

Meeting Summary
**Rural Health Care Delivery Work Group: Economic Impact of Changes to Health
Care Facilities/Economic Development Advisory Group**
October 28, 2016
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Advisory Group Member Attendees:

Bob Grace
Senator Stephen Hershey
Ken Kozel
Brett McCone
Kay MacIntosh
Commissioner Gerard O'Connor, M.D.
Joy Strand
Scott Warner (advisory group leader)

Other Attendees:

Dr. Luisa Franzini

Commission Staff Attendees:

Erin Dorrien
Paul Parker
Kathy Ruben
Ben Steffen
Suellen Wideman

Welcome and Introductions

The meeting convened at approximately 11:00 am. Erin Dorrien, the MHCC Chief, of Government & Public Affairs asked for a roll call of attendees. Scott Warner, Executive Director of the Mid-Shore Regional Council, who is serving as the advisory group leader, welcomed group members and discussed the agenda for the meeting. He also provided an explanation for an attachment that was emailed to Advisory Group members. This is information that will be collected and discussed at future Advisory Group meetings. Mr. Warner then introduced the guest speaker for the afternoon; Paul Parker who is the Director of the Center for Health Care Facilities Planning and Development for the Maryland Health Care Commission.

Defining a Freestanding Medical Facility

Mr. Parker gave a brief overview of what he would be discussing with the group. He noted that he would provide a definition of Freestanding Medical Facilities (FMFs), give a brief history of FMFs in Maryland, and discuss the original purpose of an FMF as well as recent changes in the FMF model. He then read the Maryland statute for FMFs with the following definition:

Definition of FMFs in Maryland

A "freestanding medical facility" means a facility:

- (1) In which medical and health services are provided;
- (2) That is physically separate from a hospital or hospital grounds; and
- (3) That is an administrative part of a hospital or related institution, as defined in § 19-301

Mr. Parker then described some of the additional regulations and requirements for an FMF including the requirement to be open 24 hours a day. Mr. Parker told the group that this type of facility has developed throughout the U.S. over the last 20 years and is called a Freestanding Emergency Center in other states.

Brief History of FMFs in Maryland

Mr. Parker informed the group that FMFs were conceptualized in Maryland around 2005 as a way for hospitals to extend their emergency room services following years of increasing emergency department utilization. This utilization resulted in overcrowding and decreased access to emergency care. The FMF was a way to extend services to other "satellite locations". The idea of FMFs first emerged in Montgomery County as a way to provide better access to emergency care for individuals living in Northern Montgomery County. Shady Grove Adventist Hospital wanted to expand care, and originally proposed a small five-bed hospital in the area in order to be rate-regulated. Their proposal was rejected by the MHCC.

Mr. Parker told the group that a freestanding medical facility pilot was established with two pilot projects. There are now three FMFs in operation in Maryland; the original two pilot facilities and another similar facility that had been created decades ago and was pulled under the

license as an FMF. Hospitals seeking to have an FMF must obtain a CON from MHCC and apply for a license from DHMH. The current FMFs were not created as a transition model for a hospital. FMFs are different from urgent care centers in that they must have trained emergency medical physicians and they function at a higher level of care. A second type of FMF was adopted during the 2016 Maryland Legislative session which was created to serve as a transition model. This model replaced the Limited Service Hospital.

Limited Service Hospital

Limited Service Hospitals (LSH) were created in the 1990's as an alternative model, as hospitals began to reduce inpatient hospitalizations. LSHs can only be created from a hospital. LSHs, however, eliminate the capability to admit or retain patients for overnight hospitalization and provide an emergency or urgent care center for the purpose of providing advanced life support. They must obtain an exemption from CON from MHCC and apply for a license from DHMH. Mr. Parker told the group that there are no limited service hospitals in Maryland.

