STATE: **MARYLAND, Health Care Commission (Add'l: Health Services Cost Review Commission)**

WEBSITE: http://mhcc.maryland.gov/mhcc/default.aspx

Criteria	Description	Source
What facilities or equipment reviewed (i.e., urgent care, insurance companies)	Health Care Facilities: a. Hospital b. Limited service hospital c. "related institution" (maintains facilities and equipment to provide domiciliary, personal, or nursing care for 2 or more unrelated individuals who are dependent on nursing care or the subsistence of daily living) or (ii) Admits or retains the individuals for overnight care) [§19-301] d. Ambulatory surgery facility e. Inpatient rehab of disabled f. Home health agency g. Hospice h. Freestanding medical facility (med and health services are provided that is physically separate from a hospital or its grounds and is an admin part of hospital) [§19-3A-01] Does not look at hospital mergers or community health centers	MD HEALTH GEN §19-114(d)(1)
What actions reviewed	1. Building, developing or establishing a new health care facility; 2. Moving an existing health care facility to another site, with exceptions (e.g., relocations to within the same county) 3. Changing the type or scope of any health care service offered by a health care facility, where the change a. Establishes a new medical service; b. Establishes a new open heart surgery, organ transplant surgery, burn treatment, or neonatal intensive care program; c. Establishes a new home health agency, general hospice care program, or freestanding ambulatory surgical facility; d. Builds or expands ambulatory surgical capacity in any setting owned or controlled by a hospital, if the building or expansion would increase the surgical capacity of the State's health care system; e. Results in: The establishment of a new subunit by an existing home health agency; (ii) The expansion of a home health agency into a jurisdiction not included in a previous Certificate of Need; or (iii) A transfer of ownership of a subunit or a facility based home health care service of an existing health care facility that separates the ownership of the subunit from the home health agency or home health care service that established the subunit; f. Closes an existing medical service, except as provided in Regulation .03 or .04 of this chapter, or is a temporary de-licensure that meets the requirements of Regulation .03C of this chapter; g. Closes an existing health care facility or converts it to a non-health-related use, with the exception of: i. The closure of an acute general hospital or its conversion to a limited service hospital, as provided in Regulation .03 or .04 of this chapter; or ii. The temporary de-licensure of a health care facility that meets the requirements of Regulation .03C of this chapter;	MD HEALTH GEN §19-120; Code of Maryland Regulations 10.24.01.01

	4. Capital expenditures exceeding $10 million for a hospital, $5 million for non-hospital; exception for the purchase of major medical equipment 5. Change the bed capacity at a health care facility	
Exceptions	Closure of a hospital or part of a hospital does not require a CON, only notification, so long as, in certain instances, a public information hearing is held.	
Decisions	No denials or agreed settlements; hold a "status conference" to encourage applicants to modify applications as needed to make them approvable.	Phone interview
Hospitals, systems and population	Approximately 46 hospitals in 8 systems; 21 independent hospitals Population: 6,006,401	Phone interview
What are the criteria considered & how defined (i.e., "clear public need")	1. Relevant State Health Plan standards, policies and criteria 2. Need – based either on the need described in the state health plan or whether the applicant has demonstrated unmet needs of the population to be served and established that the proposed project will meet those needs 3. Availability of cost-effective alternatives - may look at cost effectiveness of the service through alternative existing facilities or through a competitive application that was also submitted 4. Viability of the project – taking into consideration financial resources and community support 5. Compliance with previous CONs 6. Impact on existing providers	
Application fee		
Decision maker (i.e., review panel, Deputy/Commissioner)	Voting commission; Commission members all have connection to the health care industry (doctors, insurance industry execs, health economists); HCC staff makes recommendations to the Commission members.	Commissioners; Phone interview
Experts	Starting to use financial experts, could use more; not charged back to the applicant.	
Scheduling/Timeline (i.e., batching? expedited, etc.)	Batching – applicant submits a letter of intent prior to meeting with CON staff; review compares applications for the same type of service in the same area.	
Public Hearings	Have evidentiary hearings and public hearings for terminations where there are fewer than 3 other providers in the jurisdiction (the county);	Phone interview
Planning	Use Plan to set stage for what's trending and establish broad goals. Additionally, sets standards for CON review that are type-specific (obstetrics, home health care, etc.)	http://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_shp/hcfs_shp.aspx
Enforcement	CON recipients report every 3 months during project implementation; Must return for a modification if project will exceed approved expenditure limit; No penalty provision; Considers compliance with past decisions on every application back to the 1990s and looks at quarterly progress reports submitted during the implementation phase of a project and whether/how many modification requests were submitted. May revoke CONs but rarely do so.	Phone interview

