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February 23, 2023

Alexa Bertinelli, Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **Comments on Second Draft of Proposed Amendments to COMAR 10.24.01**

Dear Ms. Bertinelli:

Thank you for the opportunity to comment once again on the new Second Draft of the certificate of need ("CON") regulations being developed by the Maryland Health Care Commission ("MHCC"). We are aware of the comments being submitted by our client, Health Facilities Association of Maryland ("HFAM"), and support them without reiterating them to avoid duplication.

We are pleased to note that a number of comments in our prior letter of September 19, 2022 were accepted, and changes were made in the Second Draft accordingly. As you may recall, we also did participate in the February 9 Webinar in which a number of topics were discussed in-depth, and where time did not permit a discussion of all comments we and others have submitted.

Regulation .01B (40) (now .01B (45) addresses multiphased plans of construction. We had suggested that the word "must" be replaced with the word "can," to recognize that there are different ways in which construction plans may be implemented. The proposed new changes in the Second Draft retained the word "must," and went even further to require that a project element be "completed" rather than simply "initiated" before the next phase would begin. This further change does not reflect the realities of phased construction projects which have multiple phases and elements that may occur in different parts of the construction site (e.g., exterior site prep vs. interior work; renovations in one part of a health care facility vs. new construction elsewhere in the same facility). Such necessary phases may be interrelated, but may not be entirely dependent upon each other, and may not require that one aspect of construction/renovation be entirely completed before the next one begins. We believe

our original suggestion to simply change the word "must" to "can" is a more effective way of dealing with these issues.

There were other comments made previously which were not addressed in the Second Draft, and were not discussed in the Webinar. Hence, we are not aware of the reasons those comments were not addressed or incorporated into the Second Draft. We repeat those comments here for your convenience, and ask that they be reconsidered:

Definitions: Section .01

.01B(31)(d): The scope of jurisdictions within the definition is unclear in relation to a replacement acute general hospital CON review. First, what is the definition of a regional health system? Second, does a single hospital with a service area that extends into contiguous jurisdictions constitute a regional health system, even if the contiguous jurisdictions are not within the hospital's primary or secondary service area? Third, if a CON application is considered to propose a replacement acute general hospital by or on behalf of a regional health system, does a jurisdiction qualify under this definition even if it is not contiguous to the replacement hospital's jurisdiction? It is unclear why a jurisdiction could be an Interested Party in a CON review because it is contiguous to a service area of another health care facility operated by the regional health system but not within the service area of the replacement acute care hospital.

.01B(31)(e): Why was the reference to issue areas over which the Commission has jurisdiction removed from the language about adversely affected? We would be concerned about persons being an interested party based on allegations of adverse effect in areas beyond the jurisdiction of the Commission.

.01B(40): The word "must" should be replace with "can" to recognize how multiphased plans of construction can be implemented.

.01B(43)(a)(iii): The reference in the definition of Participating Entity that is a third-party payer to a union providing a health plan to union members on behalf of the employer is unclear. Does this refer to employers who file CON applications involving locations or relocations? It should be clear that unions who are not third-party payers akin to an insurance company for the applicant in a CON review are not within this definition.

.01B(43)(a)(iv): Why are pharmacy benefit managers included within this definition of a third-party payer seeking Participating Entity status?

.01B(48)(b)(ii): What is the purpose of the reference to physicians who are not employees of the hospital?

.01B(51)(c): The reference to an evidentiary hearing should include the phrase "if any."
.01B after (51): Why is the definition of "threshold for capital expenditures" eliminated instead of being updated? Is it simply replaced by the Hospital Capital Threshold definition?

Noncoverage: Section .03

.03J(2): As a matter of clarity, on what basis can the MHCC determine that review by the Health Services Cost Review Commission is or is not required?

Exemptions: Section .04

.04D(3)(d)(iii): This should be clarified to refer to health care needs of the residents of the hospital service area to refer to the primary service area and to the health care needs for acute general hospital services.

.04D(3)(f): There needs to be a process for the hospital obtaining more than 10 business days to meet this requirement. Not all closures will be alike.

Ambulatory Surgery Centers: Section .05

.05A(6): An additional amendment from the current language referring to "any change" in information provided should be considered. Reference to substantial changes or material changes, or specificity to the types of changes is warranted.

Access to information and facilities: Section .06

Is the removal of the "extent permitted by law" intended to be a material change?

