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VIA EMAIL: eileen.fleck@maryland.gov

Ms. Eileen Fleck
Chief of Specialized Services
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Ref: State Health Plan for Facilities and Services,
Freestanding Medical Facilities, COMAR 10.24.19

Dear Ms. Fleck:

The current regulations prescribe toothless information hearings that do not fulfill the intent of the General Assembly. The proceedings will be empty *pro forma* rituals unless the regulations provide for the availability of independent information to empower effective local participation and a local governmental role that is analogous to the responsibilities that the regulations accord to the Maryland Institute for Emergency Medical Service Systems (MIEMSS).

The preparation of objective studies of the impact of any proposed major change in hospital services should be the rule in Maryland rather than an exception resulting from special interest legislation. Moreover, the constrained role of the City of Takoma Park as a limited party resulted in a crippled Takoma Park medical campus that almost surely will be abandoned in five years, discouraging future compromises between local governments and hospitals. The regulations should require that hospital relocations and downsizings only leave behind sustainable facilities.

Encouraging the integration of Freestanding Medical Facilities (FMF) and urgent care centers would provide Maryland patients with a wider choice of necessary medical options, fostering state medical goals of reducing the unnecessary use of emergency facilities and promoting the establishment of long-term primary care relationships. Consequently, modified regulations should require integrated emergency and urgent care centers unless proponents of isolated urgent care centers provide compelling documentary evidence of the efficacy of a segregated facility. Moreover, the MHCC should not continue to prescribe conditions for the maintenance of standalone urgent care facilities in the absence of legal authority to regulate such facilities.

Integrated Emergency and Urgent Care Centers Should be Incentivized

The FMF regulations should be revised to encourage the licensing of combined freestanding Emergency and Urgent Care Centers (EUCCs) by at least requiring applicants to establish that any proposed isolated urgent care center will prove to be efficacious.

It was inappropriate for the MHCC to approve a proposed Takoma Park urgent care facility cavalierly in the face of unanswered historic documentation submitted by Holy Cross Hospital detailing that an isolated Takoma urgent care center is no more likely to serve the needs of existing ER users than the 40 existing local urgent care centers that collectively have failed to make a dent in county ER usage. The finding that "I do not conclude that it is appropriate to require AHC [Adventist Healthcare] to commit to a more expensive form of urgent and emergency care delivery, the freestanding medical facility model, at this time," additionally flies in the face of the competent evidence submitted by the City of Takoma Park that the urgent care center would be unlikely to serve up to 75% of the 48,000 patients presently utilizing the WAH ER annually. Response, p. 3.

Without holding an evidentiary hearing or seeking an impact study, the reviewer uncritically leapt to the unwarranted conclusion that a geographically segregated Takoma urgent care clinic would be frequented by most of the lower acuity patients presently served by WAH emergency services, just because it is going to be operated by WAH at the same location as the prior ER. White Oak Decision, p. 38. It was an abuse of discretion to turn a blind eye to the likelihood that anxious patients will go directly to segregated full service ERs run by WAH or Holy Cross to avoid the possibility of being sent to an ER eventually.

Integrated EUCC facilities discourage the use of hospital ERs for sporadic crisis visits to address short-term medical needs by promoting the establishment of long-term relationships with primary care providers and specialists located close to home. Patients are more likely to return for follow-up and ongoing primary care appointments if they utilize the same facility where they receive emergency care or if they use adjacent medical providers attracted to the EUCC.

The convenient availability of an integrated EUCC reduces patient anxiety and addresses state policy concerns about the misuse of ERs by patients who belong in urgent care. Geographically segregated medical facilities force patients to "guess whether they should be seen in the urgent care or the emergency setting. This adds another anxiety to the experience," the Mayo Clinic reports. This avoidable division will motivate many patients to "play it safe" by proceeding directly to the nearest ER, skipping the more cost effective and potentially faster walk-in clinic.

The Mayo Clinic, which operates an integrated facility in La Crosse, Wisconsin, that was developed with the close participation of nursing staff, writes that by providing patients "[w]ith the combination of Emergency and Urgent Care in one location we eliminate the need to decide 'emergency room or urgent care' - just one entrance to both services and we will triage your situation and get you on the right track for care ... A Triage Nurse will assess each patient, and based on the health condition and established policies, he or she will determine which level of service is appropriate for each patient ... During peak volume periods, we will provide 'urgent care services' using a 'fast track' process, which will allow us to be more efficient with our space and our staffing and reduce the length of stay for these patients. Likewise, caring for more complex conditions in the 'emergency services track' ensures those patients receive the level of care that they need in a more comfortable, private environment."