Quality of Care	Quality of care assessments are incorporated into the rate setting equation. Look at quality measures including: mortality rates, patient services, readmission rates, administrative claims data, infection incidents, patient complaints, AHRQ info (www.ahrq.gov) and investments in population care. 19 Hospital Quality Alliance (HQA) process measures for heart attack, heart failure, pneumonia, and surgical infection prevention were used in the Initiative. 10% of potential revenue allotment is based on quality assessment. MHCC also bases hospital rates on hospital-acquired conditions (such as infections that the patient did not have upon admission to the hospital); MHCC compares expected incidents to actual number of observed incidents and sets rates accordingly. Provides both an incentive to meet pre-set reduction targets as well as information and data on which hospitals can base their reduction strategies.	Phone Interview http://www.hscrc.state.md.us/init_qi_qbr.cfm http://www.hscrc.state.md.us/init_qi_MHAC.cfm
Data	MHCC collects data directly from health care facilities and insurance companies; requests and maintains data from quality reporting organizations, the Centers for Medicare & Medicaid Services, and Maryland and Washington DC Hospitals; the Medical Care Data Base (MCDB), which is Maryland's All Payer Claims Database (APCD). The MCDB is comprised of enrollment, provider, and claims data for Maryland residents enrolled in private insurance, Medicare, or Medicaid Managed Care Organizations. The MCDB supports estimates of cost and utilization, policy analyses, and evaluations of demonstration programs, and is a decision support tool for State partners, such as the Maryland Insurance Administration and the Health Services Cost Review Commission.	Health Data and Quality website, access to databases http://www.hscrc.state.md.us/hsp_Data1.cfm
Rate Setting	Program: Health Services Cost Review Commission comprised of 7 unpaid, appointed Commissioners from the hospital industry (business, union leaders, CMS, former secretary of health, hospital rep and doctor) statutorily tasked with: 1. Certifying costs of a facility are reasonable; 2. Setting rates that reflect the cost of that service (taking into consideration uncompensated care and medical education); 3. Setting rates without "undue discrimination or preference"; 4. Setting rates prospectively; 5. Including a provision in rates for reasonable uncompensated care. 37 full time employees dedicated fully to rate setting and supporting the Commissioners, including rate setters, policy analysts, admin and IT assist Goal: ensure benefits of hospital consolidation while avoiding unnecessary increases in costs to consumers/payers; Primary policy goals: 1. Efficiency and cost containment; 2. Maintaining access; 3. Equity and fairness; 4. Accountability; 5. Financial stability/sustainability; 6. Effectiveness. Rates apply to: all payers equally—no independent negotiating prices between hospitals and private insurers—including Medicaid (however Medicaid receives 6% discount rate); rates are set for all of the hospitals, with the exception of several small specialty hospitals. Does *not* apply to physicians despite trend of hospital systems acquiring group practices—this is not currently a concern, though, as MD physician fees tend to be lower than in other states. Approach: "global budgets" are set for each hospital, taking into account historically approved revenues based in part on the hospital size, whether it is a teaching hospital, and historic utilization; If volume decreases, hospital may raise rates to maintain its global budget. Adjustments to the global budget can be made for inflation, population growth, and market shifts. Additionally, hospitals may submit applications to modify its global budget if it believes it is	"Maryland All-Payer Hospital Payment System" PowerPoint presentation (2013) Phone interview

	inadequate or in anticipation of particularly large capital projects and the hospital currently is charging rates below its comparable peer group. Also applies quality-based reimbursement payment adjustments. Uncompensated care: hospitals permitted an "add-on rate" to generate funds sufficient to cover uncompensated care <u>Data Collected</u>: daily hospital services ● ambulatory and admission services ● ancillary services ● supplemental birth schedules ● days/beds over capacity ● ambulatory visits ● Gross Patient Revenue by rate center ● Unit Rate Compliance Schedules ● unaudited financial data ● <u>Benefits</u>: - Lowered costs – in 1976 Maryland's cost per case was 25% above the US average; in 2010 cost per case was 3% below the US average - All payers contributing equally to financing uncompensated care - Favorable hospital bond ratings - Have experienced early entry of new procedures/medical technologies to the state as limiting the mark-up on supplies/keeping costs down encourages coverage by insurers MA and NY previously engaged in rate setting; VT, PA, HI, NJ have inquired into rate setting and are considering implementing program	
Other	Health Care Commission has several divisions within it: 1. Planning and analyzing CONs; 2. Helping proliferate medical homes; 3. Maintaining electronic records; 4. Data analysis. HCC additionally has an information-providing function in which it publishes insurance information to consumers and conducts special studies as requested by the legislature.	Phone interview