2004	.67%
Shady Grove Adventist Hospital	July 1, 2004	.75%
Sinai Hospital	July 1, 2004	.65%
Saint Joseph Medical Center	January 1, 2005	1.04%

III. SYSTEM REFINEMENTS AND CHANGES IN METHODOLOGY

The Research and Methodology Division of the HSCRC is responsible for the research, policy development, and information systems activities of the Commission. The staff devotes considerable time to developing, analyzing, and implementing policy changes to the existing payment system; coordinating activities related to policy development; developing and analyzing alternative methods of rate determination; developing data reporting requirements to ensure that the information needed for policy development and research are available; and conducting research that has policy implications for the Commission and is of general interest to the health services research community. Recent changes, refinements, and reviews are described in the following sections.

A. System Redesign

From 1977 to 1992, Maryland had the lowest growth in cost per adjusted admission in the country. For the subsequent six years, however, Maryland led the nation with the highest growth in cost per adjusted admission. In 1992, the cost per adjusted admission was 13% below the national average; in 1998 and 1999, Maryland was near the U.S. average.

The Commission became increasingly frustrated with its inability to control charge and cost per case, the growing obfuscation of system incentives, and lack of enforcement and control of the regulatory process. Conversely, the hospital industry's frustration was largely centered on the growing complexity of the rate-setting system. This complexity resulted from a variety of factors over time, including Commission policy changes that attempted to improve the rate-setting system. Other modifications, many of which originated from the industry itself, attempted to make the system of comparing hospitals more fair and equitable. All parties were concerned about the lack of stability and predictability within the system.

To reform the system, the HSCRC formed a panel called the "Redesign Work Group" to advise on changes to the system. The group met between September 1999 and January 2000. Included in these discussions were HSCRC Commissioners and staff, industry representatives, payer representatives, labor unions, business leaders, and other interested parties from across Maryland. The Work Group's meetings resulted in a series of recommendations that covered four broad categories: structural changes to the regulatory system, long term goals for industry payment levels, administrative savings to be achieved within the system, and reductions in the complexity of administering the system.

A number of changes were implemented. As of July 1, 2000, the then current rate system was eliminated and replaced with an approach that determined inpatient case targets for each

hospital. The consensus goal of the Redesign Work Group was to develop a system that would gradually outperform the nation in the long run, but at the same time preserve payment stability for Maryland hospitals.

The agreement among the Commission, the hospital industry, and payer representatives was scheduled to run for three years, at which time the effects of the agreement would be assessed and renegotiated as necessary. When the redesign agreement was negotiated, Maryland's net patient revenue per admission was at the national average. At the end of Fiscal Year 2003, the HSCRC estimated that the net patient revenue per case was four percent below the national average. The goal of outperforming the nation was met, but industry profitability was below the national average. The low profitability relative to the nation resulted in greater capital needs in hospitals as the industry's ability to invest was constrained and average age of plant increased.

In preparation for Fiscal Year 2004, a number of workgroups met to address the status of the rate regulatory system, examining issues ranging from the financial status of hospitals to technical details of how hospital efficiency should be measured in the system. While technical details remain open for discussion, a number of broad issues under the original rate redesign agreement were considered and adjusted to reflect the situation three years later. While the goals of the original agreement were fundamentally unchanged, the Commission recognized that the system's improvement relative to the nation was faster than originally intended, leading to weaker-than-expected financial performance. To address this issue, the Commission set a target to be two percent below the nation for net patient revenue per admission at the end of Fiscal Year 2006. This new three year target would result in a temporary erosion of Maryland's position relative to the nation on the Medicare waiver test. At the same time, however, hospitals

would have the opportunity to improve profitability and to increase their investments in facilities, new clinical technology, and new information systems.