Similarly, the reduction of patient anxiety from having to make an uninformed choice has been a primary goal associated with the creation of four hybrid integrated centers run by Centura Health. "The biggest factor is the patient. If they have an injury, they're stressed and they've got to make a decision about where to go for care... What this offers is you don't have to think about it. Just go to the center, and we'll take care of it," explained Centura President Gary Campbell.

Comprehensive Hospital Relocation Planning is Desperately Needed

The State Health Plan should require the comprehensive resolution of all issues regarding the provision of hospital services relating to a hospital relocation. The absence of a precise methodology for providing sustainable services at the former sites of general acute care hospitals invites continued *ad hoc* planning and rank speculation resulting in hollowed out medical facilities that are doomed to fail. Unless dual medical campuses are incorporated into the comprehensive CON process for hospital relocations, prudent jurisdictions should oppose relocations and consolidations hammer and tongs, avoiding the more collaborative Takoma approach which resulted in an unsustainable campus.

The current draft regulations, and the example set by the White Oak CON proceeding, encourages hospitals to leave FMFs out of vaguely configured second campuses in order to simplify the decision-making process. Hospitals should not be encouraged to game the CON process by transforming existing medical campuses into Potemkin wellness villages serving as unsustainable temporary place markers to facilitate approval of the move of an acute care general hospital. WAH reported to an appointed Takoma Park advisory committee that it did not include a FMF in its relocation proposal because it was advised by MHCC staff that inclusion would have jeopardized approval of the entire application.

It is disturbing that the regulations make it appear that the MHCC learned nothing from a decade of dealing with the White Oak move, the fallout of which included placing a final nail in the coffin of Laurel Regional Hospital. This segmented planning is contrary to the planning goals of the CON process, but consistent with the blind eye that the state cast toward LRH's deteriorating financial condition, and the White Oak reviewer's practical invitation for WAH to pull the plug on the Takoma campus after five years led the City of Takoma Park to conclude that the decision "appears to envision a dying campus" and that WAH "appears to envision a campus at risk." Response, December 2, 2016, p. 5.

WAH's relocation was approved despite the MHCC reviewer's serious articulated reservations about the financial fitness of the Takoma behavioral hospital, which is a fiscal house of cards due substantially to the projected loss of Medicaid funds from emergency admissions. Rejecting calls for a FMF to address the fundamental issue, the reviewer passed the buck by instead mandating a future audit of the financially impaired behavioral unit following its fourth year of operation, warning that WAH might "have to reassess its ability to continue to viably serve all acute psychiatric patients in need of service and this reassessment would undoubtedly focus on bringing psychiatric beds back to within the general hospital setting." White Oak Decision, p. 36.

The other flimsy condition mandated by the MHCC is a requirement that the proposed Takoma "urgent care center must be open 24 hours a day. Adventist Healthcare, Inc may not eliminate this urgent care center or reduce its hours of operation without the approval of the" MHCC. *Id* at 180. However, the 24/7 hours might be a short-lived and illusory benefit doomed to fail since overnight demand for urgent care, as distinguished from emergency care, is likely to be light, and since the decision invites further change by providing that "operating hours would be reasserted over time, based on usage." *Id* at 27. "The Mayo Clinic Emergency and Urgent Care Center writes that "[o]ccasionally 'urgent care services' are needed in the middle of the night, for example, a baby crying with an earache. This isn't a medical emergency, but may feel like one to the anxious parents." La Crosse Campus Emergency & Urgent Care Center, web page.

It remains unclear whether the MHCC even has legal authority to impose conditions on urgent care services. The irresponsible failure of the decision to address this critical question is particularly unsettling since the 2012 MHCC decision recommending rejection of the earlier White Oak CON lamented that while it would be "tempting to condition any approval on the establishment" of Takoma urgent care services, "the Commission does not have an adequate enforcement mechanism to ensure the implementation of such services outside the hospital." *MHCC White Oak Decision* (2012), p 39. In the absence of such authority, the MHCC should eschew prescribing urgent care centers and rescue the dysfunctional Takoma Park campus.

