Maryland

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Informal Comments to State Health Plan for Facilities and Services: Acute Care Hospital Services, COMAR 10.24.10

1 message

James C. Buck <jbuck@gejlaw.com> Wed, Jun 28, 2023 at 3:31 PM
To: "mhcc_regs.comment@maryland.gov" <mhcc_regs.comment@maryland.gov>

Dear Ms. Bertinelli and Ms. Tepe:

I write to provide informal comments to the draft State Health Plan for Facilities and Services: Acute Care Hospital Services, COMAR 10.24.10 (the "Proposed Regulations"). More specifically, I write to identify a few typos our firm identified in reviewing the Proposed Regulations as follows:

1. On page 8, under the title The Maryland Hospital Payment Model, the second sentence states: "Since the late 1970's, Maryland has operated under a waiver from Medicare rules that allows Maryland to set hospital rates for both private payors and government, so long as certain conditions are met. Since the previous update of this Chapter of the State Health Plan in January 2009, the Certificate of Need regulatory process and hospital rate setting system which is unique to Maryland has continued to evolve." We believe this should state . . . "both private payors and government payors. . . " or "both private and government payors. . ."

2. On page 9, last full paragraph, the second sentence states: "There is also an opportunity to propose that a different model by considered for adoption during 2026." We understand "model by considered" should be "model being considered."

3. On page 14, under the section on "Geographic Accessibility," the first sentence reads: "A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility for the population in the likely serve area." It appears "service area" misspelled.

4. On page 43, in the definition of "Inpatient Unit Program Space per bed" the reference to "HIPPA" should be to "HIPAA."

Regards,

James

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INSTITUTE FOR JUSTICE

June 14, 2023

VIA EMAIL

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
mhcc_regs.comment@maryland.gov

Re: Public Comments on COMAR 10.24.10 – Draft State Health Plan for Facilities and Services: Acute Care Hospital Services.

To the Maryland Health Care Commission:

The Institute for Justice (IJ) is a national public interest law firm dedicated to securing Americans' constitutional rights. This includes the right to earn a living free from unreasonable government interference. Individuals around the country, and in Maryland, want to improve access to healthcare at affordable prices, by offering innovative healthcare services, but certificate of need (CON) laws often stand in their way. For more than a decade, IJ has been working to reform CON laws around the country through litigation and legislation. IJ submits these comments to encourage the Maryland Health Care Commission (MHCC) to reduce the burdens associated with CON for acute hospital services. Doing so will increase access to needed care in Maryland.

INTRODUCTION

CON laws prevent healthcare providers from offering medical services. This harms patients. To improve access to healthcare, MHCC should make it easier for facilities to open. MHCC should take the opportunity while amending the State Health Plan for Facilities and Services: Acute Care Hospital Services ("Draft Plan") to reduce the burdens associated with the CON process.

Decades of evidence show that CON laws are harmful. CON laws increase the costs of healthcare, decrease its availability, and decrease the quality of healthcare. By any of these measures, CON restrictions should be loosened. MHCC should remove unnecessary requirements, especially any that may be duplicated by existing licensure requirements. And MHCC should generally focus on making the CON process easier to navigate to ensure that everyone in Maryland has access to quality healthcare.

TO INCREASE ACCESS TO ACUTE HOSPITAL SERVICES, RETHINK CON

The Draft Plan considers utilization data from 2009–2019. Over this decade, Maryland's population increased by approximately 7.5%, yet the Draft Plan shows sharp declines in the use of all acute hospital services except outpatient visits. Maryland's

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usage rates are also all lower than the U.S. averages. As a threshold matter, MHCC should be concerned about these numbers.

These declines in use, despite an increase in the population, could be a sign that healthcare facilities are being underutilized or are otherwise inaccessible. Healthcare can be inaccessible for many reasons. Many people skip going to the doctor when healthcare is too expensive or too far away. Clearly, CON laws are not working to solve the problems with cost or location of services. As discussed below, healthcare costs decrease and the number of facilities increase when CON regulations are reduced or eliminated. MHCC should remove CON barriers for acute hospital services to ensure that patients have access to needed services.

