November 27, 2017

VIA EMAIL

Eileen Fleck
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Chief, Acute Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215

Re: *Proposed Permanent State Health Plan for Facilities and Services—*
General Surgical Services, COMAR § 10.24.11
Comments Submitted by the University of Maryland Medical System

Dear Ms. Fleck:

I write on behalf of the University of Maryland Medical System ("UMMS") to provide comments on the proposed State Health Plan for Facilities and Services: General Surgical Services, COMAR 10.24.11 (the "Proposed Chapter").

UMMS supports the Proposed Chapter and urges the Commission to adopt the Proposed Chapter with the modifications discussed below.

On August 25, 2017, UMMS provided written comments on the July 20, 2017 draft chapter. UMMS appreciates that the Commission made several changes in response to those comments. However, several problems noted in the previous comments were not resolved. Those points are reiterated and expanded upon below.

1. The Proposed Chapter Should Provide Greater Flexibility for the Location of an Ambulatory Surgical Facility Established in Connection with the Conversion of an Acute General Hospital to a Freestanding Medical Facility.

The Proposed Chapter would restrict the location of an ambulatory surgical facility ("ASF") that is established through the conversion of a general hospital to a freestanding medical facility ("FMF"). Specifically, under these circumstances, the ASF must be located on the campus of the FMF or adjacent to the FMF campus.

In its previous written comments, UMMS urged the Commission to give hospitals more flexibility to locate an ASF established under § .06A(2). For convenience, the relevant comments are restated below:

Pursuant to MD. CODE ANN., HEALTH-GEN. § 19-120(o)(3)(i), an FMF established through a hospital conversion must generally remain on the site of, or immediately adjacent to, the site of the converting hospital. If the hospital converting to an FMF is either the only hospital in a county or one of two hospitals in a county that are part of the same merged asset system, an FMF established through a hospital conversion may be located within a five mile radius of the converting hospital and in the primary service area of the converting hospital. Id. § 19-120(o)(3)(ii); COMAR 10.24.19.04C(4). Depending on the configuration and size of a site immediately adjacent to a hospital converting to an FMF, these statutory limitations on the location of an FMF established through a hospital conversion could severely limit the ability of a converting hospital to establish an ASF on the same campus as the FMF and for a health system to continue to provide needed surgical services to the community formerly served by the hospital.

Hospitals are considering conversions to FMFs not only due to declining inpatient utilization but also because aging physical plants and campus limitations make further renovations and improvements impractical and not cost effective. Accordingly, it may not be feasible for a hospital converting to an FMF to also establish an ASF on the same site as a converting hospital, at a site immediately adjacent, or at a suitable site within five miles, as applicable.

Moreover, the requirement that an ASF established in conjunction with a hospital conversion to an FMF be located on the FMF campus may not be the most cost effective alternative. Instead, a hospital converting to an FMF may identify more cost effective alternatives, including the ability to purchase or lease space that has already been built as an ASF or a POSC or space that could be renovated for less than the cost of new construction on the FMF campus. Given that a hospital's operating rooms already exist in the State's surgical capacity and a hospital's conversion to an FMF will necessarily decrease the State's surgical capacity, the Commission should not arbitrarily confine the location of an ASF established in conjunction with a hospital conversion to an FMF to the FMF campus.

Moreover, the HSCRC has discretion to determine whether ambulatory surgical services provided on the campus of an FMF will be rate-regulated as a hospital service, and the HSCRC must approve the opening of a new outpatient service at an FMF. COMAR 10.37.10.07-2. Thus, if the HSCRC does not permit ambulatory surgical services, a hospital converting to an FMF will not be able to take advantage of the opportunity to convert hospital operating rooms.

In addition to the rationale set forth above, UMMS also urges the Commission to consider that an FMF converted from a general hospital must be an administrative part of a parent general hospital. Indeed, the parent hospital must join as an applicant for an exemption and must provide certain information supporting the exemption request. COMAR 10.24.19.04C(3)(b), C(5), C(8)(f), and C(8)(k). Thus, upon conversion of a general hospital to an FMF it is reasonable for the hospital to examine the community needs for outpatient surgical services within the area surrounding the proposed FMF as well as within the area surrounding the parent hospital. Hospitals should have the flexibility to place services where they will be most effective in meeting the needs of the entire population served by the parent hospital.

Accordingly, UMMS renews its proposal that a hospital converting to an FMF be permitted to locate an ASF within five miles of the FMF or five miles of the parent hospital. UMMS respectfully requests the following modifications:

a. COMAR § 10.24.11.06A(2)

(3) A general hospital with two or more operating rooms that seeks to establish an ambulatory surgical facility with two operating rooms in conjunction with conversion of the hospital to a freestanding medical facility on the same campus as the freestanding medical facility ~~or immediately adjacent to the freestanding medical facility~~, at a site within 5 miles of the freestanding medical facility, or at a site within 5 miles of the acute general hospital that will serve as the parent hospital of the freestanding medical facility, if it seeks such an exemption:

b. COMAR § 10.24.11.06C(3)(b)

(3) A general hospital seeking an exemption to convert to a freestanding medical facility that is also seeking to establish an ambulatory surgical facility through an exemption process shall locate the proposed ambulatory surgical

> facility on the campus of the freestanding medical facility ~~or an immediately adjacent location~~, at a site within 5 miles of the freestanding medical facility, or at a site within 5 miles of the acute general hospital that will serve as the parent hospital of the freestanding medical facility.

Among the responses to UMMS' prior written comments on this point, the Commission Staff noted that, under proposed § .06B(4), a converting hospital will have flexibility to locate as many as two operating rooms within its service area pursuant to the separate exemption for establishing an ASF upon the closure of operating rooms in a general care hospital. See Proposed Section .06A(3). However, the wording of proposed Section .06B(4)(c) may inadvertently preclude this alternative. As presently drafted, Section .06B(4)(c) states:

> (c) A general hospital seeking an exemption to convert to a freestanding medical facility that is also seeking to establish an ambulatory surgical facility through an exemption process shall locate the proposed ambulatory surgical facility on the campus of the freestanding medical facility or an immediately adjacent location.

The proposed language does not specify the exemption process affected by the location restriction language. Therefore, it could be misread to apply to any exemption process that a hospital is seeking while it also seeks to convert to an FMF. In particular, a hospital that seeks to take advantage of the operating room closure exemption while it seeks to convert to an FMF should not be limited to locating the resulting ASF on the campus of the FMF. To clarify the language, UMMS proposes the following edits:

> (c) A general hospital seeking an exemption to convert to a freestanding medical facility that is also seeking to establish an ambulatory surgical facility through ~~an~~ the exemption process available for such conversion under Regulation .06A(2) …

2. The Commission Should Defer to the HSCRC on Cost Efficiency Considerations and Should Not Require Specific Adjustments to Revenue for CON Exempt Ambulatory Surgical Facilities.

As discussed in the previous written comments, the Proposed Chapter includes a new efficiency standard in the Project Review Standards applicable to exemptions to permit the establishment of an ambulatory surgical facility with two operating rooms.

UMMS pointed out that if a hospital seeks an exemption to establish an ASF by closing two hospital operating rooms, the standard would mandate that the hospital "demonstrate that the proposed ASF will result in an adjusted global budget that accounts for the lower surgical capacity of the hospital and is budget neutral or results in cost savings, with respect to the global budget of the hospital, as determined by HSCRC." Proposed Chapter, § .06C(4)(b). No other chapter of the State Health Plan mandates a global budget revenue ("GBR") adjustment in order to satisfy an efficiency standard, and it should not be required here.

The HSCRC has the authority to enter GBR agreements with hospitals and health systems and it is in the best position to determine when a GBR adjustment is warranted. The Commission has no statutory authority to require revenue adjustments. As explained in the previous written comments, it is conceivable that the establishment of an ASF upon the closure of hospital operating rooms would not result in the further reduction of a hospital's GBR if the case volume of the hospital operating rooms had been very low for several years resulting in an earlier GBR adjustment.

Therefore, UMMS proposes the following modified language:

(b) With respect to a ~~A~~ hospital proposing to establish an ASF in conjunction with closure of two operating rooms, the Commission may seek guidance from the HSCRC as to whether ~~shall demonstrate that~~ the proposed ASF will result in the more efficient and effective delivery of surgical services by the applicant ~~an adjusted global budget that accounts for the lower surgical capacity of the hospital and is budget neutral or results in cost savings for Medicare and other payers, with respect to the global budget of the hospital, as determined by HSCRC~~.

3. The Proposed Chapter Should Not Constrain an Applicant's Ability to Demonstrate That the "Optimal Capacity" Measure Should Not Apply.

The Proposed Chapter includes specified measures for assessing operating room capacity. For a dedicated general purpose outpatient operating room, the Proposed Chapter states that an operating room has a full capacity of 2,040 hours per year and an optimal capacity of 80% of full capacity, 1,632 hours per year. COMAR 10.24.11.07A(1)(b). However, the Proposed Chapter would permit an applicant to demonstrate that a different optimal capacity standard is applicable based on a number of factors. The added language (shown in underline) provides as follows:

.07A(1)(b) –

(b) Dedicated Outpatient General Purpose Operating Room:

(i) Is expected to be used for a minimum 255 days per year, 8 hours per day;

(ii) Has full capacity use of 2,040 hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases; and

(iii) Has optimal capacity of 80 percent of full capacity, which is 1,632 hours per year, which includes the time during which surgical procedures are being performed and room turnaround time between surgical cases, unless an applicant demonstrates that a different optimal capacity standard is applicable based on:

1. The ability of the ASF to maintain patient safety and quality of care at the proposed optimal capacity standard; and

2. An analysis of the cost-per case of operating at a range of utilization levels that includes the applicant's proposed optimal capacity standard, the standard described in .07A(1)(b)(iii), and utilization levels between these two standards, and that explains the basis of each assumption used in the analysis; or

3. An analysis of the benefits and costs for patients served by each surgeon operating at the proposed ASF and the benefits and costs for each surgeon when the ASF operates at the utilization level described in .07A(1)(b)(iii) and at the applicant's proposed optimal capacity standard; and the cost per case at both the applicant's proposed optimal capacity standard and the standard described in .07A(1)(b)(iii), as well as the cost per case at utilization levels between these two standards; all assumptions used in these analyses shall be explained.

This language was not changed in response to the previous comments of UMMS and other commenters. UMMS urges the Commission to adopt a simple standard under which the applicant could use the specified optimal capacity measure or propose an alternate measure, presenting whatever supporting facts and analysis may be appropriate under the circumstances, and which clearly permits the Commission to evaluate and approve a proposed alternative measure on a case by case basis.

Although UMMS is pleased that the Commission Staff confirmed at the September 19, 2017 Commission meeting as well as in its memo on the same date that it interprets the Proposed Chapter to permit an applicant to demonstrate and the Commission to approve an alternate optimal capacity on a case by case basis, the language of the Proposed Chapter does not expressly state as much and should be amended to make this point clear. As the language reads now, it expressly requires the applicant to "demonstrate that a different optimal capacity is applicable" by including an analysis comparing the operating room's cost per case at 1,632 hours and the proposed optimal capacity. UMMS is concerned that the inclusion of this requirement in the standard suggests that cost efficiency is the most important factor in determining the correct optimal capacity for an operating room and may cause the Commission not to give appropriate weight to other valid considerations, such as quality of care and patient experience. The Proposed Chapter also does not expressly state that the Commission retains discretion to weigh other considerations and approve a proposed ASF with an alternate optimal capacity even if the cost per case is higher under the proposed optimal capacity standard than the traditional 1,632 hours standard.

A better approach would be to adopt a standard that permits the Commission to consider all relevant criteria and approve requests on an open case by case basis, allowing each applicant

to demonstrate that a different optimal capacity measure should apply based generally on efficiency, cost effectiveness, patient safety, and quality of care.

Thank you for your consideration of these comments. Please contact me if you have any questions.

Sincerely yours,

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