MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

August 24, 2018

VIA ELECTRONIC MAIL & OVERNIGHT DELIVERY
Mr. Randolph Sergent
Co-Chairs, CON Modernization Task Force
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: CON Modernization Task Force—Phase Two Meeting on September 7, 2018

Dear Mr. Sergent:

This letter is a follow-up to MPCAC's June 20, 2018 comment letter in response to the MHCC Interim Report on CON modernization. Our organization is grateful for the opportunity to provide input on this critical process as the voice of independent physician specialty practices in the State of Maryland.

I understand that a focus of the upcoming CON Modernization Task Force meeting on September 7, 2018 will be CON regulation of non-hospital facilities, including ambulatory surgical facilities (ASFs). In advance thereof, I am enclosing a short document that aligns with the overall principles in the MHCC Interim Report (and our June 20, 2018 submission) that we ask the Task Force to consider in discussing reform of CON regulation as applied to ASFs.

MPCAC appreciates the Task Force's diligence as it continues to evaluate necessary change to CON regulation in order to promote access to high quality, cost-effective care in the State. Please feel free to contact me at ngrosso@cfaortho.com or (443) 520-5770 if MPCAC can be of assistance as the Task Force continues its work.

Sincerely,

Nicholas P. Grosso, M.D.
Chairman of the Board & President, MPCAC

Enclosure

cc: Ben Steffen, Executive Director, MHCC
Paul Parker, Director, MHCC Center for Health Care Facilities Planning & Development
Joe Bryce, Manis Canning & Associates

MPCAC

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MHCC CON Modernization Task Force: September 7, 2018 Meeting
Ambulatory Surgical Facilities (ASFs)

Overview:

The work of the CON Modernization Task Force comes at an opportune time to affect positive change in health care access, quality and cost in the State of Maryland. A modernization of Maryland's 40-year-old CON program affords a critical opportunity to align the State's regulatory scheme with the ongoing transitional shift in the delivery of health care. To facilitate this shift most effectively, we are convinced that any revamp of the State's CON program must have a clear focus on the removal of barriers hindering the delivery of high quality health care in cost-effective and accessible settings such as ASFs.

Key Takeaways from MHCC Interim Report:

- Industry comments which generally favor continuing CON for their particular facilities must be weighed in light of a natural tendency to protect existing interests to the potential detriment of new market entrants. *MHCC June 1, 2018 Interim Report at 5*.

- CON modernization needs to be examined through the prism of the All-Payer Model and, in particular, the Total Cost of Care model. *Interim Report at 1, 6-7*.

- In order to stay within the Total Cost of Care guardrails, it will be important to move more demand to the least costly setting in which demand can be appropriately handled. *Interim Report at 7*.

- Literature shows that, in the abstract, the overall benefit of CON regulation is debatable and does not provide strong evidence that CON reduces health care costs or improves quality. *Interim Report at 6*.

- Health care quality is an issue that may be best addressed through licensure regulation, rather than the one-time, front-end review offered by CON regulation….[E]nsuring quality of health care and that "bad actors" remain outside of the system are appropriate regulatory goals but using CON regulation may be a problematic and inefficient approach. *Interim Report at 7-8*.

Guiding Principles:

- Modernization of CON regulation must take into account the implications of such regulation on care delivery furnished outside of the hospital setting, particularly in independent ASFs.

- Maryland must guard against the risk of maintaining CON regulation as a mechanism for protecting existing interests to the potential detriment of new market entrants to avoid stifling competition, innovation and opportunities for cost-reduction.

- It is important to modernize CON regulation in ways that will enable Maryland to succeed under the Total Cost of Care model, including the movement of demand to the least costly setting in which demand can be appropriately handled. Academic and government studies have shown that shifting care into ASFs can result in significant cost savings when compared to similar services and procedures in other surgical care settings. Additional cost savings would also likely be achievable if barriers to creating larger, and perhaps multi-specialty, ASFs were removed to allow ASF operators to eliminate duplication of overhead and operational expenses.

- A robust licensure process, rather than front-end review offered by CON regulations, is the appropriate mechanism for safeguarding health care quality and for ensuring that health care facilities and providers are operated soundly and under responsible ownership.

- The current regulatory scheme that provides for an ability to establish ASFs with no more than one operating room outside the scope of the CON program impedes quality and safety improvements that would likely result from larger ASFs. Efficiencies and advances in peer review oversight, quality control, and inspection and accreditation processes would be more achievable in larger ASFs.

Elements of Existing ASF CON Regulation that Need to Be Addressed:

- The application of CON regulation to ASFs should be eliminated entirely or, at a minimum, the application of CON regulation should be eliminated for ASFs with four or fewer operating rooms and the use of a capital expenditure threshold should be eliminated.

- Barriers to creating larger, and perhaps multi-specialty, ASFs should be removed to encourage operational efficiencies and widespread implementation of quality and safety best practices.

ORIGINAL SENT VIA EMAIL FROM DR. LOWENTRITT

Dear Chairwoman Phillips, Chairman Sergent, Mr. Steffen, and Mr. Parker,

I appreciate the hard work that continues to be required to manage the CON task force, and I am grateful to be a part of it. The discussions have been animated and productive. My concern is our ability to give each topic its due amount of consideration within the time allotted. Although I am trying to represent physicians and patients with my comments on other topics, my personal experience is mostly with ambulatory surgery facilities (ASFs). Since the ASFs are being considered in the next meeting along with hospice, residential treatment centers, addiction treatment centers, and maybe some of the general principles we didn't get to last meeting, I want to get my thoughts out to you directly. Please feel free to share these comments with staff or with the consulting group.

The Commission has given us the task to think creatively and not to be afraid to make bold choices. For most of the topics at hand, that runs up against the stakeholders who have mostly succeeded and built businesses that flourish within the status quo of regulation. As the Phase One summary stated, there was the most consensus for removal of CON in the ASF space than for any of the other facilities discussed. With ASFs, I see opportunities to make significant changes that are completely in line with the six principles you laid out last meeting.

ASFs are smaller facilities and are typically spread throughout communities, creating fairly easy access to care. Care given in ASFs is usually reimbursed at significantly lower rates than care given in a hospital setting, so delivering care in this environment would lower the overall cost of care. Quality is strictly monitored through both CMS inspections and accrediting organizations.

The trend nationally across most medical specialties is for less invasive and disruptive treatments that allow for surgeries to be done in an ambulatory setting. Much of the innovation in surgical care now is with these exact goals in mind. However, these procedures often come with significant costs of new equipment and specialized personnel. I think this point should help drive our thinking on how CON impacts the overall level of care given in ASFs. Maryland's current policy of allowing single-OR ASFs to be established without a CON has led to a high number of overall ASFs in operation in the state, as described by Mr. Parker earlier in the year. This leads to inefficiency in each of these ASFs, as all equipment and personnel cannot be used optimally as would be the case for multiple running rooms.

There are also quality and safety efficiencies that could be obtained through multi-OR ASFs. It would be simpler for ASFs to consistently implement effective processes and procedures to ensure quality care is delivered if there were more multi-OR ASFs where policies and staff training could be standardized under the same roof, as opposed to inconsistent practices that may exist at a multitude of separate, single-OR ASFs. Furthermore, as the definition of an operating room is mostly related to the level

of anesthesia being provided, there is a potential perverse incentive to use a lower level of anesthesia just to improve efficiency.

For all the reasons listed above, I believe that there is no clear need for CON for ASFs. If the Commission feels CON should remain, the limit should be raised to allow for the more efficient operation of these facilities. As Mr. Rosen and I stated earlier in the year, if the goal is to raise the limit, an even number allows for more efficient use of personnel and space, and I would suggest any ASF with four or less rooms should be exempt.

Given that there is a single meeting for discussion of ASFs, hospices, residential treatment centers and addiction treatment centers, and each is important to the overall work of the group, my ask for our next meeting is that we ensure that each topic receives adequate discussion time and consideration. And if we decide that we are unable to give application of CON to ASFs sufficient time in the upcoming meeting, then I ask that we find a way to add a meeting or commit to carry over the discussion to the next scheduled meeting.

Thanks for your time in considering this, and I am happy to speak to anyone further.

Sincerely,
Ben Lowentritt, MD