I. CON laws harm patients.

CON laws were adopted in the 1970s, at a time when the federal government was experimenting with ways to decrease its healthcare costs. It induced states to enact CON laws by conditioning certain federal healthcare reimbursements on whether or not they had CON laws. The theory behind CON laws was that reducing the supply of healthcare would reduce government spending. Thus, the architects of CON laws knew they would *reduce* the supply of healthcare. That was a feature, not a bug. Congress, however, quickly recognized that CON laws were an abject failure because they "failed to control healthcare costs and [were] insensitive to community needs."[1] In 1986, Congress repealed the federal mandate that initially induced states to adopt CON laws.[2]

Yet CON laws persist in more than half of the states today. One reason is because hospitals, the beneficiaries of the reduced competition, go to great lengths to ensure their survival. But decades of scientific research now show that CON laws lead to fewer healthcare facilities,[3] higher costs for individual payers and government payers, and increased mortality rates for many common conditions,[4] all while failing to increase the quality of healthcare.[5] In comparison, states with no CON laws enjoy greater access to healthcare.[6] The time has come for MHCC to give providers more freedom to provide necessary care to their patients.

II. Decreasing the regulatory burdens associated with CONs will fulfill MHCC's obligations.

MHCC is charged with ensuring:

> financial and geographic access to quality health care services at a reasonable cost by advocating policies and systems to promote the efficient delivery of and improved access to health care services and enhancing the strengths of the current health care service delivery and regulatory system. [MHCC] has sole authority to prepare and adopt the State Health Plan and to issue [CON] decisions and exemptions based on the State Health Plan.

Draft Plan at 2. To achieve these goals, MHCC should decrease the burdens associated with CONs to the maximum extent possible under its regulatory authority. Doing so is in line with the best available scientific research that shows how harmful CON laws are for individuals and healthcare systems.[7]

For example, CON laws decrease access to health care services, which is directly contrary to MHCC's mandate to improve access to health care services. Likewise, CON laws are a barrier to the efficient delivery of healthcare services. At the very least, MHCC can use its discretion to exempt providers from CON requirements to make healthcare more accessible throughout Maryland.

III. The requirements in the Draft Plan are unnecessary to achieve its goals.

Many of the requirements in the Draft Plan could be achieved through licensure, instead of through a program that restricts which providers may enter the market. The Draft Plan requires providers to meet a variety of qualifications when they submit a CON application, but many lack substance. For example, "an acute care hospital shall provide high quality care." Draft Plan at 12. This standard is meaningless without specifying how MHCC measures quality.

Moreover, the Draft Plan provides that hospitals must explain how they're planning to improve for any Quality Measures on which they scored below average in the most recent Maryland Consumer Guide for Hospitals. *Id*. That provision is only applicable to hospitals that already have a CON, but it implies that having a CON doesn't ensure that a hospital will meet the average standard of quality for the state. In fact, hospitals that have gone through the CON process routinely receive below average scores, showing that CONs do not ensure that healthcare services meet quality standards.

The Draft Plan also tries to achieve "Geographical Accessibility" by requiring that acute hospital services be situated so that "90 percent of the population in the health planning region . . . are within" "30 minutes under normal driving conditions." Draft Plan at 13–14. While it may be logical to attempt to persuade providers to locate somewhere close to population centers, this encourages providers to be concentrated in one area instead of more evenly spread throughout the state. This standard may actually harm rural communities.

* * *

These comments are not a comprehensive review of the Draft Plan. Rather, they are intended to guide MHCC in its global consideration before it adopts any new plan or new CON requirements. MHCC should take a close look at whether current standards

are achieving their goals and should follow the strong body of evidence that shows health outcomes improve when CON laws are eliminated.

Thank you for considering these comments and please contact me with any questions.

Sincerely,

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[1] Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in A "Managed Competition" System*, 23 Fla. St. U. L. Rev. 141, 147 (1995).
[2] *Id.*
[3] *See* James Bailey & Eleanor Lewin, *Certificate of Need and Inpatient Psychiatric Services,* 24 J. Mental Health Pol'y & Econ 114 (2021).
[4] Thomas Stratmann, *The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services*, 15 J. Risk & Fn. Mgmt. 272 (2022).
[5] *See, e.g.*, Christopher Denson & Matthew D. Mitchell, *Economic Report on Georgia's Certificate of Need Program* 18–30 (Apr. 2023) (reviewing and summarizing 90 peer-reviewed studies on CON's effect on cost, access, quality, and availability for underserved populations), https://www.georgiapolicy.org/wp-content/uploads/2023/04/CON-report.pdf.
[6] Matthew C. Baker & Thomas Stratmann, *Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws*, 77 Socio-Economic Planning Scis. 101007 (2021).
[7] *See* note 4, *supra*.