Transition Model of FMF

Mr. Parker continued his discussion by describing a transition model of the FMF that replaced the limited service hospital in 2016 legislation. General hospitals can make this transition in a streamlined process as opposed to the CON process. This Legislation allows FMFs to provide rate regulated observation. It also allows other outpatient services to be rate regulated. Mr. Parker then described outpatient surgical services in an FMF, and the current regulations for CON for outpatient surgery if there are two or more sterile ORs.

Mr. Parker noted that the MHCC is in the process of finalizing regulations for the two types of FMFs (CON review and non-CON for conversion of general hospitals). He explained to the group that exemption reviews do require some process review. There are also public information requirements and requirements for MIEMSS for changes in the transport system. The Commission has adopted proposed regulations and has received some comments. The MHCC was advised that there were some problems, specifically with making the transformation model an easier non-CON path. Mr. Parker stated that the final process for the regulations and formal comments will take place in November and the adoption of formal regulations should take place in 2017.

Commissioner O'Connor asked if the conversion of Chester River Hospital to an FMF would fall under a satellite model or a transition model. It was noted that conversion of this hospital would not satisfy access or overcrowding. Mr. Parker said that it would be a transition, and the hospital would then be an administrative part of the parent hospital which is a requirement of an FMF. Commissioner O'Connor asked if there was a distance limitation for the FMF. Mr. Parker said that the Medicare regulation is 35 miles from the parent hospital. Ben Steffen, the Executive Director of the MHCC, said there is the possibility of an exception for this requirement. A short discussion of observation beds followed. Kay MacIntosh, the Economic Development and Marketing Coordinator for the Town of Chestertown commented that the group started to look at a FMF model for the hospital. She then asked if the group would look at other models. Ms. Dorrien said the group would look at many different models for the region as a whole.

Guided Discussion

Following Mr. Parker's presentation, the group moved on to a guided discussion of five questions led by Mr. Warner. He noted that hospitals are often the main employer in a rural area and asked:

- 1) Does a health care system have an impact on attracting citizens to move/stay in an area whether they are retirees or young adults with families?**

Commissioner Gerard O'Connor, M.D. was the first of the group to reply stating that in his experience, patients say they never would have moved to the area if they knew there was a possibility that the hospital would close. Ms. MacIntosh noted that when it comes to real estate in the area, the three factors that help sell are: the local college, the hospital, and the beautiful surroundings of the County. She said that for young families, the loss of pediatric services will be a problem.

Bob Grace, the President of Dixon Value headquartered in Chestertown, Maryland told the group that his company has 400 employees. Some of the employees have concerns about the local educational system, the medical care, and the hospital. The company is trying to attract younger employees, but if the hospital should close, he asked "where will we be?" It will make a huge impact not having everything in the County. He stated that it may be more attractive to locate the company elsewhere.

Commissioner O'Connor noted that it will be difficult to attract employees without a full-service hospital nearby. Plus, he said, the County will be without sub-specialists. Ms. MacIntosh remarked that there will then be a loss of population. The families of physicians, who have a positive impact on the County, would also leave. Another Advisory Group member said that even now in Chestertown, since some medical services have left, a person having an appointment that should only be one to two hours long has to now travel and this turns into an all-day event.

Joy Strand, the CEO of McCready Health, discussed her experience in Crisfield, Maryland. She said that there, they have a lot of retirees and a large elderly population. Ms. Strand said that one of the reasons that people move there is because of the hospital in addition to the availability of primary care, diagnostics and the emergency room. She noted that they have a pediatrician that comes there to provide care.

Mr. Warner thanked everyone for their comments to this question, as well as the examples they provided. He said it seems as though the issues are the same in Dorchester County and on the lower Eastern Shore as they are in Kent County. He also noted that some of the conversation touched on the next question as far as businesses that may have concerns about health care facilities and may be looking to relocate. The group was then asked about question two.

2) To what extent does a local health care system maintain a local economy?