Project Changes: Section .17

As a general comment, there needs to be a significant discussion of the types of Commission "approvals" other than CON applications that are subject to the Project Change process. This is a major change to the CON process that will add cost and increase workload among facilities and the Commission staff alike. The statute reflects legislative intent to create paths for certain types of projects outside the CON process,

such as merged asset system projects that qualify for exemptions, certificates of conformance, and similar processes. It is contrary to that legislative intent to create a broad and general reference to "approvals" that includes references to projects legislatively separated from the CON process.

First Use: Section .18

Here too, the scope of the draft regulations relating to approvals other than a CON merits substantial discussion. Currently First Use Approval is a concept used in relation to the CON process. There can be a major effect on the timing and implementation of other forms of projects if First Use concepts are to be applied beyond the CON process.

Emergency CON: Section .20

.20B: We question why a hard copy of a request for a CON in an emergency needs to be provided in "hard copy" unless it is clear that the hard copy is solely an after the fact confirmatory document.

Thank you for the opportunity to comment. Please let us know if further information is needed at this point.

Sincerely,

Howard L. Sollins

John J. Eller /TR

John J. Eller, Jr.

HLS/lam

HFAM
Health Facilities Association of Maryland
Partners in Quality Care

February 23, 2023

Sent Via Email

Ms. Alexa Bertinelli, ESQ, Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: **Comments on Second Draft of Proposed Amendments to COMAR 10.24.01**

Dear Ms. Bertinelli:

We thank the Maryland Health Care Commission (the "Commission") for the frank and open exchanges in video conference group sessions, and for the opportunity to participate in the process of amending the certificate of need ("CON") regulations.

The members and leaders of the Health Facilities Association of Maryland ("HFAM") are gratified that some of our suggestions and comments regarding the First Draft of proposed regulatory changes, which were provided in our first comment letter of September 16, 2002, were found helpful and were accepted with appropriate changes in to the Second Draft. We also participated in the February 9 Webinar, in which some of the more consequential changes were discussed.

In some cases, though changes in regulations were proposed by us, we are unsure as to whether we did not communicate effectively in our comments, or if a disagreement remains about changes that should be made.

For example, regarding Regulation .01B (39) which addresses an "entity" that would qualify for merger/consolidation approval, a change was proposed in the Second Draft to allow a merged asset system to include an entity with common ownership "or control." However, that does not solve the problem of allowing those merged asset systems that have ownership or control manifested through multiple entities rather than a single "entity" as would continue to be required by the proposed regulation.

There are presently some major merged asset systems in Maryland that previously have obtained merger/consolidation approvals that may or may not be treated as such under the revised regulation. Based on the Webinar, we did not have the impression that the Commission is seeking to change or narrow the definition of merged asset system. Hence, we suggest for further

consideration that a merged asset system be defined to include "a group of entities with overlapping ownership or control."

Regulation .07A (2) was modified to permit more flexibility in Letters of Intent submitted on behalf of entities not yet formed. We had asked for flexibility in allowing minor changes among owners of the applicant entity, and it is not clear from the revised language whether such changes would be permissible. Clarification of the language is recommended.

Regulation .09B (2) addresses the timing of exceptions. The increased time permitted for filing and replies is welcomed but does not include language that previously existed that required such filings to be made at least 10 days before the next Commission meeting. Without such language, there would not be sufficient time for all filings to be properly considered by the parties, and preparation for responses to be made at the Commission meeting at which those filings would be considered.

Regulation .10 deals with the new concept of a "Consent Agenda." Though additional language has been added regarding the implementation of a Consent Agenda, there does not appear to be a definition of a Consent Agenda, and no justification has been provided for the establishment of a Consent Agenda. This is a concern because important dealings of the Commission could occur outside of a public forum, which is not consistent with the notion of open meetings allowing the public (including applicants) to learn about concerns and issues of importance to the Commission.

Regulation .12 deals with the new notion of "Holder" Responsibilities, which generated many comments from providers, and was the subject of in-depth discussion during the Webinar. The primary justification for the requirements to be imposed on a Holder that was articulated by Mr. Parker during the Webinar was that the Staff is thinking that exemptions are a form of CON approval and all similar projects including those subject to CON requirements should be treated the same.

The expressed desire is to achieve a procedural equivalency among different forms of approval (i.e., procedural equivalency for merged asset system applicants which are eligible for a merger/consolidation exemption from CON, and non-merged asset system applicants which are not eligible).

However, a different form of approval for merged asset systems outside the CON application process is exactly what is codified in statute. It was the expressed intention of the Maryland legislature to create a process that is exempt from the CON process and instead require merged asset systems to be subject to a different process exempt from CON because the changes are among existing facilities and services.

There was legislative support for such integration and efficiencies, without the constraints of the post approval process applicable to CON approvals. In our view, the draft regulations would

contradict the existing statutory authority. This topic needs significantly more discussion and consideration, both as to the underlying justification for the proposed changes as well as the problematic mechanics of implementation (e.g., imposition of and compliance with performance requirements; progress reporting; dealing with project changes after approval) that were addressed in detailed comments previously made.

Finally, there were many other comments HFAM submitted previously that were not discussed at the Webinar and did not result in any changes in the Second Draft of Proposed Amendments. For your convenience, and so that it won't be necessary to retrieve and sort through our prior filing of comments, we are repeating here those comments which have not been addressed. We ask that these comments be reconsidered.

Definitions: Section .01

.01B (7): In defining "bed capacity" or "physical bed capacity," a discussion of shell space and surge capacity is warranted. Health care facilities should have the capability to anticipate future needs for space in a consumer-focused, market-driven, efficient, and cost-effective way.

.01B(22)(b): It is unclear why the existing definition of health care facility is amended to remove the exclusionary reference to continuing care retirement communities in light of the language of Health-General Article, Section 19-114(d)(2)(ii).

.01B(30)(a) and (b)(i): In defining "Initiation of Construction" the three references to "all" should be revised to make clear that the intention is to require the applicable permits necessary to do the work according to the appropriate construction steps to initiate construction or do the preconstruction site work, since some permits may not be needed until later points in the construction process. "All" is too broad in this context.

.01B(33)(b)(ii): Licensed bed capacity should ensure the availability of shell space or surge capacity. Health care facilities should have the flexibility to plan for and implement measures for future space needs. This is especially important as baby boomers age, and skilled nursing and rehabilitation centers continue to play a key role in providing accessible care to Marylanders fighting multiple chronic conditions.

Coverage: Section .02

02A (3): The reasons for the removal of the text from the reference to changes in bed capacity are unclear. As noted above, shell space and surge capacity are important aspects of facility planning. Waiver beds are a well-established and essential part of capacity planning. Thus, for example, the exclusion for waiver beds under the 10 beds/10% rule for nonhospital health care facilities should not be changed.

Noncoverage: Section .03

.03B(1)(a)(i): To be consistent with Medicare process, disclosures at 5% or above should be the standard.

.03B(1)(b): We know this is a part of the current process, but we propose that the purchase price not be part of the determination request. The MHCC does not have authority to regulate purchase prices, and this should not be part of the regulatory process.

.03C: We have a concern with the provision that a health care facility other than a hospital may be required to hold a public informational hearing on closure. Some closures are voluntary, some are required by financial or other external events, and sometimes as part of the regulatory process. There are licensing and certification notice requirements already in effect. An effective process must be in place to ensure the timely, effective, and safe discharge of residents, while under the care of staff. Timing is of the essence. Coordination with residents, families, and staff in such situations if important, though we question use of a public informational hearing as the best tool for this to occur.

.03D (4): We suggest the Temporary Delicensure process permit health care facilities to have the flexibility to request authorization for different groups of beds to be temporarily delicensed in stages without having to wait for the end of a 12-month period to make a new request for each group. The process should be more flexible and enable the facility to make such a request such as would be appropriate when a facility is undertaking renovations of different sized units in sequential fashion

.03D (8): We strongly urge that the requirement for the MHCC to give notice of the abandonment of temporarily delicensed beds under the current regulation should not be deleted. The current, available notice is important, not burdensome, and should be preserved.

Preapplication Procedures: Section .07

.07B: The rationale for removal of the current language referring to who should be the applicant is not stated and is unclear.

.07B: If an applicant requests a preapplication conference, one should be held, in lieu of the proposed “may” language. Or one should be required unless waived by the applicant.

Procedures for Review: Section .08

.08E (2) and former (4): The current but deleted language in two places identifying changes to an application that are not modifications is important and should be restored. Such changes do occur, and it is disruptive to a smooth process for this change to be made. Also, minor

changes among ownership of an applicant during a CON review should be permitted under a further amendment.

.08F (3): There is no limit to the number of Interested Parties or Participating Entities. Filings can be massive, yet, under the current regulation only one 25-page response is permitted. There should be additional language permitting the applicant to file, in the alternative, and without permission an additional 10 pages per set of comments where there are two or more comments.

.08G(3)(e): The new term of art "Terms" is included in the draft regulations without definition or explanation. The reference to "Terms" should be removed unless the basis and meaning for a "Term" of a prior CON separate from a Condition is established.

Commission Decision and Action: Section .09

.09B (3): As noted concerning responses to comments, here too there is no limit to the number of Interested Parties or Participating Entities. Filings can be massive, yet, under the current regulation only one 15-page response is permitted. There should be additional language permitting the applicant to file, in the alternative, and without permission and additional 10 pages per set of responses to exceptions where there are two or more exception filings.

.09C: The current but deleted language referring to the role of participating entities not being interested parties and not having a right to appeal is essential and should be restored.

Miscellaneous Rules: Section .10

.10G (1): There various references here and in the draft regulation to a whether a submission is "consistent" versus "not inconsistent" without clarity whether the distinction is intentional. For example, here, under .10G (1), "not inconsistent" with the State Health Plan is more appropriate.

Evidentiary hearings: Section .11

.11: The current but deleted reference to seeking oral argument in the question whether to hold oral argument on whether to hold an evidentiary hearing should be restored.

.11B(1)(a)(i): The word "full" in relation to a hearing is unclear.

.11B(1)(b)(iv): It is highly problematic for the Reviewer to act as a party to the hearing and to have the authority to call witnesses. The Reviewer should act as the impartial authority. This is a major concern.

.11B (4): Costs of transcription should be shared equally among any party making use of the transcript.

Special Procedures: Section 14

.14A (2): Given the 30-day process for Executive Director review, the regulations should require the agency do provide confirmation of receipt of the determination request.

Project Changes: Section .17

.17B (2): The MHCCs inflation regulation is not always the most effective. The draft regulations do refer to the use of other guidance approved by the Commission and posted on its website. The MHCC should consider permitting applicants to propose an inflationary index that is, after the CON is issued, more reflective of the project in progress.

First Use: Section .18

Here too, the scope of the draft regulations relating to approvals other than a CON merits substantial discussion. Currently First Use Approval is a concept used in relation to the CON process. There can be a major effect on the timing and implementation of other forms of projects if First Use concepts are to be applied beyond the CON process.

Thank you for your consideration and for this opportunity for HFAM to participate in the further development of CON regulations.

Be well,

Joseph DeMattos, MA
President and CEO

cc: Ben Steffen, Executive Director, MHCC
Paul Parker, Director, MHCC
Caitlin E. Tepe, AAG, MHCC
The Honorable Adrienne Jones, Speaker, Maryland House of Delegates
The Honorable Bill Ferguson, President, Maryland Senate
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JOHNS HOPKINS
MEDICINE

February 23, 2023

Alexa Bertinelli
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Re: Informal Comments, Procedural Regulations COMAR 10.24.01, Revised Draft

Dear Ms. Bertinelli:

Thank you for the opportunity to comment on the Maryland Health Care Commission's revised draft of its proposed procedural regulations.

Definitions
We support the revisions to the definitions of 10.24.01.01B(2) Adversely affected, 10.24.01.01B(3) Aggrieved party, 10.24.01.01B(17) Contested review, and 10.24.01.01B(34) Interested party.

We echo staff's comments from their January 26, 2023 memo "Re: COMAR 10.24.01 Draft Regulations", regarding striking the right balance, which state: *Existing providers who are recognized as interested parties serve a valuable role and provide an important perspective in evaluating whether a CON application has met all required criteria. However, interested parties obtain significant rights in the review, such as the right to file an appeal of the Commission's decision, and their inclusion in a CON review can delay the review process and limit free economic competition.*

.05 Ambulatory Surgery Centers
We believe section .05 Ambulatory Surgery Centers: Determination of Coverage and Data Reporting, specifically sections 10.24.01.05A(2)(c) and 10.24.01.05A(6), would benefit from additional consideration. They read:

A. Determination of Coverage.

(2) A person shall obtain a determination of coverage from the Commission before:

(c) Making any change in the information provided for initial determination of coverage.

(6) Notice. Before seeking to establish a new operating room or any other rooms in which procedures are performed, or to make any change in the information provided for initial determination of coverage, a person shall provide notice to the Commission at least 45 days in advance that includes all information required by COMAR 10.24.11.04A.

We believe the use of the phrase, "any change in the information provided for initial determination of coverage" is overly broad and unreasonable. We recommend eliminating these phrases from the sections above. Existing sections already detail the types of changes that require approval.

If the sections referenced above are maintained, we recommend revisions that would specifically list the types of information changes to the initial determination that would require notification. Lastly, Commission staff may consider using its annual survey of Maryland Freestanding Ambulatory Surgery Facilities, which all ambulatory surgery centers are required to complete, to collect this type of information, in lieu of a separate notification.

Thank you for your consideration.

Sincerely,

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Director of Health Planning
Johns Hopkins Health System

LeadingAge Maryland
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February 23, 2023

VIA EMAIL: alexa.bertinelli@maryland.gov
Alexa Bertinelli, Esq.
Assistant Attorney General
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4160 Patterson Avenue
Baltimore, Maryland 21215

SUBJECT: Comments on revised proposed regulations - COMAR 10.24.01 Certificate of Need Health Care Facilities

Dear Ms. Bertinelli:

LeadingAge Maryland is a community of not-for-profit aging services organizations serving residents and clients through continuing care retirement communities, affordable senior housing, assisted living, nursing homes and home and community-based services. We represent more than 140 not-for-profit organizations, including the majority of CCRCs in Maryland. Our mission is to expand the world of possibilities for aging in Maryland. We partner with consumers, caregivers, researchers, faith communities and others who care about aging in Maryland.

LeadingAge Maryland appreciates the opportunity to comment on the proposed regulations under COMAR 10.24.01, Certificate of Need (CON) Health Care Facilities. We submitted informal comments during September of 2022. Below you will find the comments we submitted previously which have not been addressed in the newly proposed revised regulations released January of 2023.

I. General Observations.

We appreciate the work of the Maryland Health Care Commission (MHCC) CON Modernization Task Force and Governor Larry Hogan's 2015 Regulatory Reform Commission which was the impetus for these proposed regulations. LeadingAge Maryland also recognizes the

significant changes in the MHCC's enabling statute since COMAR 10.24.01 was last modified in 2015. Our general comments are as follows:

A. CON Process is Cumbersome. The current CON process is cumbersome and arduous on applicants. In our review of the proposed regulations, MHCC is provided more power and oversight than the previous regulations. This makes Maryland an even more challenging State in which to operate healthcare settings. For instance, the length of time it takes to work through a CON application process can be 2-3 years. This costs providers significant resources in lawyer fees. We urge the Commission to continue to evaluate how the application process can be simplified where appropriate. **We do appreciate that in the proposed revised regulations applicants are now provided with 5 additional days (now 15 days, up from 10 days) to secure the requested additional information. We also appreciate that an additional 10 days may be given to an applicant depending on the situation.**

B. Allow flexibility in counties where there is only one hospice CON given. In smaller counties, like Charles, Calvert, etc, there is only one CON given. This gives no choice to families who need to seek hospice services for a loved one. We would suggest allowing support from a hospice in a neighboring county. **The proposed revised regulations did not address this comment, and we would appreciate consideration.**

C. Expiration on CONs that are issued but not utilized. For example, some hospices in the state have received a CON but they are not utilizing it; it's akin to squatting. If there is a CON issued, demonstrating that there is need, an organization should have a given amount of time to address that need. **We appreciate the revisions the Commission has proposed under section 12(E) to address this concern, including provisions such as requiring holders to submit semiannual rather than annual progress reports, and allowing the Commission to withdraw a CON if it finds that the holder has failed to demonstrate sufficient progress in implementing the project.**

D. Support change of ownership provisions. Currently the Office of Health Care Quality (OHCQ) approves change of ownership. We are unclear under the proposed regulations who has final authority. What happens if OHCQ and MHCC disagree? Further, the proposed regulations require identification beyond the owner to include information about affiliations of the owner and source of funds for making the purchase. Our members applaud and are supportive of steps to promote transparency, and encourage that this process be carefully discussed so as to not unnecessarily delay transfers of ownership or potentially disrupt the lives of individuals receiving care in a nursing home. **The proposed revised regulations did not address or clarify these**

concerns, and we would ask that the Commission provide clarification on this process and delineation of authority between OHCQ and MHCC.

E. Concerns over requirement to hold public informational hearings. This appears to apply to not only new home health business, but also to providers who wish to de-license bed capacity. For example, a CCRC that wishes to reduce their SNF bed capacity would first need to hold a public hearing. There are many reasons a skilled nursing unit may need to be downsized or closed. This requirement is overly burdensome on the provider especially because stakeholders may not fully understand or appreciate the drivers behind the decision. **The proposed revised regulations do not address this concern, and we ask the Commission to consider this in future revisions.**

II. Specific Concerns.

A. .01(B)(2) Definitions. We have confusion around what exactly is meant by "adversely affected". Further clarity would be appreciated. **The proposed revised regulations do not appear to provide additional clarity on this term, and we would ask the Commission to clarify in future revisions.**

B. .03(D)(4) Non-Coverage by Certificate of Need or Other Commission Approval. We strongly recommend that MHCC eliminates the requirement that limits a facility more than one time in a 12-month period. **The proposed revised regulations do not appear to address this concern. We would urge the Commission to consider this concern in future revisions.**

C. .03(J)(1)(a) and (b) Non-Coverage by Certificate of Need or Other Commission Approval. Under this proposed regulation, a facility with less than 60 beds cannot have an AIT without a partnership. It's important to recognize that this limits the number to under 60 beds and affects the ability to train new NHAs in the state.

D. .03(K)(4) Non-Coverage by Certificate of Need or Other Commission Approval. We recommend change to 10 percent, not 20 percent- based on residents going home on home health and not as many going to comprehensive care. This would allow for more external admissions. **The proposed revised regulations did not address this suggestion. We urge the Commission to consider this suggestion in future revisions.**

E. .08(C)(3) Procedure for Review of Application. LeadingAge Maryland supports placing time limits on MHCC in its request for additional information. **The proposed revised regulations appear to provide applicants with slightly longer timeframes for providing requested information by the Commission, but do not appear to**

place additional time limits on the Commission's response time to applicants. We urge the Commission to consider this in future revisions.

F. .09(E)(3) Commission Decision and Action on CON Applications. A 6-month stay is too long. MHCC should have adequate number of reviewers prepared at any time to not unnecessarily extend review period. **The proposed revised regulations do not appear to shorten the 6-month stay if there is not a reviewer available at the Commission. We urge the Commission to address this concern in future revisions.**

G. .10(A)(2) Miscellaneous Rules and Procedures – What is meant by a "a reasonable period of time"? Further clarity would be appreciated. **The proposed revised regulations do not appear to clarify this term, and we would ask the Commission to address this in future revisions.**

We understand that a workgroup to review these proposed regulations has not been formed yet, but the Commission may consider convening a workgroup in the future depending on the volume of comments received. Given the significant challenges with the CON process, LeadingAge Maryland urges that a workgroup is formed focused on high interest areas.

LeadingAge Maryland greatly appreciates the opportunity to provide these comments. Please contact me if you have any questions.

Sincerely,

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Maryland

Alexa Bertinelli -MDH- <alexa.bertinelli@maryland.gov>

Comments re COMAR 10.24.01

James A. Forsyth <jaforsyth@comcast.net> Thu, Feb 23, 2023 at 3:40 PM
To: alexa.bertinelli@maryland.gov
Cc: ben.steffen@maryland.gov, paul.parker@maryland.gov, caitlin.tepe@maryland.gov

Dear AAG Bertinelli –

In response to Director Steffen's prior request, please consider this email as an additional Comment on the MHCC's proposed revisions to COMAR 10.24.01 et seq.

Comment: Specifically, 10.24.01.03A(1) (*see* p. 17 of Staff's Draft) concerning CON exemption of the Acquisition of an Existing Health Care Facility, as applied to Nursing Homes, should be amended by including an additional requirement that the notice to MHCC must also include the number of resident rooms, if any, housing three of four beds, both currently and after the proposed acquisition of the facility.

Rationale: As you know, the relevant chapter of the State Health Plan considers such multi-bed rooms to be inappropriate living environments. Accordingly, COMAR 10.24.20.05A(4)(a)(i) prohibits new nursing home projects from developing resident rooms with more than two beds per room. Further, COMAR 10.24.20.05A(4)(b)(i)

requires existing nursing home renovation / expansion projects to reduce the number of resident rooms with more than two beds per room. Therefore, the proposed amendment would align MHCC's procedural regulations with these substantive provisions while calling attention to an important infection control issue that impacts public health and resident safety, particularly when future pandemics are threatened.

Finally, in my view it is not good public policy to promote or allow the continuation of multi-bed room configurations especially when they are expressly prohibited from being included in new or renovated facilities. This raises quality of care, patient safety and quality of life issues. The process of revising COMAR 10.24.01 et seq. affords a timely opportunity for MHCC to take further leadership in addressing this important matter.

Thank you for Staff's consideration of this Comment.

Best,

Jim

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