

**DRAFT**

**STATE HEALTH PLAN FOR FACILITIES AND SERVICES:  
ACUTE PSYCHIATRIC HOSPITAL SERVICES  
COMAR 10.24.07**

**Maryland Health Care Commission**

**December 17, 2020**

*Informal Written Public Comments  
Accepted until January 15, 2021 at  
5:00 p.m.*

*Send comments to: Eileen Fleck,  
Chief, Acute Care Policy and  
Planning*

*By email:*

*Eileen.Fleck@maryland.gov*

## Table of Contents

.01 Incorporation by Reference.....	1
.02 Introduction.....	1
A. Purposes of the State Health Plan for Facilities and Services.....	1
B. Legal Authority for the State Health Plan.....	1
C. Organizational Setting of the Commission.....	2
D. Plan Content and Certificate of Need Applicability.....	2
E. Effective Date.....	2
.03 Issues and Policies.....	3
A. Issues.....	3
B. Policies.....	8
.04 Procedural Rules:.....	10
A. Docketing Rules.....	10
B. Acquisition of a Psychiatric Hospital.....	11
.05 Standards.....	12
A. General Standards.....	12
B. Project Review Stan.....	12
.06 Methodology for Utilization Forecast for Acute Psychiatric Hospital Beds.....	18
A. Geographic Area.....	18
B. Period of Time Covered.....	18
C. Services and Age Groups.....	18
D. Data Source.....	20
E. Method of Calculating Utilization.....	20
F. Calculation of "Other Psychiatric Bed Days".....	21
G. Utilization Projections.....	21
H. Mathematical Formula.....	22
I. Update, Correction, Publication, and Notification Rules.....	24
.07 Definitions.....	26

## **.01 Incorporation by Reference.**

This chapter of the State Health Plan for Facilities and Services: Acute Psychiatric Hospital Services is incorporated by reference in the Code of Maryland Regulations.

## **.02 Introduction.**

### **A. Purposes of the State Health Plan for Facilities and Services.**

The Maryland Health Care Commission (Commission) has prepared this chapter of the State Health Plan for Facilities and Services (State Health Plan) to meet current and future health care system needs for all Maryland residents with respect to acute psychiatric services by assuring access, quality, cost and efficiency. The State Health Plan serves two purposes:

(1) It establishes health care policy to guide the Commission's actions. Maryland law requires that all State agencies and departments involved in regulating, funding, or planning for the health care industry carry out their responsibilities in a manner consistent with the State Health Plan and available fiscal resources; and

(2) It is the foundation for the Commission's decisions in its regulation of health care facilities and services. The State Health Plan ensures that changes in the health care delivery system and in health care facilities and services are appropriate and consistent with the Commission's policies. The State Health Plan contains policies, methodologies, standards, and criteria that the Commission uses in making decisions on applications for Certificates of Need, Certificates of Conformance, and Certificates of Ongoing Performance. The State Health Plan should provide a vision for positive change in the delivery of health care services.

### **B. Legal Authority for the State Health Plan.**

The State Health Plan is adopted under Maryland's health planning law, Health-General Article §19-114, *et seq.*, Maryland Code Annotated (Health-General). This chapter partially fulfills the Commission's responsibility to adopt a State Health Plan annually. Health General §19-118(a)(2) provides that the State Health Plan shall:

- (1) Be consistent with the Maryland All Payer Model Contract;
- (2) Include methodologies, standards, and criteria for Certificate of Need (CON) review; and
- (3) Prioritize conversion of acute care capacity to alternative uses where appropriate.

### **C. Organizational Setting of the Commission.**

The Commission is an independent agency, which is located within the Maryland Department of Health for budgetary purposes. The purposes of the Commission, as enumerated at Health-General §19-103(c), include:

(1) Development health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission; and

(2) Promotion of the development of a health regulatory system that provides, for all Marylanders, 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 enhancement of the strengths of the current health care service delivery and regulatory system.

The Commission has sole authority to prepare and adopt the State Health Plan and to issue Certificates of Need, Certificates of Conformance, and Certificates of Ongoing Performance. Health-General §19-118(e) provides that the Secretary shall make annual recommendations to the Commission on the State Health Plan and permits the Secretary to review and comment on the specifications used in its development. However, Health-General §19-110(a) clarifies that the Secretary of the Maryland Department of Health does not have power to disapprove or modify any regulation, decision, or determination that the Commission makes regarding or based upon the State Health Plan. The Commission pursues effective coordination of its health planning functions with the Secretary, with State health-related agencies, and with the Health Services Cost Review Commission to assure an integrated, effective health care policy for the State. The Commission also consults with the Maryland Insurance Administration as appropriate.

### **D. Plan Content and Applicability.**

This chapter of the State Health Plan is applicable to the establishment of a psychiatric hospital, the relocation of a psychiatric hospital or a hospital with a psychiatric unit, and the addition of psychiatric hospital bed capacity at a psychiatric or general hospital. Under this chapter, specific CON approval is required for beds designated to serve children, adolescents, or adults. Hospital capital projects that exceed an expenditure level established in law also require a CON, and when these projects involve changes in the delivery of psychiatric hospital services, this chapter applies.

### **E. Effective Date.**

An application or letter of intent submitted after the effective date of these regulations is subject to the provisions of this chapter.

