Final Meeting Summary
Freestanding Medical Facility Work Group Meeting
Friday August 28, 2015
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees:

Lisa Adkins
Hugh Guest
John Hamper
Robert Jepson
Dean Kaster
Julie May (by phone)
Brett McCone
Neil Moore (by phone)
Lisa Myers
Amy Perry (by phone)
Dennis Phelps
Renee Webster
Jennifer Wilkerson
Patti Willis

MHCC Staff Attendees:

Eileen Fleck
Paul Parker
Kathy Ruben
Suellen Wideman

Other Attendees:

Miriam Suldan
Clarence Brewton

Introductions and Work Group Purpose

The meeting convened at approximately 10am. Eileen Fleck, Chief of Acute Care Policy and Planning thanked everyone for attending the work group meeting and asked participants to introduce themselves. Ms. Fleck then explained that the purpose of the work group is to provide feedback on the draft standards that MHCC staff developed for a new category of facilities in Maryland, freestanding medical facilities (FMFs). Ms. Fleck noted that the MHCC staff needs to develop regulations in order to establish a routine review process of this type of facility.

Ms. Fleck explained that the meeting summary will serve as the record of the work group's recommendations and discussion of issues. She noted that the work group members are not expected to reach consensus on issues, but achieving consensus is helpful in providing guidance to MHCC staff. Ms. Fleck asked the work group if they had questions about the purpose of the work group or Certificate of Need (CON) regulations generally, and there were none.

Issues and Policies

Paul Parker, Director of the Center for Health Care Facilities Planning and Development described the issues and policy section of the State Health Plan (SHP) chapter to the work group

as introductory information and a set of policy objectives. He explained that this section serves as a preface to project review standards, and for other services, historically it has included a lengthy discussion about the services addressed in the SHP chapter. In the draft SHP chapter on FMFs, the MHCC took a different approach, only briefly discussing the historical background on FMFs. Freestanding medical facilities began operating in Maryland about ten years ago on a pilot basis under Maryland statute. The pilot period ended in June 2015, and the MHCC will be accepting applications to develop new FMFs, as it would with any regulated health care facility.

Mr. Parker noted that the Issues and Policies section of the draft SHP chapter includes a discussion of the importance of access to care. He stressed that the draft language is an initial regulatory policy that MHCC staff will be refining the policy over time. He then read the following text on page nine of the draft SHP chapter.

> *Maryland's initial regulatory policy with respect to development of FMFs should be structured to require meaningful analysis of a full spectrum of clinical facilities where non-complex medical care can be handled without appointments as part of the applicant hospital's justification for proposed development of an FMF*.

He stated that the MHCC staff wants to evaluate proposed FMFs within the broader context of medical care delivered on a non-scheduled basis including emergent and urgent medical care. He added that the other major criteria for evaluating proposed FMFs include cost-effectiveness, efficiency, and quality of care.

Mr. Rob Jepson requested clarification on the intent of the language on page nine read by Mr. Parker. He asked whether the burden of proof is on the applicant to have considered other alternatives to an FMF or whether MHCC would consider the application in the context of other services that exist. Mr. Parker replied that in any proposal to develop an FMF, the applicant would be expected to have evaluated other alternatives. He also noted for all CON projects an applicant is expected to evaluate alternatives.

Policy Objectives

Mr. Parker next reviewed the policy objectives in the draft SHP chapter. He explained that the policy objectives are a set of broad parameters set based on the MHCC's goals that also provide a basis for specific standards. The policy objectives for FMFs address improving access for emergency medical services as well as providing services in the most cost effective manner. The policy objectives also stress matching capacity to the needs of the population served. In addition, FMFs must provide high quality care and continually seek to improve the level of achievement and use services appropriately. Finally, the objectives for the development of FMFs must align with other major initiatives of the Commission in terms of promoting electronic health

records as a way to improve quality. Mr. Parker asked members of the work group if they had feedback or questions about the introductory section of the draft SHP chapter. Several work group members asked questions and provided feedback on various issues, as indicated below, before the work group returned to the planned agenda.

Comments and Questions from Work Group Members

Establishment of an FMF

Mr. Brett McCone asked whether non-hospital related entities, such as a group of doctors, a large insurer, or one of the larger out-of-state chains, would be permitted to develop an FMF. He noted that the draft SHP chapter seems to imply that only hospitals may establish an FMF. Mr. Parker agreed that the policy is intended to only allow acute care general hospitals to develop an FMF. Ms. Suellen Wideman mentioned that when FMFs were first considered by the Maryland General Assembly, the only option presented was establishment by an acute care general hospital. Mr. Parker noted that while we have seen the development of this type of facility across the nation by entities other than hospitals, the intent in Maryland is that only acute care general hospitals establish FMFs.

Mr. John Hamper asked whether hospital service areas or geographic boundaries will be used to evaluate a hospital's proposal for an FMF. Mr. Parker stated that the draft SHP chapter indicates that a hospital's service area will be used to evaluate the proposed location of an FMF.

Evaluation of Cost-Effectiveness

Mr. Hamper commented that in order to achieve cost-effectiveness, given hospitals have fixed budgets, the MHCC needs to coordinate with HSCRC and reassess the budgets of hospitals based on volume shifts. In his view, the issue was not addressed in the draft SHP chapter. Mr. Dennis Phelps commented that HSCRC would plan to reassess hospitals' budgets, but it may not be appropriate to include in the SHP chapter. Mr. McCone commented that it is important to balance policy objectives. For example, if an FMF is established to address overcrowding, then consideration must be given to access, whether it is geographical or financial access.

Evaluation of Impact

Mr. Jepson asked for clarification on the following standard: "The proposed establishment, expansion, or relocation of an FMF shall not have an undue negative effect on existing hospitals or other FMFs." He specifically asked how MHCC staff would quantify the impact of a proposed FMF when processing an application. Ms. Fleck asked Mr. Jepson if he thought the regulations should be more specific. Mr. Jepson responded that the regulations should not be more specific, but it is hard for an

applicant to quantify the impact of a proposed FMF. It was suggested that each application for a new FMF would have to be evaluated separately to determine if there is an undue negative impact on an existing hospital or FMF.

Ms. Amy Perry asked if someone could explain the impetus for the legislation directing MHCC staff to develop CON regulations for FMFs. She asked what problems is solved by having FMFs. Mr. Parker responded by providing a brief history and overview of Shady Grove Adventist Hospital's development of the first FMF in Maryland. The Hospital is located in Montgomery County, and an area north of the Hospital (around Rockville) experienced a significant growth in population over a decade ago resulting in severe overcrowding in the Hospital's emergency department. Rather than expand the capacity of the Hospital, Adventist HealthCare designed a small hospital facility in another location. However, the Commission had an unfavorable opinion of this project.

A satellite emergency department was then planned to address overcrowding in the Hospital's emergency department and improve access to emergency care for the growing population. The State legislature suggested that Maryland may need a new category of facility, a freestanding emergency facility, and a single pilot project in the Germantown area was developed. This pilot facility was not rate regulated. However, a few years later, the legislature returned to this issue and created a second pilot project on the Eastern Shore. It also established a policy of rate regulation for all FMFs. Mr. Parker asked if he had provided sufficient background on the development of FMFs in Maryland. Ms. Perry said that his explanation completely answered her question, and she can understand why FMFs need to share revenue with the "parent" hospital.

Mr. Parker commented that the draft impact standard does not quantify an "undue negative effect." Instead, the impact standard simply states that an FMF should not have an undue negative effect on an existing hospital or other FMF. The standard then describes the impact analysis required for applicants. The impact standard also states that "A project shall not have an undue adverse impact on the financial viability of any hospital or other FMF." Mr. Parker noted that the MHCC did not attempt to delineate the negative effect of a proposed FMF on other facilities, for example by declaring that a reduction of 20 percent of the volume is unacceptable. However, as shown below, the standard states that an applicant is expected to quantify projected changes to the cost of emergency services to the extent possible.

> *An applicant shall provide an analysis of how the cost of emergency services for the health care system will change as a result of the proposed establishment, expansion, or relocation of an FMF, quantifying those projected changes to the extent possible.*

Mr. Parker said that how HSCRC adapts the global budget to a specific region where an FMF is developed is an important consideration, but MHCC will not be directly evaluating proposals based on changes to global budgets. The Commission, however, wants to be consistent with HSCRC policies.