Maryland
Hospital Association

June 14, 2023

Eileen Fleck
Chief, Acute Care Planning and Policy
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215A

Dear Ms. Fleck:

On behalf of Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the opportunity to comment on COMAR 10.24.10- State Health Plan for Facilities and Services: Acute Care Hospital Services.

MHA suggests the Maryland Health Care Commission (MHCC) consider whether the proposed standards align with MHCC's goals to reduce burden of certificate of need (CON) on applicants and streamline the CON process. MHA supports these goals. However, some of the specific standards run counter to these goals.

It is important for MHCC to verify an applicant complies with state and federal price transparency and charity care policies, yet compliance should be verified only with those that enforce these policies. Further, MHA recommends MHCC discuss whether previously corrected non-compliance is a reason to deny a CON and whether MHCC has the authority to add conditions to CON in response to this non-compliance. MHCC should avoid regulatory scope expansion.

The Work Group considering this state health plan chapter updates also discussed whether it was essential for an applicant to provide two additional alternatives to the proposed project. This can be time-consuming and unnecessary. The Commission should consider whether an alternative could be put in place. For example, allowing an applicant to provide an explanation why fewer than two alternatives were considered.

We look forward to further discussing these regulations and continuing to work with the Commission and staff as they move through the regulatory process.

Sincerely,

Erin M. Dorrien

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Vice President, Policy

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June 28, 2023

VIA EMAIL

Alexa Bertinelli and Caitlin Tepe
Assistant Attorneys General
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Re: Proposed Draft State Health Plan Chapter for Facilities and Services: Acute Care Hospital Services, COMAR § 10.24.10, et seq.
Informal Comments Submitted on behalf of the University of Maryland Medical System

Dear Ms. Bertinelli and Ms. Tepe:

I write on behalf of the University of Maryland Medical System ("UMMS") to provide informal comments to the Maryland Health Care Commission's proposed amendments to the State Health Plan Chapter for Facilities and Services: Acute Care Hospital Services, COMAR § 10.24.10 *et seq.* (the "Proposed Regulations").

UMMS appreciates the opportunity to provide informal comments and urges the Commission to adopt the Proposed Regulations with the modifications discussed below.

I. COMAR 10.24.10.04A – General Standards

The introductory paragraph to the general standards under COMAR 10.24.10.03(A) states that "[e]ach hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards *that is applicable to its project* as part of its Certificate of Need application." (emphasis added). The next sentence, however, subjects an applicant for a request for exemption from Certificate of Need ("CON") review to demonstrate consistency with each general standard regardless of whether such standard is applicable to the applicant's proposed project. An exemption from CON review is intended to be a more streamlined and less burdensome process than a CON application. Thus, the same standard should be applied to an applicant for exemption from CON review as an applicant for a CON. The last sentence of the introductory paragraph should thus be amended to state:

"Each hospital that seeks an exemption from Certificate of Need review for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards that is applicable to its project as part of its exemption request."

A. Information Regarding Charges – COMAR 10.24.10.04A(1)

The Proposed Regulation relating to a hospital's compliance with price transparency laws and regulations should be amended to clarify that only violations of such laws as determined by the Health Education and Advocacy Unit of the Attorney General's Office shall be considered by the Commission. While members of the public may file complaints associated with perceived violations of hospital price and transparency laws and regulations with the Health Education and Advocacy Unit of the Attorney General's Office, the public is often not as informed of a hospital's actual obligations under such laws and regulations. Thus, mere complaints, which the Attorney General's Office does not substantiate, should not be considered by the Commission in connection with a CON application or CON exemption request. There should also be a reasonable temporal limitation on substantiated violations that have been rectified through remedial actions by the hospital. UMMS, therefore, proposes the following changes to Proposed Regulation COMAR 10.24.10.04A(1)(c):

"(c) A hospital's compliance with price transparency laws and regulations shall be validated by Commission staff through requesting information from the applicant hospital, the HSCRC, any violations as determined by the Health Education and Advocacy Unit of the Attorney General's Oeffice within the preceding two years, and other entities as appropriate."