Commissioner O'Connor provided an answer for this question. He said that there were about 700 hospital employees at the University of Maryland Medical Center at Chestertown. The hospital provides about \$28 million in income for the County. Ms. MacIntosh said that in Kent County, about 9% of the jobs are related to the hospital. The group then moved on to the next question. Ms. Dorrien stated that she would like to hear from Ms. Strand and Mr. Ken Kozel, the CEO of Shore Regional Health with respect to question three.

3) How do national and state trends in health care delivery (declining inpatient care, movement toward global hospital budgets, increase utilization of community base care, move toward population health initiatives etc) advantage or disadvantage rural areas?

Ms. Strand said that there are advantages and disadvantages to the Total Patient Revenue and models in Maryland. She noted that there are challenges in both rural and urban settings. However, the challenges are different because of the unique attributes of each setting. She told the group that many rural hospitals in the U.S. have closed or merged. Ms. Strand said that Total Patient Revenue is not a silver bullet, but that Maryland seems to be doing well with the waiver. She asked, however, “What do we do in Maryland to stay viable?” She added “Nobody wants to see their hospital close”. Commissioner O'Connor stated that Global Budget Revenue keeps people out of the hospital by providing community-based care. He also noted that the hospital in Chestertown is “in-the-black”.

Ms. Dorrien then asked Mr. Kozel to share his thoughts on the advantages and disadvantages of Total Patient Revenue from Shore Regional Health's perspective. Mr. Kozel said that one of the original challenges was that the competitors were still fee-for service and were taking over the market share. This is no longer the case since all hospitals in Maryland are Total Patient Revenue. He said that one of the greater challenges today is maintaining quality as a result we don't meet quality indicators.

Mr. McCone commented that nationally, we are seeing a number of rural hospital closings including small hospitals and critical access hospitals. He noted that closings do not only happen to hospitals that are not financially tenable, but also to hospitals that do not have a certain volume of patients. He said that attracting physicians to rural areas costs. Mr. McCone then outlined for the group the differences in payments to critical access hospitals (CAH) and under Maryland's Global Budget Revenue (GBR). CAHs are paid for most inpatient and outpatient services to Medicare patients at 101 percent of reasonable costs. He told the group that under Maryland's GBR there is no cost shifting where a hospital can charge higher rates to private insurance to make up for the low rates Medicare is paying.

Mr. Steffen said that the group would further discuss Global Budget Revenue and Total Patient Revenue. He said that the group would also hear from Dr. Alana Knudson from the Walsh Center for Rural Health Analysis, about the PA model and GBP for rural hospitals. Rural providers must identify performance improvement opportunities for their hospitals and networks, and develop strategies for successfully transitioning to population health. Incentives are given for delivering safe, efficient care. Mr. McCone said that Medicare is looking at PA which is a demonstration. They are also looking nationally at other efforts. Medicare has a Payment Advisory Committee that published a paper, *Emergency Room Care in Rural Areas*, which examines viable alternatives. Mr. Steffen noted that the work group would look at various frameworks for funding.

Ms. Strand described the work group's charge and said that the group needs to look at creative ways to look at health care. There is nothing to prevent the group from creating a new model of care. The work group has to understand what is out there and what can be done to make it work better. Mr. Kozel explained that at some point, decreasing hospital census and low patient volume can compromise outcomes. The hospitals still need to maintain equipment and physicians. Mr. McCone said that all hospitals must eliminate unneeded services and change incentives.

Mr. Warner then presented the next question to the group:

4) How can changes to the health care sector be leveraged to positively impact the economic development of the region?

Ms. MacIntosh said she would like to see health systems share resources, and see some of the smaller hospitals benefit from pooled resources. Ms. MacIntosh then stated that they are excited about telemedicine. She also described the Chester River Wellness Alliance which is a collaboration of health and wellness practitioners, business owners, and individuals who are committed to building a community of health. Ms. MacIntosh noted that there are a lot of community initiatives out there.

Ms. Dorrien told the group that other advisory groups had also discussed telehealth. She told the group that she would share a presentation on telehealth that was given to one of the other Advisory groups. Mr. Kozel noted that in addition to more primary care givers; greater coordination of care, strategic partnerships, and enhanced education can be leveraged to positively impact the economic development of the region.

