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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:

Requiring the mandatory integration of Freestanding Medical Facilities (FMF) and urgent care centers would provide Maryland patients with a wider choice of necessary medical options and foster state goals of reducing the unnecessary use of emergency facilities and promoting the establishment of long-term primary care relationships. Additionally, revised regulations should require the coordinated resolution of all issues pertaining to a proposed hospital relocation, so that all facilities created, including FMFs, are sustainable.

The preparation of an objective study 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, to provide greater medical choice, the MHCC should permit the establishment of an independently run FMF as a pilot project. Finally, the Maryland public should be better involved regarding the further evolution of these regulations.

Integrated Emergency and Urgent Care Centers Should be Mandatory

The FMF regulations should be revised to require the licensing of combined freestanding Emergency and Urgent Care Centers (EUCCs). Integrated 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. 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.

Recently, the White Oak (WO) MHCC reviewer cavalierly turned 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. Without holding an evidentiary hearing or seeking an impact study, her analysis uncritically concludes that a geographically segregated Takoma urgent care clinic would be frequented by most of the lower acuity patients presently served by WAH emergency services, primarily because it is going to be operated by WAH at the same location as the prior ER. WO Decision, p. 38. Her 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," is the result of a flawed and superficial analysis that caps off a ten-year obstructive effort that reportedly began with the MHCC telling AHC that a CON application with a FMF would be rejected and ended with Montgomery County officials publicly discussing details regarding the White Oak decision, including the MHCC timetable, weeks before the opinion was rendered.

More realistically, the City of Takoma Park asserted that 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. Further, Holy Cross Hospital presented materials demonstrating 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. It was inappropriate for the reviewer to reject reasonable requests to hold an evidentiary hearing regarding complex issues associated with the relocation of a major general hospital of Maryland's most populous county, relocating 1,600 employees, an amount exceeding the total employment of the next nine largest Takoma Park employers. Takoma residents have good reason to expect mitigation of some of the negative medical and economic impact of the hospital move that recently was projected to generate $721.6 million in regional economic benefits.

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."

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. It seems appropriate to require the application of the CON review process to the licensing of new FMF facilitates, and there is a credible argument that the public interest is served by a CON waiver to encourage facilities to downsize rather than close. However, 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.

The current draft regulations, and the example set by the White Oak CON proceeding, encourage hospitals and reviewers to leave FMFs out of vaguely configured second campuses in order to simplify the decision-making process. Hospitals should not be allowed 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 and to provide political cover.

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." WO 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." WO Decision (2012), p 39. 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.

Unless both medical campuses are incorporated into the comprehensive CON process for hospital relocations, jurisdictions should continue to oppose relocations hammer and tongs, avoiding the more collaborative Takoma approach which resulted in an unsustainable campus.

The MHCC Should Accept Responsibility for Facilitating a Takoma EUCC

Revised regulations should require the evaluation of any relocated general hospital and any FMF that is to be left behind, during a comprehensive CON review process. However, a truncated review process should be specified for any Takoma Park EUCC application, since a FMF is consistent with the plan that resulted from a prolonged CON review that could have included a FMF if not for MHCC threats and footdragging. Clarifying the availability of a FMF CON waiver addresses concerns of the City of Takoma Park that, once the facility is vacated, a third CON process might be required to construct a FMF using the existing emergency department.

It would be anomalous to treat a 109-year-old building like a brand new project, just because the MHCC failed to take responsibility for resolving all issues relating to the White Oak move comprehensively and because the MHC refused to place clarifying language in SB 707. Residents of Takoma should not be disadvantaged by having the future of its medical campus undercut by the prospect of a third CON process that could have been avoided if MHCC staff, according to WAH, had not threatened to reject any WO application including a EUCC/FMF.

Over recent years, without providing an explanation, the MHCC has maintained conflicting positions regarding whether it was required to issue final FMF regulations by July 1, 2015. In 2014 the MHCC wrote "[i]n the previous monthly update, Staff mistakenly noted that this is required by July 2015. A Certificate of Need will be required to develop a freestanding medical facility beginning July 1, 2015; however, Staff is not required to have final regulations by this date." MHCC Update, October 16, 2014, p. 5. MHCC staff consistently have refused to provide the basis for this significant procedural change that appears to undermine the clear intent of the Maryland Assembly for FMF licenses to be issued after July 1, 2015. The MHCC's recalcitrance inappropriately extended the functional duration of the moratorium. Although the 2010 legislation proscribed licensing until July 1, it did not prohibit the mere filing of an application that could have been approved after that date. On July 1, the White Oak CON record remained open, and the White Oak recommended decision was adopted 5 months and several weeks later.

Further confusion was created by a statement of MHCC Executive Director Ben Steffen during a subsequent MHCC meeting, "[w]e also are beginning work on the freestanding medical facility state health plan. We are required to have a plan out after July 1. We are not ready yet, to convene any public groups on that but staff is working to meet that deadline. Freestanding medical facilities have been in existence in the state, but there has been a moratorium for several years. With the publication of our evaluation in January, we are also responsible for developing a plan for how these facilities might be established going forward." Meeting, May 18, 2015.

The following month, Director Paul Parker's presentation acknowledged that the 2010 legislation envisioned that regulations would guide the preparation and review of FMF applications, but neglected to explain why the regulations were not promulgated prior to the expiration of a moratorium on licensing that was instituted at the MHCC's request to provide time for regulations to be prepared. MHCC Meeting, June 18, 2015. Further, it was misleading for the MHCC staff to discuss the commission's CON licensing authority without revealing that at least one potential applicant was dissuaded from seeking a FMF license in the absence of regulations.

Participants during the June meeting seemed to agree that the MHCC's authority to approve FMFs immediately commenced on July 1 and did not depend on the promulgation of final regulations, a view inconsistent with the Takoma FMF warning. However, instead, both drafts of the regulations, without an explanation, simply assert that "a new FMF may not be established in Maryland after July 1, 2015, until this chapter, which contains review criteria and standards … is in effect and the Commission issues a CON finding that the application is consistent with the standards and criteria in this chapter and with CON review criteria FMF Regs, p. 4, n. 2.

The MHCC should accept responsibility for avoiding further bogging down the prospect of a Takoma EUCC by treating the reuse of the emergency department of a 109-year-old general hospital building like a brand new project. Without a FMF, the Takoma campus will fail.

Hospital Impact Studies Should be Routinely Mandated

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 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 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).

Alternatives to FMFs Run by Hospitals that Abandon Communities

I compliment the willingness of members of the MHCC to discuss the possibility of having independently run FMFs. Alternative medical providers should be made available to residents of Maryland communities. Last legislative session the members of various communities testified at length regarding 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. Meetings, June 2015, February 2016.

WAH, my local hospital, should be pursuing a Takoma EUCC actively, rather than fixated 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 in the site of a former hospital building or right next to it. WAH is seeking 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 the White Oak relocation proposal without an evidentiary hearing and without supplying a detailed plan for its hollowed out Potemkin Village of Health and Wellbeing. 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.

WAH's January comments about the initial draft regulations neglected to request that future FMF legislation address and remedy its perceived concern that the Limited Service Hospital (LSH) process applies to hospital closings and downsizings but not to relocations. Subsequently, WAH refused to cooperate with the Takoma Park effort to clarify the availability of a CON waiver for a Takoma FMF. Earlier, during both CON proceedings, WAH made unenforceable promises about its future actions rather than pursuing the potential applicability of the LSH process, despite earlier invitations from the city. 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.

It would be in the best interests of all Maryland communities to increase the pool of potential FMF providers. The MHCC should encourage FMF applications from qualified independent medical entities and seek ways to ensure coordination of services and to reduce any existing financial barriers to wider participation. Instead of just complaining and pursuing more shortcuts, WAH should start making use of its considerable advantages which include entrenchment, land ownership, history of wellness/nutritional excellence, great food, and a caring/talented staff.

FMF Regulations Should Be Publicized More Widely

The failure of the MHCC to disseminate the draft widely among the community of Maryland medical consumers is a serious deficiency of the regulatory process. The abbreviated and impeded comment period lends credence to the perception of medical consumers and legislators testifying 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 certain hospital changes. The *pro forma* notification requirements are a small price for hospitals to pay for provisions that include a CON waiver and expansion of reimbursable services.

The stealthful dissemination of the revised draft regulations is complemented by the two-week comment period interrupted and truncated by the 4th of July holiday period and by the selection of a working committee dominated by medical industry insiders belonging to the MHA, despite general public interest in FMFs demonstrated during last winter's legislative session. The ability of the public to participate in the regulatory process is further impeded by the failure of the MHCC working group web page to identify the existence of a comment period, and by the MHCC decision to withhold until after the close of the comment period, the dissemination of notes of the working group meeting held shortly before the draft regulations were published.

Please establish integrated emergency and urgent care centers, initiate comprehensive hospital relocation planning, seek independently operated FMFs, facilitate a Takoma Emergency and Urgent Care Center (EUCC), and involve the public in the further evolution of this planning process.

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)