Mr. Dennis Phelps remarked that any language included in regulations should be broad enough to allow HSCRC leeway to make an assessment. Mr. Phelps noted that in order to get paid, the FMF has to meet Medicare criteria for "provider-based status," including being within 35 miles and integrated with the management of the parent hospital. Ms. Webster said there are also practical considerations such as transportation and nursing staff that have to be considered for Medicare regulations. Mr. Parker suggested that the MHCC staff include language in the introductory section of the draft SHP chapter that discusses HSCRC's policies regarding development of an FMF.

Definition of FMF

Ms. Jennifer Wilkerson commented that the draft SHP chapter used vague words to describe FMFs, and her impression is that there are a lot of gray areas. For example, the draft SHP chapter fails to state that these facilities must be open 24 hours a day and seven days a week (24/7). Ms. Fleck asked if she was referring to the introductory section of the draft SHP chapter where MHHC staff first discussed freestanding emergency centers in general and then later discussed the model of this facility in Maryland. Mr. Phelps commented that the required operating hours for an FMFs are included in the Maryland statute. Mr. Jepson asked if there would be changes to the definition. Ms. Webster responded that there are no proposed changes in Maryland. However, she said that there may be a few minor changes to COMAR 10.07.08 generated from the work group's discussions.

Mr. Parker explained that the draft SHP chapter includes a generic discussion of freestanding emergency centers where MHCC staff used words such as "generally" or "usually" because there are many different models of freestanding emergency centers and not all of them are open 24/7. However, in Maryland this type of facility is called an FMF, and all FMFs are required to be open 24/7. Ms. Fleck stated that MHCC staff can add to the definition of FMFs in the draft SHP chapter to reflect the statute and licensure regulations.

Quality of Care and Policy Objectives

Mr. McCone noted that only two process measures for evaluating the quality of services provided in FMFs in Maryland were listed on page 11 of the draft SHP chapter, "throughput" and "time to hospital admission." Mr. McCone asked if there were other outcome-based measures that would be introduced. He also asked if

Policy 5 on page 12 meant that a hospital had to demonstrate compliance with the standard or whether it is just a policy objective. Policy 5 is shown below.

> *An acute care general hospital operating an FMF shall assess the primary care needs of the population in its service area and maximize the number of people in its service area who have a regular source of primary care.*

Mr. Parker explained that the policy objectives in SHP chapters broadly guide the Commission's recommendations and are not project review standards. However, he noted that there are project review standards that address the policy referenced by Mr. McCone. For example, Mr. Parker stated that when an FMF is being developed, the hospital must address the handling of patients without a regular source of care and explain the steps that it has taken to minimize the flow of patients seen at its an emergency department or FMF for non-emergency care. In addition to addressing specific project review standards, Mr. Parker noted that he would expect an applicant to show how its project is consistent with the broad policy objectives.

Mr. Parker stated that the draft SHP chapter has three specific quality measures. For example, applicants will be required to address the National Quality Forum process measures that apply to hospital emergency departments. Mr. Parker added that it also makes sense to look at these quality measures for FMFs. Initially, Mr. Parker commented that outcome measures were not included in the draft SHP chapter, but may be included in the future. However, Ms. Fleck disagreed, noting that the draft SHP chapter stipulates compliance with the outcome measures contained in the Maryland State Health Improvement Process Plan. For example, the Plan includes goals for reducing visits by patients with specific conditions such as asthma or hypertension. Ms. Renee Webster noted that since FMFs are treated as an extension of hospitals' emergency departments (EDs), any quality measure applied to an ED would apply to the FMF. Mr. Parker added that there will always be the need to update outcome and process measure of quality because the field of quality measurement is evolving.

Project Review Standards

Need Standard

Mr. Parker returned to a question raised earlier by Mr. Jepson, noting that CMS requires that an FMF be located within 35 miles of the parent hospital. However, Ms. Webster added that services need to be provided as an integral part of the parent hospital, and in some urban areas even ten miles may be difficult due to traffic issues with transferring patients from the FMF to the parent hospital. CMS requires that a majority of patients be transferred to the parent hospital. Mr. Jepson

commented that his concern is that hospitals might inappropriately use FMFs to shift market share.

Mr. Parker explained that the current approach in the draft SHP chapter is to use the service area of the parent hospital to determine where an FMF can be developed. An FMF has be established in the parent hospital's service area which is defined as follows.

> *the zip code areas from which, cumulatively, 85% of patient visits to a hospital's ED or an FMF originate, inclusive of the zip code areas ranked from highest to lowest providing the highest proportion of the hospital ED or FMF's total patient visits in the most recent twelve-month period for which patient origin information is available.*

It was noted by one work group member that geographically, this would include a smaller area than the hospital service area as a whole. Mr. Parker agreed and commented that it is the appropriate approach for emergency services. Mr. Phelps suggested that the language in the draft SHP chapter should allow for flexibility and not include a specific number of miles, in case the CMS standards for Medicare providers change. The work group discussed revising the draft need standard to include the following language, "within the service area of the parent hospital and consistent with provider-based status regulations." This change was proposed by some work group members due to the importance of meeting CMS regulations regarding provider based status.

Ms. Wideman read the statute of Health General §19-3A-02 pertaining to adopting regulations that require FMFs to be open 24/7. Ms. Webster commented that FMFs are a priority for CMS due to their growth in recent years, so it is important to consider CMS's regulations carefully.

Ms. Wilkerson asked about a scenario where an acute care general hospital becomes a limited service hospital and then wants to establish an FMF. Mr. Parker told the group that there would be an in-depth discussion about the relationship of the limited service hospital (LSH) concept and FMFs at a later time. However, he noted that no limited service hospitals have been developed in Maryland, and there is not a parent hospital for an LSH, unlike an FMF. Mr. Parker suggested that it may be important to integrate the two concepts or consider eliminating one category of facility.

Mr. Parker asked if anyone had an alternative view on the criteria to use for evaluating whether the proposed location for development of an FMF is acceptable. He added that he believed the draft standard reduces the likelihood of a hospital developing an FMF to take away market share from its competitors. Mr. Jepson

asked that the Commission keep in mind that not all service areas are alike. In situations where the primary service area of two or more hospitals overlaps, he noted that the impact standard will be an important consideration.

Mr. Parker continued the discussion of the need standard by noting that there are two basic justifications for establishing an FMF, the need to address overcrowding at the parent hospital's ED and the need to improve access. He noted that in most cases he would expect both overcrowding and access issues to be cited as justification for an FMF. Mr. Parker next explained that the need standard also describes the types of analyses that determine if there is overcrowding or a problem with access. He asked for feedback on the draft need standard, including specifically whether the description of the analysis required for applicants provides sufficient guidance. Mr. Jepson said that the rationale behind using overcrowding and access problems as the basis for considering establishment of an FMF is good.

Ms. Patti Willis commented that the wording "access to ED services" may be too narrow in scope. She explained to the work group that in places such as the Eastern Shore, FMFs may improve access to healthcare in general not just access to emergency services. She said that while an FMF is not intended to replace primary care, in rural areas where getting access to primary care is an issue, EDs and FMFs become that front door for access to healthcare. Ms. Willis explained that transportation time is an issue in rural areas, and an FMF can reduce travel time, getting individuals to the appropriate level of care in the right amount of time.

Mr. Jepson asked how the issue of using the ED for primary care for healthcare fits with the State's desire to decrease acute care utilization. Ms. Willis responded that although it does not fit with the State's mission, the reality is very different in rural areas where revenue differentiation make primary care recruitment almost impossible. EMS vehicles put on miles transporting people for what may be considered primary care in rural areas, but in Queen Anne's County EMS is engaged in some innovative programs to address that issue. She agreed that the challenge requires community education and other approaches that are detailed in the draft SHP chapter. Nevertheless, Ms. Willis suggested that the Commission also keep in mind the reality for rural areas when drafting standards about primary care access for the SHP chapter.

Mr. Parker stated that he understood Ms. Willis's point. He then explained that the draft SHP chapter requires that an applicant include two things in a needs assessment. First is a good description of the service area population. Second is a statement of the problem that needs to be resolved as well as a plan of how the FMF addresses the specific problems identified. The applicant also needs to show how its community health assessment, which is required of every hospital, relates to the

development of the proposed FMF. Within the community needs assessment, there should be a discussion of the need for primary care and the approaches that have been tried.

Mr. Parker explained that the need standard requirements align with another SHP chapter, COMAR 10.24.10. In this SHP Chapter, a hospital seeking to expand its ED capacity must use the American College of Emergency Physicians' (ACEP) Guidelines. Similarly, an applicant seeking to establish an FMF must use the ACEP Guidelines to evaluate needed capacity. In addition, when an expansion of a hospital ED or development of an FMF is proposed, the applicant must explain the steps taken to discourage patient visits for low acuity conditions that could be handled at other facilities. Ms. Fleck noted that in response to this standard, an applicant could address the issue of a lack of primary care and the efforts that have been made to encourage patients to obtain primary care elsewhere.

Mr. Parker asked for additional feedback on the need standard, specifically whether the needs assessment required of applicants is sufficient to demonstrate whether overcrowding or access is a problem. Mr. McCone asked whether it is up to the applicant to measure the use of urgent care in the service area and how that should be measured. He asked whether it would be sufficient to simply identify all the facilities. Mr. Parker responded that the applicant needs to explain how the availability of urgent care supports a demonstration of need for an FMF. Mr. Parker added that urgent care is defined as "the provision of medical services on a walk-in basis for primary care, acute or chronic illness and injury."

Mr. McCone asked for clarification about the need provision for describing the insurance status of the population as well as the requirement for an estimation of the number of uninsured, underinsured, and indigent patients in the projected service area. He wanted to know if this related to the impact on prices, if prices are set for FMFs, or whether it was related to a financial barrier to using urgent care. Mr. Parker confirmed that the standard was included based on both concerns noted by Mr. McCone. Mr. Parker commented that there are limitations on financial access to urgent care, and FMFs will provide better access than urgent care centers for uninsured individuals. Applicants will have to describe the limitations on access to urgent care in the service area.

Mr. Phelps asked if anyone was collecting data on the urgent care centers. Mr. Parker responded that since urgent care centers are unlicensed facilities, they are not regulated. They are treated essentially the same as physicians' offices. Mr. Parker added that although the MHCC started looking at urgent care centers over the past year as part of the final report on the utilization and financing of FMFs for the legislature, there is no robust data base with information on utilization. Mr. Jepson

asked for confirmation that the burden of analyzing alternatives is on an applicant, and Mr. Parker agreement with his assessment.

Ms. Lisa Myers noted that from an EMS perspective, it does not matter how many urgent care centers there are in an area because patients cannot be transported to an urgent care center. Mr. Parker noted that the MHCC is not trying to equate urgent care with FMFs. However, they are one of a few options for unscheduled care, so an applicant will have to research options for unscheduled care in the service area, as will MHCC staff.

Mr. Dean Kaster noted that the impact section of the draft SHP chapter does not reference the impact that an FMF may have on urgent care centers in the area. Mr. Parker said that the focus would be on the impact of FMFs on hospital emergency services and other FMFs.

Ms. Wilkerson pointed out that on page 14, under .04B(1)(iv)(a) of the draft SHP chapter there is no mention of how patient observation may fit into the discussion of crowding. She asked if this should be more explicit and if FMFs can have observation beds. Ms. Wideman said that observation beds are not forbidden by statute. MHCC noted that the topic of observation beds would be covered at the next meeting. However, Mr. Parker asked the representatives of the current FMFs if those facilities had observation beds. Mr. Jepson said that the Germantown Emergency Center observed patients if they were waiting for tests, lab results, or x-ray results. It was noted that the facility could not obtain the same reimbursement for these patients as a hospital ED when there is an ordered observation of a patient.

Mr. Phelps said that the question of reimbursement to FMFs for observation had been raised before. He noted that FMFs do not get reimbursed at the same level as a hospital ED. The FMFs have relative value reimbursement based on clinical care time. Ms. Webster said that these facilities are not set up to be long-term observation facilities especially since they do not have dietary capabilities. Mr. Parker posed a question to the work group asking if there should be something included in about observation and crowding.

Access

Mr. Phelps asked whether the draft explicitly addresses the access to financial aid policies of FMFs. He proposed that FMFs should follow the same financial assistance policies as the parent hospital since they are considered part of the hospital. Ms. Willis noted that these facilities are a department of the parent hospital. However, Mr. Phelps asked if the draft SHP said that FMFs are a department of the acute care hospital, and Mr. McCone noted that the definition in the draft SHP chapter states that FMFs are regarded as a hospital department. Mr. Parker said that

the MHCC staff can include as an access standard that the FMF has the same charity and financial assistance policy as the parent hospital.

Mr. Hugh Guest asked if cultural aspects of the population to be served by an FMF, such as different languages, come into play when evaluating access to services. Mr. Parker said that language definitely affect the ability of individuals to access services. An application for an FMF should describe the barriers to emergency services and how the proposed FMF will address this issue.

Ms. Myers suggested that in .04B(2)(a) and (b) the word "medical" be removed, and the standard refer instead to emergency services to avoid confusion with providers of emergency services, commonly referred to as EMS. No one objected to this proposed change.

Ms. Willis said that there was nothing in the draft SHP chapter that requires the parent organization to work with EMS jurisdictions in the development of an FMF. She noted that this was critical when developing the FMF in Queenstown. Ms. Myers noted that she thought the Montgomery County EMS also worked closely with Shady Grove Adventist Hospital in its development of an FMF. Ms. Webster noted that the draft SHP chapter refers to working with the Maryland Institute for Emergency Medical Services and Systems and perhaps that addresses the concern raised.

Mr. Jepson expressed concern about EMS being in a position of picking sides if there are two hospitals with overlapping services areas that are both seeking to establish an FMF. Ms. Fleck suggested that MHCC staff could add language that referred to coordinating with the EMS system. However, Ms. Willis explained that her concern is considering the impact on the EMS system in terms of transport times and return to service time. Other members of the work group suggested that the issue could be addressed in either the need or impact standards. Mr. Parker said the staff would work on addressing the issue under the need or access standard.

Mr. Parker then summarized the access standard briefly. For .04B(2)(c), Mr. McCone suggested the following text instead "A new or relocated FMF shall be located to optimize accessibility for patients who are currently served in the applicant hospital's service area." Mr. Parker agreed with this proposed change.

Cost and Effectiveness Standard

Ms. Fleck noted that the cost effectiveness of a proposed CON project must be addressed by an applicant for most CON projects. For the draft SHP chapter on FMFs, she explained that an applicant is expected to demonstrate the cost-effectiveness of the proposed FMF by comparing at least two alternate approaches for achieving the same objectives. The applicant needs to identify the primary objectives of the project and provide capital cost estimates,

operational expenses, and operational revenue over a period of time. The applicant also needs to quantify, to the extent feasible, the measures used to evaluate the cost effectiveness of the proposed project and explain why other less expensive models of unscheduled care delivery such as urgent care centers cannot meet the needs of the population. The applicant also needs to explain the steps it will take to comply with the Maryland State Health Improvement Process Plan. The Plan's goals include reducing the number of visits due to diabetes, hypertension, asthma, and mental health conditions. Finally, an applicant must describe what it will do to promote care coordination and its evaluation of those efforts in terms of the parent hospital's ED and the proposed FMF.

Ms. Fleck asked if there are any questions or changes that need to be made or if the language needs to be more specific. Mr. McCone asked whether an applicant has to identify at least two alternate approaches. Mr. McCone wanted to know if this could be either a geographical alternative, a service alternative, or both. He said that MHCC staff may have answered this question already by requiring that an applicant evaluate the availability of urgent care services. He then asked if it is a requirement for an applicant to look at urgent care from a service perspective. Mr. Jepson replied that having to identify two alternative approaches is a routine question for CON applicants. Ms. Fleck commented that MHCC staff may follow up if they think there is an obvious alternative that was not considered by the applicant. Mr. McCone then asked if it was implied that it would be the parent hospital who has to address coordination of patient care. Ms. Fleck replied that the parent hospital is the applicant.

Before moving on to a discussion of the efficiency standard, Ms. Fleck asked if anyone had additional feedback on the cost effectiveness standard. Mr. Jepson asked if HSCRC provides advice and counsel on the cost effectiveness of proposed FMF projects. Ms. Fleck explained that HSCRC usually looks at the hospital's budget and rate setting, and CON staff reviews cost effectiveness and efficiency.

Efficiency Standard

Ms. Fleck explained that the efficiency standard requires that the applicant demonstrate that the delivery of emergency services in its service area will improve as the result of the proposed project. An applicant must also describe how the FMF will affect the efficiency of emergency services delivery, how process improvement will be accomplished, and the effect on the cost per visit. In addition, the applicant must detail the actions that will be taken to integrate care at the parent hospital's ED in a way that will reduce the need for costly visits at the hospital's ED and the proposed FMF.

Ms. Fleck asked if there were any questions about this standard or if there were specific measures of efficiency or specific measures of care integration or coordination that should be used by the applicant. Mr. Jepson asked a general question about whether the MHCC staff felt that they had covered the State's goals in the draft SHP chapter. Ms. Fleck replied that the staff tried to address the State's goals by referring to the State Improvement Plan, and she asked

whether Mr. Jepson had any specific suggestions. He did not. The work group then moved on to the next standard, financial feasibility and viability which was led by Kathy Ruben, Health Policy Analyst with the MHCC.

Financial Feasibility and Viability Standards

Ms. Ruben noted that, as with the CON regulations for other types of services, an applicant is expected to demonstrate that the project will be feasible and viable, and the project will not have an undue negative effect on the financial viability of the parent hospital. Ms. Ruben noted that financial reports indicate that Maryland's FMFs rarely generate net income when viewed alone. However, based on the combined revenue generated by admitted patients that were first seen at an FMF, then FMFs may be generating net income for the parent hospital or system.

Ms. Ruben described the analysis required by the applicant in order to demonstrate the financial feasibility and viability of the proposed FMF. An applicant must present financial and utilization projections for ED visits as well as staffing levels. In addition, the applicant must demonstrate that within three years of opening, the FMF and the parent hospital will generate net positive revenue on a combined basis. The applicant also must provide evidence of community support for the project. Mr. Jepson asked if his understanding that a proposed project did not have to be financially viable on a stand-alone basis was correct. He was told by the MHCC staff that this was correct. Lastly, Ms. Ruben noted that an applicant must describe any current or projected regional workforce shortages of emergency trained personnel that could affect staffing and how it would address recruiting challenges.

When Ms. Ruben asked the group whether it agreed that the financial viability of the FMF should be evaluated on a combined basis with the parent hospital; they agreed. Ms Ruben then asked if there were other factors that affect the financial viability of the project that should be included in the draft. She also asked whether additional specific measures of community support should be included. Mr. Hugh Guest said that when he used to work in Cincinnati, Ohio, the Board of Health and the city council met on a yearly basis to make sure there was an understanding between the community and the City. Mr. Guest noted that he did not see that type of cooperation between local government and hospitals or medical services in Maryland. He wanted to know if that type of cooperation would be required. A short discussion among the work group members and MHCC staff about community involvement followed Mr. Guest's comment.

Ms. Ruben asked if there were additional questions or concerns about this section of the draft proposal. Ms. Willis asked if there was a specific reason that three years was selected as the time frame in .04B(6)(b)(iv). Ms. Fleck said that three years was typical across health plans. Mr. McCone suggested a wording change, in .04B(6)(b)(iv). Instead of referring to "net positive revenue," he proposed that the standard refer to "net positive operating income." MHCC staff agreed with this proposed change.

Impact Standard

Ms. Ruben provided a summary of the impact review standard. She explained that the proposed project should not have an undue negative effect on existing hospitals or other FMFs, the applicant must project the impact of the project on the parent hospital's ED patient volume and payer mix, as well as on the parent hospital's financial performance, ability to maintain specialized staff, and ability to deliver care to indigent and underserved populations. The applicant must also address how the proposed project will affect the cost of emergency services for the health care system. Ms. Ruben asked if there may be other potential negative impacts that should be added to the draft State Health Plan chapter.