Mr. Warner presented the final question to the Advisory Group members:

5) What policies or programs should be in place to increase economic development surrounding a relocated or converted facility? (ie the establishment of economic enterprise zones)

Commissioner O’Conner said that one thing that should be in place to increase economic development is the transportation system. He noted that we have to “revamp the transportation system; and told the Advisory Group that Kent County spent 1.3 million last year to transport patients. He also mentioned economic enterprise zones.

Ms. MacIntosh told the group that Chestertown was designated as an Enterprise Zone to expand businesses around the hospital. Additional policies or programs that she mentioned that may increase economic development included: reimbursement for medical school, providing transportation for families (not just patients), and having more flexible visiting hours. Ms. MacIntosh remarked to the group that when a facility leaves an area, “why do all of the jobs have to also move”? She asked “Why can’t some of the hospital departments such as scheduling or billing stay in the area”?

Wrap Up and Next Steps

Ms. Dorrien thanked the entire Advisory Group for a productive session and described some of the next steps for the Advisory Group and for the larger Work Group. Some of the ideas generated during this Advisory meeting may be expanded upon in future meetings. Advisory Group members should complete the questions below to inform future meetings. Advisory group members will be contacted by email about the date for the next meeting. Ms. Dorrien noted that the next large Work Goup meeting will be held November 1st in Cambridge, Maryland. Mr. Grace asked Ms. Dorrien if there was a schedule for additional Work Group meetings. Ms. Dorrien informed the group that there will be a meeting on January 9th. There will also be meetings in March and May, however, the dates for these meetings have not been selected. The meeting adjourned at approximately 1:00 pm.

Rural Health Economic Development Advisory Group
Questions to be Answered/Discussed in Future Meetings

I. Health Industry Employment

Current Employment

What is the current staffing of the hospitals located in the five county region and where do they live?

Chestertown:

Number of employees:

Counties they live:

Easton:

Number of employees:

Counties they live:

Cambridge:

Number of employees:

Counties they live:

What is the current compliment (total employed) of all medical practices owned by Shore Health in each county (Caroline, Dorchester, Kent, Queen Anne's and Talbot)?

How many of these practices are located in whole or part in each county?

Future Employment

What is the forecasting of the staff required in each hospital once the new regional medical center is built in Easton?

Number of employees:

Chestertown:

Easton:

Cambridge:

II. Construction Impact for Shore Health Regional Medical Center

Is there a plan to have at least some percentage of the construction of the regional medical center to be awarded to companies in Talbot County or companies located in the five county region?

III. Real Estate Impact

What is the impact on commercial real estate and real estate taxes when any of these three hospitals move, down size or close? This is in relation to the private ancillary businesses, e.g. doctor practices, therapy centers, treatment centers, etc. (This relates to both short-term and long-term plans.)

Example specific to Easton:

Given the long-term plans to build out office space at the regional medical center site, what will be the impact on the Idlewild Avenue/Dutchman’s Lane corridor?

Will all of the office space build-out at the regional medical center site be under the non-profit umbrella and what is the timing?

IV. Retail Sales Impact

What is the economic impact on the towns of Chestertown, Easton and Cambridge from a retail sales perspective, when the hospital moves or converts to a FMF?

V. Engagement with local employers and labor

How much outreach does the UM Shore Regional Health system reach out to local vendors?

VI. Staff retraining

Will there be a need to retrain staff upon as the UM Regional Health System reconfigures there services?

If so, how will it affect each location?

Chestertown:

Easton:

Cambridge:

VII. Define disposition of a facility – how can it be repurposed?

What are the plans for facilities that will be abandoned by a move to new facility or service restructuring in each of the towns?

Chestertown:

Easton:

What are the specific plans for the existing Easton hospital when the regional medical center is complete?

What are the specific plans for the other facilities in Easton that will be relocated to the regional medical center?

Cambridge: