SUMMARY – HOSPITAL COMMENTS

UMMS – University of Maryland Medical System
MERCY – Mercy Medical Center
BON SECOURS – Bon Secours Baltimore Health System
AAMC – Anne Arundel Medical Center
MEDSTAR – MedStar Health
CARROLL – Carroll Hospital (part of LifeBridge Health)
MHA – Maryland Hospital Association

Scope of CON Regulation

PROJECT CATEGORIES TO KEEP

- Establishing hospitals
- Relocating health care facilities (HCFs) outside of the facility's primary service area
- Changing psychiatric bed capacity if the facility is not eligible for Medicaid reimbursement
- Introducing specialized burn treatment, cardiac surgery, organ transplantation, and psychiatric services
- Establishing a "satellite" freestanding medical facility (FMF) outside of the hospital's primary service area

UMMS

Most. Two specific changes recommended. (See below.) Reference to MHA Work Group for possible future recommendations
MERCY

Most. No specific recommendation. (See below.)
BON SECOURS

Most. No specific recommendation. (See below.)
AAMC

Most. No specific recommendation. (See below.)
MEDSTAR

Most. No specific recommendation but specific comments are anticipated from an MHA Work Group by end of Issue phase of study. (See below.)
MHA

PROJECT CATEGORIES TO ELIMINATE

- Relocating existing health care facilities within the facility's primary service area
- Changing non-psychiatric bed capacity of a health care facility (and psychiatric hospital bed capacity if eligible for Medicaid reimbursement
- Introducing new medical services (with exception of psychiatric services not eligible for Medicaid reimbursement)

- Introducing neonatal intensive care services
- Establishing home health agencies (HHAs), hospices or freestanding ambulatory surgical facilities (FASFs)
- Expanding HHAs or hospices (geographic/capital threshold)
- Expanding FASFs (add operating rooms/capital threshold)
- Closing or temporarily delicensing a medical service
- Closing a health care facility or conversion of a health care facility to a non-health-related use
- Making a capital expenditure (CAPEX)

UMMS

- Making a CAPEX for hospital projects not changing bed capacity or expanding services (or raise threshold significantly)
- Changing hospital outpatient services projects (moving regulated services to unregulated space or deregulating services within hospitals)

MERCY

- Opportunity to deregulate exist. But no specifics.
- Smaller health systems should not be negatively affected by deregulation.
- Shift focus of regulation to hospital revenues rather than CAPEX thresholds

BON SECOURS

- Making a CAPEX – Requirements should be reconsidered
- Adding services when access is created – e.g., mental health services. Consider deregulating if need for the service is identified in a Community Health Needs Assessment

AAMC

Making a CAPEX for hospital projects (including renovations) not changing bed capacity or expanding services

MEDSTAR

No specific recommendation but specific comments are anticipated from an MHA Work Group by end of Issue phase of study. "Under Maryland's current All-Payer Model, significantly eroding or removing Certificate of Need barriers would not be appropriate. Maryland's hospitals, like all stakeholders, are willing to modernize CON and the State Health Plan, but the core principles of CON should remain in place."

MHA

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Scope of Review Criteria and Standards

DUPLICATION OF REGULATORY EFFORT AMONG STATE AGENCIES

- No need for CON process to include analysis of financial feasibility, viability, or availability of more cost effective alternatives in light of Health Services Cost Review Commission's (HSCRCs) authority
- Certain health care planning concerns could be more effectively regulated and managed by the Maryland Department of Health (MDH) or HSCRC ("little change" may be required in latter's authority)
- Preferable for quality issues to be within exclusive control of MDH

UMMS

- Other regulatory requirements might be leveraged. Recommend further exploration of licensing and certification.
- Reference to MHA Work Group for possible future recommendations

MERCY

Unnecessary duplication of regulation of hospital charity and uncompensated care, as well as financial assistance policies. Overseen by HSCRC.

BON SECOURS

- Charity care should not be part of CON process – regulated by HSCRC and embedded in All Payor Model
- Quality is appropriate consideration as part of CON but coordinate with MDH, accrediting agencies
- Needs to be more coordination between MHCC, MDH, and HSCRC

AAMC

No response.

MEDSTAR

- General standard for charity care for hospitals should be eliminated or moved to the HSCRC's authority
- MHA's work group will discuss these questions and provide specific responses at a later date
- Modernizing CON may require a broad look at MHCC's "core missions" like CON, and the appropriate resources to complete these core missions.

MHA

THE STATE HEALTH PLAN (SHP)

- Out-of-date SHP standards, ambiguous standards, and inconsistent application of review standards are "choke points" in CON review process

- Examples of out-of-state standards – acute psychiatric services, neonatal intensive care services, acute care hospital services (general standard for quality), and cardiac surgery (financial feasibility standard)
- Example of inconsistent application – cardiac surgery (minimum volume standard)
- Many review standards are duplicitous with regulatory control of MDH, HSCRC, and quality monitoring by national bodies

UMMS

- Out-of-date SHP standards – e.g., acute psychiatric services
- SHP needs to updated and flexible enough to account for emerging technologies
- Reference to MHA Work Group for possible future recommendations

MERCY

- Overall, SHP provides appropriate guidance
- Should be more explicit, data driven and consistent with current health care trends
- Methodologies for volume capacity and criteria for CON review should align with population health efforts
- Should increase efforts to solicit input from other industries

BON SECOURS

- Out-of-date SHP standards – e.g., acute psychiatric services, acute care services needs critical evaluation
- Needs to reflect current hospital payment model and total cost of care model
- Assessment of need is too retrospective and historic – needs to be more predictive based on new payment model
- Eliminate or critically evaluate role of Administrative, Executive, and Legislative Review, petitioning the state for changes

AAMC

- Out-of-date SHP standards, e.g., behavioral health
- Out-of-date need projections
- Need projections should not be solely based on historical data – should incorporate emerging technologies, inpatient to outpatient shift, new competitors, etc.

MEDSTAR

- "SHP should begin with a clear purpose, accompanied by two to three key goals and objectives. The purpose and goals should align with the model because the state is collectively at risk to achieve the model's goals. In particular, the plans goals should take into account the model's influence on the demand for health care services, which in turn influences the 'need' for services."
- Regulations are static
- Out-of-date SHP standards, e.g., acute psychiatric services
- SHP needs to be updated and flexible enough to account for changes in emerging technologies
- More specifics to come from MHA's work group

- "When ripe for commission action on a chapter of the State Health Plan, the commission should welcome comments at a public meeting"
- "At a minimum, at the end of this review process, when the commissioner-led work group releases its final recommendations for commission action, the full commission should allow presentations and comments before voting."
- "At a minimum, hospital requirements to report charity/uncompensated care are not needed or should fall under HSCRC jurisdiction."

MHA

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Project Review Process

COMPLETENESS REVIEW

Should be subject to timing and procedural limitations. Multiple rounds of questions occur and later questions may involve material in application. Limit to one round and limit questions to issues essential to determining compliance with standards. Rules should require confirmation of completeness within specific time frame after questions are answered or submission of follow-up questions limited to inadequate previous responses.
UMMS

Completeness questions can cause significant delays – recommend limiting staff to one round of completeness questions – questions must be germane and essential
MERCY

Review process should be streamlined – Ideally, a condensed application should warrant a reduced timeline for completeness review
BON SECOURS

Some aspects of review process that tend to slow the process down include completeness questions (subject matter experts could be valuable resource) – perhaps narrowing or focusing the scope of the completeness questions
AAMC

Limit completeness questions to one round – limit questions to those essential to making a decision
MEDSTAR

Completeness questions add significant time to process. Unnecessarily detailed questions. Excessive volume of supporting documentation. (e.g., manuals, brochures, registration forms). Process needs to be eased. References should be accepted on what is available and how it is used.
CARROLL

Completeness questions can cause significant delays. Recommend limit to one round of completeness questions. Questions must be germane and essential to making a decision.

MHA

REVIEW PROCESS LENGTH OF TIME

Impose more clear regulatory timelines regarding the length of each step of the review process and clear guidance as to what relief is available to applicants such as deemed approvals
UMMS

150 day timelines are not being met by staff. Suggestions. Limit completeness question rounds and eliminate non-germane questions. Let HSCRC handle charity care, uncompensated care, other financial issues in review. Consider using more subject-matter experts. Reduce required filings. Reduce requirements for renovation projects – simple narrative. Eliminate pro forma documentation of information already filed for other purposes. More to come from MHA work group.
MERCY

Review process should be streamlined to reduce overall length of time but same steps maintained. Suggestions. Simplify application form. Reduce time for each step.
BON SECOURS

Timelines too often not followed. Suggestions. Subject-matter experts. Narrow focus of completeness review. Handle project modifications differently. Earlier financial feasibility review by HSCRC. Reconsider role of interested parties, removing incentives for slowing down process. Use two Reviewers to avoid limited knowledge or scheduling conflicts. Give priority to larger projects and outsource smaller projects.
AAMC

Review schedule is restrictive. Must wait six months between review cycles. Timelines for steps in review process are not followed. Must have enforced time periods in process. (e.g., Baltimore City HHA review. Applications filed in December 2016, docketed in July 2017. But still no Commissioner/Reviewer appointed.
CARROLL

150 day timelines are not being met by staff. Suggestions. Limit completeness question rounds and questions. Let HSCRC handle financial issues in review. Consider using more subject-matter experts. Reduce required filings. Reduce standards in SHP. Eliminate steps in process that do not add value.
MHA

PARTICIPATION BY INTERESTED PARTIES

Appropriate to limit criteria and standards that can be addressed by interested parties to ones that directly involve the interested party. Competing applicants should be able to address any standard to the extent that their proposal better meets the standard.
UMMS

Adverse impact of project must be demonstrated by the interested party with well-organized, data-driven analysis. Should not be presumptive. Possibly limit participation to interested parties in same service area as applicant or to projects with specialty or regional impact. Insurance companies should not be interested parties in hospital projects.
MERCY

Consider restricting interested party participation if project is a hospital modernization using hospital's own capital in its own service area with no rate increase. Interested parties must demonstrate adverse impact first as a threshold standard, not during the process.
AAMC

Interested parties should be limited to hospitals within a certain distance of the applicant and should only be qualified if project is claimed to adversely affect patient care or unreasonably limits patient choice.
CARROLL

DIFFERENT REVIEW PROCESSES FOR DIFFERENT TYPES OF PROJECTS

Support elimination of CON review requirements for many types of hospital projects. As an alternative, consider abbreviated review for some projects. 90-day expedited review in New Jersey noted as potential model. Consider expedited review for any project without interested parties.
UMMS

A fast track could be considered for projects with no interested parties and documented need in SHP. Other factors could be projects without rate increases or demonstration of significant cost savings.
MERCY

Abbreviated reviews for specified projects.
BON SECOURS

Establish criteria for eligible projects and adhere to maximum time frame of 150 day.
AAMC

Support an abbreviated process for certain projects. Limited to brief description of purpose, cost, funding, timeline, and operational impact of project.
CARROLL

The previous MHA CON Task Force discussed a "fast track" approach for projects with no interested parties and a documented need in the State Health Plan. Other possibilities include no assumption of hospital rate increases or project that demonstrate significant cost savings.
MHA

Post-Approval Performance Requirements

Greater flexibility for post-CON project changes. Reduce scope of impermissible changes when there is good cause. Staff review only for some cost increases with ability to appeal staff decision to full Commission.
UMMS

Should be changed for projects without new beds or services.
MERCY

Modification should be streamlined if certain criteria are met.
AAMC

Eliminate quarterly reporting requirement. Construction schedule is sufficient. Notification if project completion delayed beyond 60 or more days.
CARROLL

Reduce requirements, particularly for projects without new beds or services.
MHA