Charity Care and Financial Assistance Policy – COMAR 10.24.01.04A(2)

Proposed Regulation 10.24.01.04A(2)(b) proposes that a hospital make a determination of eligibility for charity care or financial assistance within three (3) days. This standard is impracticable and inconsistent with MARYLAND CODE, HEALTH-GENERAL § 19-214.1 referenced in the immediately preceding Proposed Regulation. Maryland Code, Health-General § 19-214.1(h), provides, in relevant part:

"Each hospital shall develop a procedure to determine a patient's eligibility under the hospital's financial assistance policy in which the hospital: . . . (7) When a patient submits a completed application for financial assistance, determines the patient's eligibility under the hospital's financial assistance policy within 14 days after the patient applies for financial assistance and suspends any billing or collections actions while eligibility is being determined." (emphasis added).

Thus, the Commission's Proposed Regulation eliminates 11 days provided for by statute for a hospital to make a determination of eligibility after a patient submits a completed application for charity care or financial assistance. The Proposed Regulation should be amended to be consistent

with the statute referenced in COMAR 10.24.10.04A(2)(a) and to use the same terminology found in the statute as follows:

> (b) The policy shall provide that the hospital shall make a determination of eligibility within ~~three~~ fourteen ~~business~~ days following a patient's completion of an application for charity care services, application for medical assistance, or both.

As mentioned above, the general public is often not as informed of a hospital's actual obligations under laws and regulations governing financial assistance policy laws and regulations. Accordingly, mere complaints filed with the Health Education and Advocacy Unit of the Attorney General's Office, should not be considered by the Commission in connection with a CON application or CON exemption request. UMMS proposes the following changes to COMAR 10.24.10.04A(2)(d):

> "(d) A hospital's compliance with regulations for financial assistance shall be validated by Commission staff through requesting information from the applicant hospital, the HSCRC, any violations as determined by the Health Education and Advocacy Unit of the Attorney General's Oeffice within the preceding two years, and other entities as appropriate."

Project Review Standards – COMAR 10.24.10.04B

UMMS proposes the following changes to the project review standards.

A. Geographic Accessibility – COMAR 10.24.10.04B(1)

In the Proposed Regulations, the first sentence of Regulation 10.24.10.04B(1) was amended to remove the objective criteria, i.e., travel time, from the regulation requiring that an acute care hospital being replaced on a new site shall be located to optimize accessibility for the population in the likely service area. This objective criteria is necessary to ensure applicants understand the standard under which the Commission will evaluate optimal geographic accessibility. The Proposed Regulation should be revised to add back the objective criteria and to correct the spelling of "service" as follows:

> "A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for the population in the likely service area."

Non-Geographic Barriers to Access – COMAR 10.24.10.04B(2)

Proposed Regulation 10.24.10.04B(2)(a), under "non-geographic barriers to access," provides that:

> "An acute care general hospital shall only deny admission if it is unable to provide the appropriate level of care for a patient or if a patient's admission is involuntary and the hospital or hospital unit has been issued a waiver by the Commission that permits it to serve only voluntary patients."

The purpose of this Proposed Regulation is unclear. If the Commission intends for this regulation to require that a hospital with an emergency department provide an emergency medical screening when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay, the Proposed Regulation is duplicative of the Emergency Medical Treatment & Labor Act of 1986 ("EMTALA"), 42 U.S. Code § 1395dd. The Commission should instead draft the regulation to state:

> "An acute care general hospital shall comply with the Emergency Medical Treatment & Labor Act of 1986 ("EMTALA"), 42 U.S. Code § 1395dd and a hospital with special capabilities may only deny a transfer of a patient with an emergency medical condition if the receiving hospital does not have the capacity to treat the individual ~~admission~~ or it is unable to provide the appropriate level of care for a patient or if a patient's admission is involuntary and the hospital or hospital unit has been issued a waiver by the Commission that permits it to serve only voluntary patients."