Holy Cross Hospital (HCH) argued to the MHCC that Maryland law ostensibly treats urgent care clinics as large doctor's offices, which are free of requirements regarding hours and staffing. Similarly, exceptions filed by Montgomery General Hospital assert that the "urgent care conditions are unenforceable" and "illusory" because the MHCC has "no ongoing enforcement authority under the CON after licensure and first use. Further, nothing in the law requires WAH to obtain Commission approval before changing the hours of operation of an urgent care center or before shutting down the center altogether." MGH, p. 16. The MHCC should require integrated EUCCs or declare a moratorium on approval of unregulated urgent care centers pending the passage of legislation authorizing the regulation of segregated facilities.

Hospital Impact Studies Should be Routinely Mandated

The regulations should provide a means to integrate into the CON process studies of the impact of proposed radical changes to hospital services. The MHCC should lead the way to enactment of legislation to provide for objective medical impact studies of any community facing a proposal to radically alter its existing medical services. The credibility of Maryland healthcare planning is undercut by reliance on special interest legislation to accommodate particular communities while ignoring similarly situated equally deserving communities. Perhaps county governments can share in the cost of such studies in return for a role comparable to that which SB 707 and the regulations accord the Maryland Institute for Emergency Medical Service Systems (MIEMSS). See discussion MHCC February 18, 2016, Meeting, at 1:34:48).

The integrity of the Maryland hospital regulatory process is undermined by the *ad hoc* politically motivated amendment of last winter's FMF legislation to establish an isolated moratorium on Eastern Shore conversions pending the outcome of a $500,000 medical needs study. A more enlightened approach would have mandated the preparation of routine studies of the medical needs of all similarly situated communities faced with hospital closings or downsizings, including equally deserving residents of Hartford County, who lobbied in vain to secure passage of a last-minute amendment that would have added their community to the moratorium and study that is limited to their neighbors. All Maryland residents deserve hospital impact studies.

The State of Maryland should mandate an even-handed process requiring studies of the impact of any proposed hospital closing or downsizing. With lives in the balance, special interest legislation should not dictate the availability of critical objective information needed by any Maryland community contending with a changing hospital landscape. Jurisdictions concerned about proposed hospital closings, relocations, and downsizings should be working together rather than falling prey to divide and conquer manipulations engineered by the MHA.

The current Chesapeake Rural Health Workgroup is likely to be afflicted by "groupthink" because its membership does not include physicians, nurses, patients, or caregivers, and because its regional preoccupation might inherently prejudice the study against retention of the Chestertown hospital, several commissioners complained during the MHCC's September 20 meeting. *Infra*. Concern was expressed about the lack of geographic diversity of the "Easton-centric" workgroup, whose membership was stacked by the legislation. It was further noted that the workgroup does not contain any Kent County physicians with practical knowledge delivering local medical services. Moreover, another commissioner expressed concern that the "political" study left out Western Maryland's two rural counties, which share many medical issues with the study area. See https://www.youtube.com/watch?v=89sS6uhPBTY (around 1:20:00).

The absence of an independent study and an evidentiary hearing facilitated the White Oak reviewer's erroneous travel time analysis which utilized 2013 software that failed to reflect projected gridlock from 8,500 residences and 38,000 jobs projected by county planners to result from adoption of the 2014 White Oak Science Gateway Master Plan, despite major transit improvements. Utilization of the existing 2,709 population appears also to have underscored the finding that any "marginal improvement in the economic well-being of the service area population that can be logically assumed for the replacement WAH at White Oak is incidental to the project rather than a strategic objective of the project," in response to the contention that WAH was "abandoning the indigent and uninsured populations that it currently services."

Preparing for the master plan process, the highest residential density scenario considered by the Montgomery Planning Board staff found that the construction of 7,351 White Oak residences would result in only 817 Moderately Priced Dwelling Units (MPDUs), 429 affordable units, and zero subsidized units replacing the existing 2,709 residences which include 2086 affordable units and 120 subsided units. The analysis concluded that "[i]ncreasing density poses a risk that redevelopment will result in rent increases that will eliminate market affordable housing options." See White Oak Science Gateway Master Plan Staff Draft, Affordable Housing Analysis, March 8, 2013. The White Oak decision is divorced from reality.