Mr. Jepson asked exactly what was meant by the term "undue negative effect." He also noted that for .04B(7)(a) there were five indicators of a negative effect that were mentioned yet in .04B(7)(b) there are no indicators mentioned other than financial impact. He commented that more specificity is required in .04B(7)(b), and he suggested possibly using the same five indicators in .04B(7)(b). Ms. Fleck noted that an applicant may have difficulty addressing the same parent hospital indicators for other hospitals.

Ms. Willis agreed with Mr. Jepson that section .04B(7)(b) of the draft SHP chapter needs to be more specific in terms of the negative impact on other providers. She also noted that in .04B(7)(a), MHCC staff used the words "existing hospitals or other FMFs" and in .04B(7)(b) used the words "other health care facilities". Ms. Willis said that the wording in the second case is vague and should be more consistent. Another work group member commented that less specificity is better for pragmatic reasons. Mr. McCone asked if the words "health care system" in .04B(7)(c) referred to the broader health care system rather than the parent hospital or health care system. Ms. Fleck confirmed that Mr. McCone was correct.

Quality Improvement Standard

Ms. Ruben summarized the quality standard. She noted that an FMF must provide high quality care and continuously work to improve the quality and safety of services. She also explained that specific performance measures that will be used to evaluate proposed FMFs include median time from arrival to departure for patients who are admitted to the applicant's hospital, median time from arrival to departure for patients not admitted following an ED visit, and the admit decision time (the time between the decision to admit and actual admission to the hospital). Ms. Ruben also noted that the applicant must include a description of all quality measures used.

Ms. Ruben asked for suggestions on the most meaningful quality measures to include in the draft SHP chapter. Ms. Meyers suggested that it may be helpful to evaluate the data collected from the pilot FMFs to consider its use for quality measurement. She also asked whether data collection from the FMFs would be ongoing or only collected periodically during the CON application process. Mr. Parker responded that the data collected during the pilot study

was used by HSCRC for rate regulation, but it would not necessarily be useful for quality measurement. Ms. Myers mentioned that it would be useful to know the types of patients served at FMFs, mode of arrival, how often a visit results in admission, and outcomes. Another work group member suggested that readmissions should be evaluated. Ms. Wilkerson asked about the availability of data for tracking patients who get observation care, but are not admitted. Ms. Fleck commented that she did not think MHCC staff had the ability to identify those patients. It was suggested that the approach to collecting data for these patients be evaluated.

Mr. Jepson asked to hear the perspective of the Office of Health Care Quality (OHCQ). Ms. Webster responded that since OHCQ already tracks certain CMS measures for hospital EDs, the same measures should be used for FMFs because they are an extension of the parent hospital's ED. Ms. Fleck asked if the reporting on quality measures for hospital EDs affiliated with an FMF included the visits at the FMF. Ms. Webster stated that she expected it would be rolled together because FMFs bill under the same Medicare provider number as the parent hospital. Mr. Phelps commented that HSCRC collects CMS reports on quality measures and obtains a separate report for an FMF and the parent hospital's ED.

Discussion Topics for Second Work Group Meeting

Mr. Parker provided a document with a short description and comparison of the licensure regulations of FMFs, and he noted that it would be discussed at the next work group meeting. Mr. Parker explained that at the next meeting MHCC wanted to discuss the idea of having a single health care facility model that could be used both for the development of an FMF to address crowding or access issues and as a transitional model for a general hospital seeking to downsize and maintain a campus with only outpatient services. He explained that currently a hospital seeking to downsize and eliminate inpatient services has the opportunity to become a limited service hospital. Mr. Parker noted that the two models have many similarities, so MHCC staff wants to consider eliminating one of the models. Mr. Jepson asked if the limited service hospital model would be replaced by an FMF. Mr. Parker responded that it was more likely that would be the recommended outcome.

Mr. Jepson also asked if a revised draft SHP chapter would be provided for the next meeting that included changes discussed by the work group. MHCC staff responded that the same draft SHP chapter would be used for discussion, rather than an updated document. Mr. Parker suggested that members of the public have an opportunity to speak before Mr. Parker concluded the meeting. However, no members of the public wanted to comment. MHCC staff thanked the group for their participation, and the meeting was adjourned around 12:20pm.