Otherwise, the Proposed Regulation, as drafted, presents a raft of hospital compliance, billing, and reimbursement concerns, including admitting a patient based on a self-assessment and desire for inpatient hospital services. As an initial matter, an "admission" to a hospital is a term of art for compliance, billing, and reimbursement purposes. For example, for a hospital to "admit" a Medicare or Medicare Advantage patient, there must be an inpatient admission order signed by a physician or other qualified practitioner, who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The physician or other qualified practitioner must also expect "the patient to require hospital care that crosses two midnights. . . based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event." 42 C.F.R. § 412.3(a)-(d) (Medicare fee-for-service); 42 C.F.R. § 422.101(b)(2) (Medicare Advantage adopting 42 C.F.R. § 412.3). On the other hand, Maryland Medicaid defines an "admission" as "the formal acceptance by a hospital of a participant who is to be provided with room, board, and medically necessary services in an area of the hospital where patients stay at least overnight." COMAR 10.09.92.01B(6). Commercial payers define their own criteria for an admission, which may include some, all, or none of the Medicare or Medicaid criteria.

There are an enumerable list of reasons why a hospital may appropriately and lawfully deny admission to a patient, chief among which, is that an inpatient admission is not medically necessary. Alternatively, a patient may seek inpatient services outside of the patient's network, a patient may not have obtained required pre-authorization for an elective procedure necessitating inpatient

admission, or a patient may seek non-insured experimental or investigational services. *See* COMAR 10.09.92.05A-B, D (excluding from Medicaid coverage inpatient admissions that are not medically necessary, that are elective without preauthorization, or that are investigational or experimental).

As drafted, the Proposed Regulation would effectively require hospitals to admit any person who requested admission as an inpatient without regard to medical necessity or the patient's ability to pay for the treatment sought.

Identification of Bed Need and Additional Beds- COMAR 10.24.10.04B(3).

Since 2015, Maryland has consistently had the longest wait times for emergency room care in the nation according to the Centers for Medicare and Medicaid Services ("CMS"). In some circumstances, emergency department ("ED") wait times, throughput, and ED patient boarding may be caused, in part, by a lack of inpatient beds available for a hospital to transfer a patient requiring a medically necessary inpatient admission. Accordingly, UMMS suggests that the Commission expressly consider a hospital's goals associated with reducing ED wait times and patient boarding in connection with a hospital's identification of bed need or additional beds in a new Proposed Regulation COMAR 10.24.10.04B(3)(d) as follows:

> "(d) The Commission shall prioritize a project involving an applicant's addition of MSGA bed capacity to reduce emergency department wait times and emergency department patient boarding where an applicant can demonstrate such metrics are negatively affected by a lack of bed capacity."

Cost-Effectiveness – COMAR 10.24.10.04B(6)

The Commission has long required that an applicant present alternatives to a proposed project to demonstrate cost-effectiveness. Before moving forward with a CON application or request for exemption from CON review, an applicant must obviously prepare detailed cost, utilization, staffing, and reimbursement analyses in order to complete the applicable CON tables. In many instances, a CON applicant or requestor for exemption from CON review may have considered alternatives to a proposed project, such as retaining the status quo, but rejected the alternative outright. The Commission should not require an applicant with no clear alternative to its project to provide detailed capital and operational costs estimates for such alternatives, unless such largely academic projections can be done without undue burden, time, and expense. Accordingly, UMMS proposes the following changes to Proposed Regulation COMAR 10.24.10.04B(6)(a)(ii):

> "(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:
>
> i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative if such capital and operational cost estimates and projections were actually considered as part of the applicant's planning process or may otherwise be prepared without undue burden, cost, and expense to the applicant; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives."

Furthermore, it is unclear whether there would be one or even two alternative project sites to serve the proposed service area population within a Priority Funding Area as defined under MARYLAND CODE, STATE FIN. & PROC. § 5-7B for any particular project. Accordingly, Proposed Regulation COMAR 10.24.10.04B(6)(c) should be revised to state:

"(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That, to the extent it is applicable based on the service area of the population of the existing or relocated hospital, it has considered, at a minimum, ~~the~~ ~~two~~an alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);".