B. Changes to the ICC and ROC

The Inter-hospital Cost Comparison (ICC) methodology was developed as a tool for the Commission to assess the adequacy of a hospital's rates in the context of a full review of a hospital's rate structure. As the primary tool in a full rate review, the ICC begins by comparing current charge per case (CPC) targets, adjusting for allowable cost differences across facilities. HSCRC staff compares the adjusted target to a group of peer hospitals to determine if a hospital is eligible for a rate increase during a full rate review. Hospitals with adjusted targets that are more than two percent below the group average are eligible for an increase to raise their rates to two percent below the group average. The subject hospital is also allowed to raise special issues unique to that facility.

Under the ICC methodology, outpatient rates are adjusted for differences in markup, profits, the two percent productivity deduction, and labor market differences before a standard is established for each center in a hospital's peer group. The standard is the median of the adjusted outpatient rates within each outpatient center.

The choice of the median has at times resulted in large swings when the subject hospital under a full rate review is the anomalous hospital in the rate center. Abnormally low rates in the center result in windfalls under the median, while abnormally high rates result in large reductions. To address this issue, the outpatient ICC methodology was revised in April 2003 to identify outlier hospitals within an outpatient rate center and to establish a reasonable standard when the rate is identified anomalous. For hospitals not identified as outliers, the median rate would be applied as the standard for the rate center.

The inpatient portion of the ICC has also been adopted as the tool for identifying hospitals with relatively high charges. Under this version of the ICC policy, charges – not costs – are the subject of the review. While the ICC removes profits from approved charges and imposes a two-percent efficiency standard for hospitals undergoing a full rate review, neither of these adjustments is made under the charge comparison – a policy known as the “Reasonableness of Charges” comparison or the ROC. Under this policy, hospitals that are three percent above their peer group average will be identified as having high charges and targeted for a spend down to reduce their charges relative to their peers. The ROC results are issued twice per year. There were no major changes to the ROC policy in the current year, although a number of issues are currently under review.

In October 2003, the Commission modified its ICC policy to recognize the need for capital in Maryland’s hospitals. The new policy permits hospitals to apply for additional capital costs on a Certificate of Need (CON) approved project through the partial rate application process. The partial rate application allows a study hospital with a reasonable rate structure rate relief associated exclusively with capital, but requires that staff run a modified ICC analysis (both inpatient and outpatient) to limit any additional rate relief to the study hospital. Hospitals that have high charges would likely not pass even a less rigorous ICC standard and, therefore, would not be eligible for this partial rate relief. The ICC standard is applied in the case of a partial rate review for capital but without the 2% productivity adjustment. This result generates rate relief for a hospital with low charges relative to its peers, and/or hospitals that have not undergone a major capital project in a number of years. There is no Phase II ICC analysis associated with this application because the analysis is not a full analysis of the hospital’s rates.

The subject hospital must request a full rate review under the standard ICC process to have such issues considered.

The HSCRC's methodology allows the subject hospital to project capital costs as reflected by the depreciation and interest associated with the CON approved project and the projected routine annual capital replacement over the project period. Additionally, the Commission requires that the hospital:

- acquire an approved CON for the requested project expenditures;
- keep its request limited to the regulated expenditures for which the CON was granted;
- be provided a 'ceiling amount' of rate relief that could be granted through the partial rate application; and
- meet the HSCRC ROC criteria.

If the study hospital meets the above criteria, it would be able to receive 50% of its own capital costs and 50% of its peer group capital.

In June 2004, the Commission also initiated a change in policy to improve its measurement of hospital efficiency. As noted above, the ICC and ROC include adjustments for differences in patient severity (also known as case mix) across hospitals to recognize the additional resources required to treat complex cases. In the Maryland system, case mix has been measured by using a modified version of the Center for Medicare and Medicaid Services' (CMS) diagnosis related groups (DRGs). However, substantial variation in the costs of treating patients may occur within each DRG. To properly direct resources within the hospital system, the Commission will begin to measure case mix with a severity-adjusted classification system from 3M Health Information Systems. This classification system, or grouper, is the APR-DRG

system. Under this grouper, discharges within each DRG are further divided into four severity levels to better measure differences in average patient acuity across hospitals.

The Commission begins its use of APR-DRGs in FY 2006. The Commission established FY 2005 as a base period for improving data reporting. While the reporting requirements for diagnosis and procedures are the same under the CMS DRGs and the APR-DRG grouper, the latter is more sensitive to complete coding of a patient's medical record. Because this reporting affects the revenue each hospital receives, the Commission has initiated an annual audit procedure to verify the accuracy of hospitals' reported coding. In FY 2005, each hospital will engage an auditor and provide an audit report to the Commission. In FY 2006, the Commission will use its own auditor to examine coding in a large sample of cases across the industry.

The transition to this refined method for measuring hospitals' patient acuity requires a number of other changes in the system. The most significant of these changes is the manner in which case weights are calculated. Case weights are the values that, in effect, establish the reimbursement associated with each case. Traditional methods for establishing these weights have overvalued some services and undervalued others. While the change in weight calculation is highly technical, the Commission adopted this new methodology in tandem with the introduction of APR-DRGs to provide a refined case mix system with the appropriate incentives across types of hospital services.

Other elements of social costs recognized by the rate setting system depend on how case mix is measured. Costs associated with disproportionate share (an adjustment for hospitals serving a large poor population) and indirect medical education are affected by the degree to which differences in patient acuity are captured by the case mix index. The Commission's methodologies must be revised to account for these differences, but revisions may not be

completed until the industry has improved its coding. Essentially, the results will not be stable until a stable level of coding has been reached across the state's hospitals. Consequently, the Commission has placed a moratorium on hospital full rate reviews and relative hospital comparisons under the Reasonableness-of-Charges analysis from November 1, 2005 through November 1, 2007. As further protection to the system during this transition, the Commission will not recognize full case mix growth during FY 2006 and will limit the case mix growth it recognizes by a predetermined formula. This limit reflects the expectation that coding improvements will result in higher measured acuity without commensurate increases in resource use.

C. Uncompensated Care Regression and Policy

The Uncompensated Care Regression and Policy is used annually determine the amount of bad debt to be included in hospital rates. At the core of this policy is a regression equation that is used to determine the expected level of uncompensated care for each hospital. The regression was last amended in June 2002 to improve its explanatory power. Under the previous regression model, two variables were used: the percentage of Medicaid patient days, and the percentage of patient days from non-Medicare patients admitted through the emergency room. Because a number of hospitals were consistently underfunded or over-compensated by the policy, the Commission altered the first variable (percentage of Medicaid patient days) to include Medicaid, charity care, and self-pay patient days. This change increased the explanatory power of the regression by about ten percentage points. The new policy was phased in for fiscal year 2003 rates by averaging the results of the old policy with the new policy. The new methodology now forms the basis of the regression for determining the level of uncompensated care in rates.

During FY 2004, in response to cuts in its budget, the State's Medicaid program implemented hospital day limits—a maximum number of days for which Medicaid would pay for a hospital stay. This Medicaid policy affected hospitals because the HSCRC uncompensated care policy is designed to work with a lag in recognizing changes in actual uncompensated care experienced by hospitals. Hospitals would be expected to bear the cost of these program cuts without any relief under the Commission's uncompensated care policy until reported uncompensated care began to rise and be recognized in accordance with the normal procedures.

Given the Commission's concerns around industry profitability and the need for recapitalization, the uncompensated care policy was amended to prospectively recognize a portion of the impact of the day limits. The Commission recognized 80 percent of the incremental uncompensated care due to the Medicaid cuts, requiring the hospital to fund only 20 percent of the shortfall through the usual uncompensated care policy. Further, the Commission allowed hospitals with financial need to seek relief through a partial rate application to request the additional 20 percent.

The hospital day limits were expected to sunset in FY 2005, but continued budgetary pressures led the Medicaid program to extend hospital day limits to FY 2006. The Commission continued its recognition of the program's impact by extending the prospective funding of the day limit impact for FY 2006.

D. Uncompensated Care Fund

In Fiscal Year 2005, the Uncompensated Care Fund continued operating. A total of approximately \$ 62 million was redistributed to high uncompensated care hospitals, allowing the uncompensated care mark-up in hospital rates to be no higher than 7.9% for any hospital during the first six months of the fiscal year.

E. Nurse Support Program (NSP)

To facilitate and encourage the implementation of hospital-based initiatives designed to increase the number of nursing professionals providing patient care in the State, the HSCRC initiated the Nurse Support Program effective July 1, 2001. Hospitals are eligible to receive up to 0.1% of their gross patient revenue per year, to be provided through hospital rate adjustments for approved projects that addressed the individual needs of the hospitals as they relate to nurse recruitment and retention. In fiscal year 2005, \$1.5 million of Nurse Support Program funds were distributed to 50 acute care and specialty hospitals in Maryland. An additional \$138,671 million of NSP funds supported the participation of 89 clinical managers from 18 Maryland hospitals in the Maryland Healthcare Educational Institute Clinical Manager Leadership Institute.

F. Hospital Discharge Data

1. Inpatient Discharge Database:

The HSCRC Inpatient Discharge Database is considered to be one of the most accurate, complete, and timely statewide hospital discharge data sets in the country. Maryland hospitals are required to submit inpatient discharge data to the HSCRC within 45 days following the close of each quarter. The data include demographic, clinical, and charge information on all inpatients discharged from Maryland general acute hospitals. The database is used extensively for hospital rate setting purposes, by other state agencies for health planning, program development, and evaluation functions, and is also used by individuals throughout the State and the country for various research projects.

2. Ambulatory Surgery Database:

Since October 1987, the Commission has collected patient level ambulatory surgery data from hospitals. The ambulatory surgery database includes demographic, clinical, and charge information for all patients that receive hospital-based outpatient surgery services. Hospitals submit ambulatory surgery data to the HSCRC within 60 days following the close of a quarter. The collection of this data supports the HSCRC's intention to develop an outpatient rate setting tool based on the clinical classification of data.

3. Ambulatory Care Database:

The Ambulatory Care Data Reporting Regulations, effective April 1, 1997, allow the Commission to collect demographic, clinical, and charge information on hospital-based clinic and emergency department services. Hospitals submit ambulatory care data to the HSCRC within 60 days following the close of a quarter. The collection of this data supports the HSCRC's intention to develop an outpatient rate setting tool based on the clinical classification of data.

4. Chronic Care Database:

The Chronic Care Data Reporting Regulations, effective January 1, 2003, allow the Commission to collect demographic, clinical, and charge information on hospital-based chronic care services. Hospitals submit chronic care data to the HSCRC within 60 days following the close of a quarter. The HSCRC anticipates the development of a chronic care rate setting methodology based on the data collected in this database.

IV. AUDITING AND COMPLIANCE ACTIVITIES

A. Auditing Activities

A set of specific audit procedures prescribed by the Commission, known as the “Special Audit,” is performed annually at each hospital by an independent certified public accounting firm. The Special Audit tests the various data submitted by the hospitals to the Commission in their Annual Reports of Revenue, Expenses and Volumes, Annual Wage and Salary Survey, Statement of Changes in Building and Equipment Fund Balances, Monthly Reports of Achieved Volumes, and Quarterly Uniform Hospital Discharge Abstract Data Set. The Special Audit is designed to assure the Commission that the data are being reported in a uniform and consistent format, and that the reports are accurate.

B. Monitoring Activities

During Fiscal Year 2005, the Commission staff continued to use the Monthly Report of Rate Compliance (Schedule CS) as its primary tool for monitoring hospital charging compliance. An expanded Quarterly Financial Statement Summary (Schedule FS) and the hospitals’ audited financial statements continue to be used to monitor hospital solvency. The Commission continued the policy of reviewing the performance of the Maryland hospital industry on an ongoing basis.

In addition, significant transactions between hospitals and related entities continue to be reported to the Commission on an annual basis. Both the policy of reviewing the financial performance of the Maryland hospital industry and the reporting of transactions between hospitals and related entities were adopted in response to recommendations made by a joint Commission and Maryland Hospital Association committee established to study the financial condition of Maryland hospitals.

**V. ACTIVITIES AFFECTING HEALTH SERVICES COST REVIEW
COMMISSION'S REGULATIONS**

Over the past fiscal year, the Commission proposed and adopted amendments to a number of existing regulations.

COMAR 10.37.01

This regulation concerns the Commission's Uniform Accounting and Reporting System for Hospitals. On December 1, 2004, the Commission proposed to adopt amendments to Regulation .02. This amendment updates the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management"(August 1987) with Supplement 15 (August 1, 2005), which has been incorporated by reference.

In addition, the Commission adopted amendments to Regulation .03 on May 4, 2005. The purpose of this action is to require hospitals to file a wage, salary, and fringe benefits summary (WSC) schedule, and to extend the time frame for reporting all annual reports of wage and salary survey information from April to June.

COMAR 10.37.04

This regulation concerns the Submission of Hospital Ambulatory Care Data Set to the Commission. On June 1, 2005, the Commission adopted amendments to Regulations .03 and .04. The purpose of this action is to replace the managed care payer dictionary with a more expanded and refined health plan payer dictionary that includes commercial payers, behavioral health payers, health maintenance organization payers, point of service plan payers, etc.

COMAR 10.37.06

This regulation concerns the Submission of Hospital Discharge Data Set to the Commission. During the fiscal year, there were several amendments made to this regulation's

rules associated with the collection and submission of data, the discharge abstract data elements, and the tape layout format. The first change, proposed on November 29, 2004 and adopted on February 2, 2005, concerned the repeal of existing Regulation .01 and new Regulation .01. The purpose of this action is to formally add the submission of reconciliation of inpatient data between the discharge data and the financial data as a reporting requirement.

The second change, proposed by the Commission on March 2, 2005 and adopted on June 1, 2005, concerned amendments to Regulations .02 and .03. The purpose of this action is to replace the managed care payer dictionary with a more expanded health plan payer dictionary, and to expand and refine the admission source and discharge disposition to capture patient movement between facilities, and between distinct part units of the same facilities. A list of facilities was added to the regulation to aid in this effort.

COMAR 10.37.07

This regulation concerns the Submission of Hospital Ambulatory Surgery Data Set to the Commission. On June 1, 2005, the Commission adopted amendments, with non-substantive changes, to Regulations .02- .04. The purpose of this action is to replace the managed care payer dictionary with a more expanded and refined health plan payer dictionary that includes commercial payers, behavioral health payers, health maintenance organization payers, point of service plan payers, etc.

COMAR 10.37.10

This regulation concerns the Commission's Rate Application and Approval Procedures. During the past fiscal year, the Commission adopted, on October 13, 2004, an amendment to Regulation .01 and new Regulation .03-1, which it proposed for adoption on July 7, 2004. The purpose of this action is to clarify the process involved in the review of a partial rate application.

Also, on January 31, 2005, a proposed amendment to Regulation .04-1, which was originally proposed by the Commission on November 5, 2003, was withdrawn by operation of law. The purpose of this proposed, but not adopted regulation, was to describe in writing the Commission's practice of establishing a cost standard for reasonableness during the course of a full rate review.

VI. LEGISLATION AFFECTING THE HEALTH SERVICES COST REVIEW COMMISSION'S ENABLING ACT

A number of bills of interest to the Commission were introduced during the 2005 session of the General Assembly:

House Bill 147

This bill, entitled Budget Reconciliation and Financing Act of 2005 (BRFA), would permit the Secretary of DHMH to assess an administrative charge to the HSCRC, for FY 2006 only, consistent with the indirect cost charge assessed to federal grants to fund services provided to the Commission by the Executive Branch (equal to 32% of salaries, or approximately \$674,000). In addition, the bill limits the indirect costs assessment and increases the user fee cap to \$4.5 million for FY 2006 only. The bill would also require DHMH, in consultation with the HSCRC and others, to study the impact of using academic health centers on the HealthChoice Program. (Passed; Enrolled, Chapter 444)

House Bill 344

This bill, entitled Safe Nurse Staffing for Quality Care, would require a hospital to ensure direct care nursing staff meet the individual care needs of patients; and require each hospital to annually submit to DHMH a nurse staffing plan and a certification of the plan. (Withdrawn)

House Bill 345

This bill, entitled Hospital Summary Financial Statement- Physicians Charges, would require a hospital to include in a summary financial information statement information regarding how charges for services rendered by a physician will be billed separately from total hospital charges. (Passed; Enrolled, Chapter 204)

House Bill 366

This bill, entitled Prescription Drugs- Price Controls, would require the HSCRC to regulate prices at which pharmaceutical manufacturers may sell prescription drugs; require the Commission to periodically participate in or do analyses and studies that relate to prescription drug costs; and prohibit the Commission from including the amount of a penalty in the cost of a prescription drug for the purpose of regulating the price of the drug. (Failed)

House Bill 426

This bill, companion to SB 231, entitled Freestanding Medical Facilities- Licensing and Pilot Project, would establish a new category of facility in the State entitled “Freestanding Medical Facility”(FSMF); require DHMH to adopt regulations for licensing a specified freestanding medical facility; require the MHCC, in consultation with HSCRC and DHMH,, to establish regulations by July 1, 2008 for a review process to approve facilities that may seek licensure as a FSMF including efficiency, effectiveness, cost, equipment and staffing standards; establish a FSMF Pilot Project for one facility to operate by a certain hospital system located in Montgomery County without a CON; the Pilot Project facility would be reimbursed at rates consistent with a contract reached between the payer and facility, and Medicaid would be required to pay based on Medicare rates. In addition, the HSCRC and MHCC would be required to report to the General Assembly by January 2008 on operations, utilization and financing relating to the Pilot Project; and the

HSCRC and the hospital are required to report to the General Assembly by October 2005 on progress in the facility obtaining provider-based status from the Center of Medical Services.

(Passed; Enrolled, Chapter 549)

House Bill 627

This bill, companion to SB 716, entitled Community Health Care Access and Safety Net Act of 2005, would require the HSCRC to develop a uniform financial assistance policy for hospitals to provide free and reduced-cost care to “low-income” patients who lack health care coverage; establish the Maryland Community Health Resources Commission as an independent commission that functions within DHMH to increase access to health care through community health resources; alter the eligibility requirements of the Maryland Pharmacy Discount Program to cover individuals who are not Medicaid beneficiaries, who lack other public or private prescription drug coverage, and who have a specified annual household income, and to exclude Medicare beneficiaries. In addition, the bill would require the HSCRC and MHCC to jointly assess the level and underlying causes of uncompensated and under-compensated physician care for physicians who provide a minimum of 25% of their services in a hospital setting system for Medicaid; to make recommendations on alternative methods of distributing the reasonable costs of uncompensated and under-compensated physician care, and the feasibility of establishing an uncompensated and under-compensated care physician care fund. (Passed; Enrolled, Chapter 280)

House Bill 738

This bill, companion to SB 607, entitled Health Care Facilities- Certificate of Need- Obstetric Medical Services, would remove obstetric medical services from the requirements for Certificate of Need for health care facilities issued by the MHCC. (Failed)

Senate Bill 231

This bill, companion to HB 426, entitled Freestanding Medical Facilities- Licensing and Pilot Project, would establish a new category of facility in the State entitled “Freestanding Medical Facility”(FSMF); require DHMH to adopt regulations for licensing a specified freestanding medical facility; require the MHCC, in consultation with HSCRC and DHMH, to establish regulations by July 1, 2008 for a review process to approve facilities that may seek licensure as a FSMF including efficiency, effectiveness, cost, equipment and staffing standards; establish a FSMF Pilot Project for one facility to operate by a certain hospital system located in Montgomery County without a CON; the Pilot Project facility would be reimbursed at rates consistent with a contract reached between the payer and facility, and Medicaid would be required to pay based on Medicare rates. In addition, the HSCRC and MHCC would be required to report to the General Assembly by January 2008 on operations, utilization and financing relating to the Pilot Project; and the HSCRC and the hospital are required to report to the General Assembly by October 2005 on progress in the facility obtaining provider-based status from the Center of Medical Services. (Passed; Enrolled, Chapter 550)

Senate Bill 607

This bill, companion to HB 738, entitled Health Care Facilities- Certificate of Need- Obstetric Medical Services, would remove obstetric medical services from the requirements for Certificate of Need for health care facilities issued by the MHCC. (Withdrawn)

Senate Bill 716

This bill, companion to HB 627, entitled Community Health Care Access and Safety Net Act of 2005, would require the HSCRC to develop a uniform financial assistance policy for hospitals to provide free and reduced-cost care to “low-income” patients who lack health care

coverage; establish the Maryland Community Health Resources Commission as an independent commission that functions within DHMH to increase access to health care through community health resources; alter the eligibility requirements of the Maryland Pharmacy Discount Program to cover individuals who are not Medicaid beneficiaries, who lack other public or private prescription drug coverage, and who have a specified annual household income, and to exclude Medicare beneficiaries. In addition, the bill would require the HSCRC and MHCC to jointly assess the level and underlying causes of uncompensated and under-compensated physician care for physicians who provide a minimum of 25% of their services in a hospital setting system for Medicaid; to make recommendations on alternative methods of distributing the reasonable costs of uncompensated and under-compensated physician care, and the feasibility of establishing an uncompensated and under-compensated care physician care fund. (Passed; Enrolled)

VII. STATUS OF LITIGATION INVOLVING THE HEALTH SERVICES COST REVIEW COMMISSION

Over the past fiscal year, the Commission and hospitals were able to resolve all disagreements within the administrative process.

VIII. ACTIVITIES ASSOCIATED WITH IMPLEMENTATION OF HEALTH SERVICES COST REVIEW COMMISSION ALTERNATIVE METHODS OF RATE DETERMINATION

During the past fiscal year, the Commission had the opportunity to consider proposals from hospitals seeking alternative methods of rate determination, pursuant to the provisions of Health-General Article, §19-219, Annotated Code of Maryland and COMAR 10.37.10.06. Under its law, the Commission may promote and approve experimental payment methodologies that are consistent with the fundamental principles inherent in the Commission's legislative mandate. The applications for alternative methods of rate determination fell into one of four

general categories: 1) ambulatory surgery procedure-based pricing; 2) global pricing or case rate arrangements for selected inpatient procedures; 3) partial capitation or risk sharing arrangements; and 4) full capitation.

IX. ACTIVITIES ASSOCIATED WITH IMPLEMENTATION OF HEALTH SERVICES COST REVIEW COMMISSION ALTERNATIVE METHODS OF FINANCING HOSPITAL UNCOMPENSATED CARE

In September of 1996, the HSCRC approved a methodology that spreads the costs associated with uncompensated care more evenly across all hospitals in the State. The methodology called for an assessment of .75% to be made against all hospitals, with those funds being redistributed to hospitals that treat a higher proportion of Maryland's uninsured citizens. Regulations implementing this plan, embodied in COMAR 10.37.09, "Fee Assessment for Financial Hospital Uncompensated Care," became effective on February 10, 1997. On May 1, 1997, all hospitals began making payments into the Uncompensated Care Fund. All funds collected in May and June of 1997 were used to establish the reserve fund account of the Uncompensated Care Fund. On July 1, 1997, the HSCRC began disbursing funds to hospitals that treat a higher portion of uninsured citizens. During the last fiscal year, the Uncompensated Care Fund successfully assessed all hospitals .75% and distributed the funds that were collected to hospitals with high uncompensated care percentages.

FORMER COMMISSIONERS

<u>Former Commissioner</u>	<u>Appointed</u>	<u>Term Expired</u>
John A. Whitney, Esq.	July 19, 1971	June 30, 1972
Sidney A. Green	July 19, 1971	June 30, 1978 (Resigned)
George J. Weems M.D.	July 19, 1971	June 30, 1978 (Resigned)
Mancur Olson, Ph.D	July 19, 1971	June 30, 1977
Bernard Kapiloff, M.D.	July 19, 1971	June 30, 1977
P. Mitchell Coale ¹	March 31, 1976	June 30, 1978 (Resigned)
W. Orville Wright	January 25, 1972	June 30, 1979
Alvin M. Powers	July 19, 1971	June 30, 1979
Natalie Bouquet	October 31, 1972	June 30, 1980
Gary W. Grove	June 29, 1979	June 30, 1983
John T. Parran ²	July 8, 1977	June 30, 1982
Stephen W. McNierney ³	February 8, 1983	June 30, 1986 (Resigned)
Carville M. Akehurst ⁴	June 29, 1979	June 30, 1983
David P. Scheffenacker	September 6, 1977	June 30, 1985
Roland T. Smoot, M.D. ⁵	July 12, 1978	June 30, 1986
Carl J. Schramm, Esq. ⁶	July 8, 1977	June 30, 1985
Richard M. Woodfin ⁷	August 28, 1983	June 30, 1986
Don S. Hillier ⁸	February 24, 1982	June 30, 1987
Earl J. Smith ⁹	August 29, 1983	June 30, 1987
Virginia Layfield	June 30, 1980	June 30, 1988
Walter Sondheim, Jr.	July 1, 1987	June 30, 1991 (Resigned)
Ernest Crofoot	September 6, 1985	June 30, 1989

¹ Appointed to fill unexpired term of Sidney Green, resigned.

² Appointed to fill unexpired term of George J. Weems, M.D., resigned.

³ Appointed to replace John T. Parran, who continued to serve beyond his appointment.

⁴ Carville M. Akehurst was appointed by the Governor to Chair the Maryland Health Resources Planning Commission and by law had to leave the Health Services Cost Review Commission.

⁵ Appointed to fill the unexpired term of P. Mitchell Coale.

⁶ Carl J. Schramm, Esq. continued to serve as Acting Chairman beyond his appointment.

⁷ Appointed to fill the unexpired term of Stephen W. McNierney.

⁸ Appointed to fill the unexpired term of Gary W. Grove.

⁹ Appointed to fill the unexpired term of Carville M. Akehurst.

Richard G. Frank, Ph.D.	October 6, 1989	June 30, 1995 (Resigned)
Barry Kuhne	July 1, 1987	June 30, 1994
William B. Russell, M.D.	July 3, 1986	June 30, 1994
James R. Wood	July 1, 1987	June 30, 1995
Susan R. Guarnieri, M.D.	March 16, 1988	June 30, 1996
Charles O. Fisher, Sr.	April 28, 1986	June 30, 1997
C. James Lowthers	July 16, 1990	June 30, 2001
Willarda V. Edwards, M.D.	July 1, 1994	June 30, 2002
Dean Farley, Ph.D. ¹⁰	July 1, 1994	June 30, 2003
Philip B. Down	July 1, 1995	June 30, 2003
Dale O. Troll	July 1, 1994	June 30, 2003

¹⁰ Dean Farley, Ph.D., continued to serve as Vice Chairman beyond his appointment.

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