***Draft* Meeting Summary**
**Certificate of Need (CON) Modernization Task Force**
**Maryland Health Care Commission**
**Meeting of Monday, October 12, 2018**
**MHCC Offices, 4160 Patterson Avenue, Baltimore, MD**

**Committee Members in Attendance**
Jeff Metz, Chair
Regina Bodnar
Ellen Cooper
Lou Grimmel
Ann Horton
Andrea Hyatt
Adam Kane
Ben Lowentritt
Mark Meade
Brett McCone
Michael O'Grady
Richard Przywara (via phone)
Barry Rosen
Andrew Solberg
Renee Webster

**MHCC Staff in Attendance**
Ben Steffen
Linda Cole
Paul Parker
Megan Renfrew

**MHCC Counsel in Attendance**
Sarah Pendley
Suellen Wideman

**MHCC Consultants in Attendance**
Samantha Sender
Thomas Werthman

**Others in Attendance**
Pat Cameron
Armando Colombo
Erin Dorrien
Jack Eller
Rob Jepson
Danna Kauffman
Anne Langley
Rob Jepson

Paul Miller
Dawn Seek
Pegeen Townsend
Jen Witten

**Agenda Item 1: Call to Order, Welcome and Introductions**

Chairman Jeff Metz (chairing in place of Randolph Sergent) opened the meeting

Task Force members (in person and via phone), MHCC staff, and additional attendees identified themselves.

**Agenda Item 2: Approval of October 1, 2018 Task Force Meeting Summary**

Commissioner Metz asked the Task Force to approve the minutes of the October 1, 2018 meeting. No comments were received. Mr. Paul Parker noted the quick turnaround from the last meeting, and suggested that members should e-mail him with suggested changes.

**Agenda Item 3: Scope of Reform Discussion Focused on Specific Health Care Facility Categories**

Mr. Ben Steffen provided background and set up for the Draft Decision Matrices, which were developed to serve as a template for developing recommendations for reform. . This Decision Matrices is relatively concise, and includes a number of ideas for potential solutions and reforms that have been presented to date.

Mr. Paul Parker gave an overview of the Decision Matrices. He noted that potential solutions are not specifically linked to specific issues. Rather the potential solutions reflect a range of different approaches to reforming CON regulations around specific facility categories (comprehensive care facilities, home health, hospice, alcohol and drug abuse intermediate care facilities, residential treatment, ambulatory surgical facilities, hospitals, and a Cross-Cutting slide), and also include potential major reforms of eliminating certain categories of health care facilities . Mr. Parker noted the developing Task Force consensus around eliminating the capital expenditure thresholds for non-hospital facility categories. He added that for hospitals, the discussion had been around setting a capital threshold as a percentage of total operating revenue. Further, there are changes that HSCRC can make regarding its policies on treating capital within the global budget that would provide greater clarity on allowable projects.

Mr. Brett McCone noted that fully eliminating the capital expenditure threshold could force hospitals to elevate volume, which may adversely impact Total Cost of Care. Mr. Parker was skeptical that changes of supply of health care facilities would change demand for care, a concept was prevalent in 1970s. Mr. Solberg would keep some regulation around utilization.

Mr. Metz stated that he expected members to have strong views, but he expected all to listen to other opinions. He noted that he thought the Commission would lean towards more open health care markets and hoped that the Task Force would move toward consensus under that principle. He stated that no stakeholder should expect the Task Force to align exactly on that stakeholder's position.
Mr. Parker asked for members to review the Matrices, and he reminded members that he would welcome questions. Mr. Barry Rosen noted that Decision Matrices could exacerbate the silo issue among

providers, which could affect TCOC. Ms. Anne Horton suggested that the Matrix for Home Health Agencies was not fully developed and offered to provide additional suggestions. Mr. Steffen agreed there would be an opportunity for edits. He stated that while the Matrices provide a roadmap for possible reform, they were not definitive at this stage.

**Agenda Item 4: The Project Review Process – Getting to a Decision by the Commission**

Mr. Parker sought to discuss another central issue of CON regulation, which is the application, review and post-approval processes. He described the concept of how a more abbreviated review process might be created for certain categories of projects, while maintaining a standard CON review for others. He asked for other ideas for identifying types of projects that an abbreviated project framework would apply. He suggested MHCC staff was receptive to discussing post-approval processes. .

Mr. Parker reviewed the standard project review process schematic, and what might happen within time frame for staff review of 90 days (150 days if an evidentiary hearing). Mr. Przywara asked about frequency of evidentiary review process. Mr. Parker noted that evidentiary hearings have occurred infrequently (4 in last 15 years). Mr. Parker also noted that time requirements prescribed in regulations for CON reviews, especially for contested cases, are often not met. He observed that uncontested cases are more likely to be reviewed within the timeframes prescribed in regulations (90 days from docketing). He noted that there no penalties for not meeting the time deadlines. He observed that if the Commission was required to meet the review deadlines, there would be more rejections of CON applications.

Mr. Parker presented a series of slides on the alternate CON review process, titled: "Imagining an Alternative Project Review Process for Certain Types of Projects."

Mr. Parker offered a list of facilities and programs that could be served by an alternative review process, created by statutory and regulatory changes. These could include:

- Adding bed capacity
    - Hospitals, comprehensive care facilities, hospices, intermediate care facilities, residential treatment centers
- Changing operating room capacity
- Hospitals, Ambulatory Surgical Facilities , Free-standing Medical Facilities Introducing new services
    - Obstetrics: Hospitals
    - Pediatric: Hospitals
    - Psychiatric: Hospitals
- Adding territory
    - Home health agencies, hospices
- Non-categorical capital expenditures
    - Hospitals

Mr. Adam Kane asked if specialty hospital services should be handled as a CON process or through a licensing process. Mr. Parker responded that the question becomes whether licensure can be reformed to achieve the benefit of CON regulation. He stated that the key areas falling under an expanded licensure model would be home health, hospice, and addictions treatment. Without CON, licensure would have to play a larger role in keeping "bad actors" out of Maryland. In these services, CON's main role is to

screen bad actors from entering Maryland, and secondarily keep supply at more manageable level of development.

Mr. Brett McCone noted the lack of specificity (e.g. specific number of allowable bed additions). The second point Mr. McCone raised was whether there was any value added to CON processes if new processes are created before existing processes are strengthened. Mr. Parker agreed, noting simpler standards of project review would need to be implemented before reforms. Mr. Barry Rosen applauded adding a track for project review. He also pushed for elimination of any additional "paper pushing" in the process, which tends to bog down staff. He also questioned providing due process in a proceeding via the interested party designation, in which the intent is not fact finding. He provided, by way of example, the long-running hospice reviews of Prince George's County and Baltimore City.

Mr. Kane asked, in cases of limited services of Obstetrics and Pediatrics, whether the review process is even necessary. Mr. Parker agreed and argued these services are not prone to proliferation and the CON process is not needed.

Mr. Parker presented a series of application/information requirements necessary in a revised streamlined CON process:

- Description of the project
- Project budget
- Pro-forma schedules of revenues and expenses
    - Isolating on the project itself
    - For the entire facility
- A description of how the project complies with the State Health Plan (streamlined)
    - Need for the project
        - What alternatives were considered by the applicant
    - Financial feasibility of the project/long-term viability of the facility
    - Impact on cost and charges
- Attestation of truthfulness

Mr. Solberg questioned the need for an applicant to consider alternatives. Mr. Parker commented that MHCC would have difficulty assessing the need for a project, unless alternatives have been considered. To make an abbreviated process work, the applicant would need to address need for the proposed facility, demonstrate viability, and estimate the effects on costs and charges.

Mr. Parker then reviewed a potential approach for completeness review and docketing

- Questions with three weeks of application filing (15 working days)
- Response by applicant – three weeks but, in practice, more time would be allowed if requested
- Docketing application within two to four weeks of receipt of response – docketing only connotes that questions were asked and a response was received
- Publication of notice in Maryland Register starts 30 day period for comments on project by interested parties.

Mr. Parker explained that the MHCC staff would issue a report on the project's substantive compliance or non-compliance with applicable criteria and standards. The outcomes would be threefold as follows:

1. Staff issues brief report finding that the project is substantially in compliance with applicable criteria and standards
   OR
2. Staff issues brief report finding that the project is not substantially in compliance with applicable criteria and standards
   OR
3. Staff issues brief report finding that a determination of substantial compliance cannot be made and identifies additional information required for determination

Mr. McCone noted the amorphous nature of staff's determination of "substantial compliance." Mr. Parker further clarified Commission staff's action across the three outcomes. Mr. Solberg believed the opportunity to file exceptions may not be sufficient, as applicants may not be sophisticated enough to use the "planning speak" required in such responses. Further, the withdrawal of application would be prohibitively expensive. Mr. Rosen noted the language in the paragraph and argued that the proposed language should more directly address approval or denial.

Mr. Parker then turned to a discussion of whether interested party participation was warranted in the new process. He identified five situations when the interested party participation is currently permitted:

- Adding beds
- Adding Operating Rooms (ORs)Introducing Some New Services
- Adding Territory
- Non-Categorical Capital Expenditures

He posed three questions:

1. If the need standard of the State Health Plan limits capacity expansion based on use of existing capacity, is a concern with the impact of capacity expansion on other providers necessary?
2. If an objective of reform is allowing more competition (by qualified applicants) why should competitive impact be viewed as a legitimate basis for interested party participation?
3. Why are interested parties allowed in non-categorical capital expenditure project reviews?

Mr. Solberg asked about the legal definition of "interested party." Ms. Suellen Wideman identified relevant definitions under the applicable statute and regulations. Mr. Przywara believed removal of interested parties is detrimental, forcing adversarial parties into litigation. Mr. McCone agreed. Mr. Rosen believed interested parties should have some ability to comment, but "less is more." Mr. Parker asked if there was real streamlining of the process, expanding opportunities for litigation in response to Commission action would not be a positive outcome. .

Mr. Parker then outlined a process for fast-tracking to a decision for compliance-certified and unopposed projects. Mr. Parker raised timelines for those matters without interested parties. Mr. Steffen noted the streamlined process could be a concern for interested parties, and seeking interested party status could be a tactic for slowing down process. If the goal is a fast-track process, opportunities for seeking interested party status need to be narrowed. Mr. Parker noted the process above applies to those cases where interested parties are expected, and questioned how the process could be expedited in such circumstances. Mr. McCone again noted the need to streamline State Health Plan standards and reduce review criteria is a first step in streamlining process. He observed that for major decisions such as hospital relocations, time should be taken for staff to fullyevaluate the implications of such applications. These projects may not be as appropriate for streamlining. Mr. Solberg also acknowledged the circumstances surrounding the

"big reviews" such as facility relocation and competitive reviews in which two or more applicants seek to offer the same service. He argued that the Commission needs to maintain criteria to judge controversial projects and competitive applications.

Mr. Parker raised the question , given the nature of these proceedings, whether there should be limits on the amount of time allowed for reaching decisions. He asked if there should be mandatory approvals if timelines are extended. Some projects due to complexity or interested party participation require time to reach a decision. Mr. Steffen opined that the calendar is adversely impacted by contested cases, and the better process may be to scale back non-controversial project reviews appropriately, and allow staff to have more resource time on contested projects. Mr. McCone noted that it would help to update the State Health Plan , which would give Commission better standards for rendering a decision. Ms. Regina Bodnar commented on projects that have been under review for a long time, but not yet decided upon, and the unmet need that prompted the filing of these applications still exists. Mr. Solberg agreed that control of the calendar is lost in contested cases, but involvement in other projects can also take up time. Mr. Parker agreed, and attempt to triage projects place staff on two different schedule clocks, for contested and uncontested projects. Mr. Rosen did not believe there should be automatic confirmation of projects if staff doesn't meet deadlines. Mr. Przywara asked if outside consultants have worked on CON reviews if a backlog exists. Mr. Steffen noted that consultants must maintain impartiality, which may be difficult, given that consultants often have multiple clients. The Commission has sought to remedy this potential for bias by hiring consultants from out of state. This option comes with other limitations and these consultants might not have a complete understanding of how Maryland law operates.

Ms. Ellen Cooper asked if consumers can be interested parties. Mr. Parker and Mr. Steffen suggested that a reviewer could designate interested party status on consumer groups. Ms. Wideman noted that it is in the reviewer's sole discretion to qualify an interested party. A consumer-interested party designation hasn't occurred in last 20 years. Non-interested parties can still submit comments, however. Ms. Cooper believed consumer input should not be limited.

**Agenda Items 5: Regulatory Requirements after Project Approval – Changes in Projects and Implementing Projects**

Mr. Parker addressed process after applicant changes project following approval with the following slides. Task Force commentary appears below each section. He reviewed changes in approved project that require Commission approval which include:

- Significant change in physical plant design;
- Capital cost increases that exceed the approved capital cost inflated by an amount determined by applying the Building Cost Index published in Health Care Cost Review from the application submission date to the date of the filing of a request for approval of a project change;
- Total projected operating expenses or revenue increase exceed the projected expenses or revenues in the approved CON application, inflated by 10% per year;
- Changes in the financing mechanisms of the project; and
- Changing the location or address of the project.

Mr. Parker noted most frequent change sought by applicants focused on capital cost increases. He also discussed the Healthcare Building Cost Index, and effect of published inflation index on this process. Changes in financing mechanism relates to more debt assumption.

Mr. Parker identified changes as un-approvable, and any such changes sought would invalidate the issued CON. These included:

- Changes in the fundamental nature of a facility or the services to be provided in the facility from those that were approved by the Commission
- Increase in the total licensed bed capacity or medical service categories form those approved
- Any change that requires an extension of time to meet the applicable performance requirements specified under Regulation .12 of this chapter, except as permitted under Regulation .12E of this chapter

Mr. Solberg strongly suggested that staff be permitted to modify CONs, and that they should only be brought to the Commission if they are contested in some way. In terms of impermissible modifications, he would suggest removing performance requirement bullet. Mr. McCone suggested limiting impermissible changes to those big things that affected CON in the first place; other than that, don't worry about it. Mr. Rosen agreed that paring down process is important; if issue will not be taken before the Commission, why file it at all? Mr. Przywara noted that, universally, each facility category found that capital construction and finance did not serve process in positive way.

Mr. Lou Grimmel asked about performance requirements. Mr. Parker noted that current regulations set time limits based upon project type. The aim is for a generic and flexible process: what should matter to the Commission (and serve as key performance measures) includes obligating capital expenditures, finalizing financing and initiating construction. Mr. Parker proposed, as a reform, establishing only one time period for all construction projects; once the time period is established, extensions can be granted. Annual reports (rather than quarterly) would be required, but no actual ultimate time limit. Mr. Solberg pointed to annual recertification from past MHCC procedure, but argued this process was unduly burdensome on staff. He made a separate suggestion for changing time limits. However, the regulatory process has come about because of "bad actors" that affected Maryland citizens. Mr. Parker reiterated inflexibility of performance requirements, and how this generates unnecessary burden. Performance requirements should be more customizable.

Mr. Kane asked if the Task Force should consider approaches that MHCC could use to reduce service capacity. He suggested that approaches should be developed to reduce capacity for inefficient providers. Excess capacity is a big concern as the State moves to the Total Cost of Care Model. Mr. Steffen stated that MHCC can limit the development of new capacity, but has little authority to reduce established providers. Mr. Kane suggested low-volume providers are less likely to be either efficient or high quality providers. Mr. Steffen commented that some hospice providers are authorized to serve jurisdictions where they do not offer services. He suggested that MHCC should have the ability to revoke a hospice's authority to serve a jurisdiction, if that hospice offered no services. Ms. Bodnar agreed with this assessment. Mr. Kane noted HSCRC will seek to modernize its capital policy and the Task Force should look for ways to streamline and align CON with TCOC objectives.

**Agenda Item 6: MHCC's limited authority to issue emergency CONs**

Mr. Steffen reviewed the MHCC's authority to issue an emergency CON. He noted that emergency CONs could only be issued for a limited time and in situations where an existing health care facility had been physically damaged or destroyed. He explained that the emergency CON authority did not address public health crises such as the current opioid epidemic. Mr. Przywara asked if there would be a review of

the emergency circumstances. Mr. Steffen indicated a state of emergency would not be determined by Commission, but rather the State or federal government would identify such an emergency. In a public health crises, a streamlined emergency process could be implemented and restrictions would be loosened. Task Force members agreed that the Commission could approve flexibility in situations of a natural disaster, but there was some hesitancy about circumventing CON for public health crises. Mr. Steffen suggested that under certain circumstances, the MHCC needed the ability to respond to public health emergencies without the burden of going through the entire CON application process. Mr. Solberg suggested a "bare bones" CON application process.

**Agenda Item 7: Plans for November 9, 2018 meeting**

Mr. Steffen indicated draft recommendations would be provided for consideration at least a week in advance of the scheduled meeting. Matrices will be used in development of the draft recommendations. Any amendments to the Matrices will be accepted until October 20, 2018.

**Agenda Item 8: Adjournment**

Commissioner Metz thanked the Task Force and adjourned the meeting.