WAH's lack of engagement regarding Takoma emergency issues was evidenced at an April 5 open house event where it was necessary for several city officials to educate WAH executives about the limited paramedic capabilities of the Takoma Park fire station, despite the recent culmination of a second lengthy CON proceeding. WAH's irresponsible ignorance of such basic information, known to many residents in the audience, exemplifies the need to avoid medical provider groupthink by providing the public with independent sources of medical data and emergency care that are needed for a meaningful public discussion.

Greater FMF Provider Choices Would Create a More Level Playing Field

I encourage the MHCC to continue to discuss the possibility of permitting independently run FMFs. Maryland communities would benefit from a greater choice among medical providers, particularly in light of the poor opinion of existing hospitals universally exhibited by government officials and residents at hearings during the last legislative session. Representatives of a number of communities testified at length about difficulties negotiating with hospitals that are bent upon abandoning their communities. The Kaiser Permanente and Geisinger Health systems have been cited by MHCC commissioners as potential independent FMF operators. MHCC Meeting, June 18, 2015 and February 18, 2016.

WAH should be pursuing a Takoma EUCC actively, rather than fixating on restraining its competitors. Its January 19 comments regarding the first iteration of FMF draft regulations urges the MHCC to only allow existing hospitals to operate FMFs, to put together a better definition of how a FMF should not impact nearby hospitals, and to limit the CON waiver to the establishment of a FMF on the site of a former hospital building or right next to it. WAH sought to geographically limit FMFs to the existing hospital site since the waiver-based process "would not include the rigor of the CON process and would not allow appropriate due process for hospitals that would be impacted by an FMF located five miles from a previous hospital."

WAH was not equally concerned about the due process rights of Takoma residents, whom it sometimes refers to as its partners, when it obtained approval of its relocation proposal without an evidentiary hearing and without supplying a detailed plan for its hollowed out Potemkin-type "Village of Health and Well-Being" and without having analyzed local paramedic capabilities. Ironically, in exceptions filed to a 2012 MHCC recommendation favoring Holy Cross's proposal to construct an up-county hospital, the shoe was on the other foot when Adventist Healthcare (AHC) complained that the issuance of the decision without a supplemental evidentiary hearing constituted a denial of due process. "The MHCC has always benefited from testimony, and cross-examination of witnesses and experts in CON reviews; this case should have been no different. This is particularly true when the MHCC's ruling will impact delivery of health care for years to come." Exception, p. 34, May 23, 2012.

In 2007, WAH appeared to subvert Montgomery County efforts to commission a study of the impact of the WAH hospital move on my community. "Washington Adventist supports a study as long as it reviews the health care infrastructure for the entire county as opposed to just focusing on Washington Adventist's move." Gazette, Sept 12, 2007. Instead of just complaining and pursuing more shortcuts, WAH should start competing and innovating.

Please continue to explore the potential for legislation to increase the range of choices of institutions that can run FMFs. Furthermore, the present statutory authority appears to permit qualified independent medical providers to run a FMF under the auspices of a parent hospital. Please permit hospitals to make such an arrangement, which could be extended to permit several adjacent hospitals to serve community needs by maintaining a jointly controlled FMF run by a third party.

Finally, the inexplicable failure of the MHCC to include the proposed permanent FMF regulations on the web page for state health plans, which contains all other materials leading up to the formal comment period and the selection of a FMF workgroup dominated by the medical industry insiders, lends credence to the testimony of medical consumers and legislators that SB 707 primarily was crafted to accomodate the interests of the Maryland Hospital Association (MHA) and its constituent membership. Even the MHA testified that the bill's notification process was added to stave off support for alternative bills giving county boards of health a veto over major hospital changes. The *pro forma* notification requirements are a small price for hospitals to pay for provisions that waive CON requirements and expand reimbursable services.

Please encourage the establishment of integrated emergency and urgent care centers (EUCCs), require documentation of the efficacy of regulated urgent care centers, initiate comprehensive hospital relocation planning to ensure sustainable facilities, mandate the routine preparation of hospital impact studies to provide for meaningful information hearings, facilitate independently operated FMFs so that communities have more choices, initiate better communication with consumers of medical services, and designate a role for local governments that follows the deferential model that already has been reserved for MIEMSS.

Thank you for your attention.

Sincerely,

David B. Paris, Takoma Park
Co-Chair, Washington Adventist Hospital Land Use Committee
(which sunset in March 2013) (identified for affiliation only)