Inpatient Nursing Unit Space – COMAR 10.24.10.04B(11)

Proposed Regulation 10.24.10.04B(11) prohibits expenditures for inpatient nursing units that exceed 500 square feet per bed from being recognized in any rate adjustment to an applicant's global budget revenue. There is no exception. The Commission should give consideration to and provide flexibility for specialized units that require additional support space under licensure standards, including Facilities Guideline Institute ("FGI") standards. For example, an intensive care unit is required to have 20 square feet of equipment storage per bed, provisions for staff on-call room(s), and additional space for family / visitors both within the room and in the family and visitor lounge, all of which requires more space. In larger hospitals, this additional space gets more evenly distributed when there is a larger denominator of intensive care unit beds. However, for a small ICU in a community hospital, the unit must still accommodate the larger support space but with a smaller denominator of beds which creates a much larger SF/bed ratio.

According, UMMS proposes that Proposed Regulation COMAR 10.24.10.04B(11) be amended as follows:

> "The expenditure for space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in any adjustment in global budget revenue. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed or, in the case of specialty units, such other reasonable inpatient nursing unit space per bed that an applicant can establish is required by licensure and design standards, any adjustment of global budget revenue proposed by the hospital related to the capital cost of the project shall not include the construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space."

Emergency Department Capacity and Space – COMAR 10.24.10.04B(14)

As mentioned above, since 2015, Maryland has consistently had the longest wait times for emergency room care in the nation according to CMS. In some instances, this may result from an artificial limitation in the number of ED treatment spaces due to the Commission's requirement that a hospital's emergency department be designed in accordance with a single architect's preliminary emergency department design guidelines – *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians ("ACEP Guidelines"). Indeed, the ACEP Guide itself is described by its author "as a starting point" for emergency department planning with "general guideline[s]" to be used for internal planning to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." *See* ACEP Guide (2d ed.) at 106-109. The ACEP Guide states:

> [T]here's no magic formula for a set number of examination rooms and square footage calculations for a certain number of patient visits. *There's no "if you see 'X' number of patients in a year, your department should be 'Y' square feet with 'Z' number of patient care spaces."* There are too many variables to consider. We can't reduce space programming to 'one size fits all.' The key is for you to understand how your unique variables will affect your space need, and the biggest impact is your turnaround time for patients using examination spaces.

ACEP Guide (2d ed.) at 106 (emphasis added).

Accordingly, the Proposed Regulations should provide flexibility for hospitals to design their emergency department treatment spaces to meet the needs of their service area population. The Commission should also consider a hospital's efforts to reduce ED wait times and ED boarding when considering a CON application or exemption from CON review involving ED treatment space and capacity. UMMS proposes the following modifications to COMAR 10.24.10.04B(14)(a):

> "(a) An applicant proposing a new or expanded emergency department shall classify

the emergency department service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume, unless the applicant can demonstrate a need for additional treatment spaces or departmental space based on the particular characteristics of the population to be served or efforts by the applicant to reduce emergency department wait times and patient boarding."

Definitions – COMAR 10.24.10.06

In the Proposed Regulations, the Commission deletes the definition of "merger." However, MARYLAND CODE, HEALTH-GENERAL § 19-120 permits the movement of beds or services pursuant to a "consolidation" or "merger" among the components of an organization that: (i) Operates more than one health care facility; or (ii) Operates one or more health care facilities and holds an outstanding certificate of need to construct a health care facility." UMMS recommends that the definition of "merger" be retained in accordance with the current draft of the Commission's procedural regulations, COMAR 10.24.01 *et seq.*:

"'Merger' means the union of two or more health care facilities by the transfer of all the property of one or more of them to one of them, which continues in existence, the others being merged therein."

UMMS also recommends that the definition of "threshold for capital expenditures" should reference MARYLAND CODE, HEALTH-GENERAL § 19-120(a)(4) to account for potential future statutory changes consistent with the current draft of the Commission's procedural regulations, COMAR 10.24.01 *et seq.*:

"'Threshold for capital expenditures' ~~means the lesser of 25% of the hospital's gross regulated charges for the immediately preceding year or $50,000,000~~ has the meaning set forth in Health-General Article, §19-120(a)(4)."

* * *

Thank you for your consideration of these comments. Please contact me if you have any questions.

Sincerely,

Aaron J. Rabinowitz
Senior Vice President, General Counsel
University of Maryland Medical System

cc: Kristin Jones Bryce
Senior Vice President and Chief External Affairs Officer
University of Maryland Medical System

Ruby Potter, Program Manager