## **.03 Issues and Policies.**

### **A. Issues**

#### **Appropriate Utilization of Acute Psychiatric Hospital Services**

Prior to the 1960s, most individuals with developmental disabilities and acute mental disorders were cared for in large public institutions. While the conditions in these facilities were often below the standards for other inpatient medical care, acceptable alternatives largely did not exist. In the late 1960s and early 1970s, federal and state efforts emerged that focused on deinstitutionalizing care and developing community-based alternatives for treatment, housing, and rehabilitation.<sup>1</sup> The current model for acute psychiatric care involves a relatively short episode of treatment in a hospital setting to stabilize severe symptoms, followed by community-based care post-discharge. There are four private special psychiatric hospitals in Maryland and 30 general hospitals that provide inpatient psychiatric services.<sup>2</sup>

The push to deinstitutionalize psychiatric care has been largely implemented in the State of Maryland; many State facilities have been closed and no longer care for patients who require short-term acute psychiatric services. The five remaining psychiatric hospitals operated by the State serve forensic<sup>3</sup> patients, and none of the State hospitals provide acute psychiatric services for children. The remaining hospitals operate significantly less bed capacity compared to previous years.

Community programs such as partial hospitalization and intensive outpatient programs have expanded in conjunction with the deinstitutionalization movement. As of January 1, 2020, 1, 2019, these programs were offered at 20 general hospitals and four private special psychiatric hospitals, but service capacity has been declining over time.<sup>4</sup>

Maryland is similar to the national average for inpatient psychiatric beds per capita. The number of inpatient psychiatric beds in Maryland in 2018, 34.6 beds per 100,000 residents, was slightly higher than the national inpatient psychiatric bed capacity, 33.4 beds per 100,000 residents.<sup>5</sup> Compared to neighboring states (Delaware, Pennsylvania, Virginia, and West Virginia) and the District of Columbia, in 2018, Maryland had the second lowest number of psychiatric beds

---

<sup>1</sup> Deinstitutionalization of the Mentally Disabled in Maryland, United States General Accounting Office, Region III, Philadelphia Department of Health, Education, and Welfare and other Federal Agencies. <https://www.gao.gov/assets/200/191192.pdf> [November 2, 2020]

<sup>2</sup> Maryland Health Care Comm'n Survey: Special Hospitals – Psychiatric (June 1, 2018). Licensed and budgeted bed totals include both acute and continuing care psychiatric beds. Since April 2019, one of the four private special psychiatric hospitals consolidated operations with an affiliated general hospital, creating a general hospital with a large psychiatric unit.

<sup>3</sup> Forensic patient means a person whose competency to stand trial or assume criminal responsibility are being assessed or a person who has been committed as incompetent to stand trial or not criminally responsible, or a person who is found not criminally responsible and court-ordered to be released with conditions into the community.

<sup>4</sup> Maryland Health Care Commission, Center for Health Care Facilities Planning and Development. White Paper: Maryland Acute Psychiatric Hospital Services, April 2019.

<sup>5</sup> MHCC staff analysis of the National Mental Health Services Survey data for 2018.

per 100,000 residents. Virginia had the lowest number of acute psychiatric beds per capita at 32.3 beds per 100,000 residents; West Virginia had the highest number of acute psychiatric beds per capita at 60.7. In Maryland, the total number of inpatient psychiatric beds per capita declined slightly between 2010 and 2018, from 36.0 per 100,000 residents to 34.6 per 100,000 residents.

Between 2009 and 2019, the number of psychiatric discharges per 100,000 Maryland residents from Maryland hospitals declined by 20%.<sup>6</sup> However, this rate was driven primarily by a 23% decline in discharge rates for adults. For adolescents, the rate declined 7%, while the discharge rate for children increased by 2%. For non-psychiatric discharges, there was less of a decline over the same period, 11% overall. The rate of decline for non-psychiatric discharges was sharpest for adolescents, 52%; the rates for children and adults declined by 8% and 28% respectively. While the lower rates of discharges may seem to suggest less demand for acute psychiatric beds, the number of emergency department visits with a primary psychiatric diagnosis has trended upward, which in combination with reports of long boarding times in emergency departments, suggests that demand for acute psychiatric beds may be increasing, but barriers may exist to accessing those beds.

### **Timely Admission to Acute Psychiatric Services**

Timely access to acute psychiatric care can be life-saving for appropriate patients. However, the availability of acute psychiatric beds is an ongoing challenge. Although hospitalization use rates for adult patients appear to be on the decline and the overall level of psychiatric bed capacity appears to be adequate, the work groups convened for this update of the chapter, the Psychiatric Services Work Group (Work Group) and Psychiatric Services Clinical Advisory Group (CAG) reported that, for some patients, admission to an inpatient psychiatric bed is difficult, resulting in patients boarding for days in an emergency department.<sup>7</sup> Commission staff analysis of available emergency department “boarding” data in Maryland hospitals shows that boarding of 24 hours or more occurs across regions and age ranges, but is a particular issue for patients from the central Maryland<sup>8</sup> and adolescents.<sup>9</sup> While boarding in an emergency department and waiting for an acute psychiatric placement, services provided may be limited or nonexistent. The CAG suggested that there is a need for more acute care beds for all ages in the State.<sup>6</sup>

The Work Group and CAG agreed that some acute psychiatric programs may be unable to meet the needs for high acuity patients with co-morbidities, inhibiting timely placement into acute psychiatric care. This is a particular concern for patients with developmental disabilities requiring inpatient psychiatric care. The CAG mentioned that a family may be forced to keep a child in the

---

<sup>6</sup> MHCC staff analysis of Health Services Cost Review Commission discharge data for Maryland hospitals and population estimates from the Maryland Department of Planning for 2019.

<sup>7</sup> MHCC, Psychiatric Services Work Group. Meeting Summary for May 3, 2019; Psychiatric Services Clinical Advisory Group. Meeting Summary for November 6, 2019. Meeting summaries available at: [https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups\\_pysch\\_services.aspx](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_pysch_services.aspx)

<sup>8</sup> Central Maryland refers to Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties, and Baltimore City.

<sup>9</sup> MHCC staff analysis of ED Boarding in Maryland Hospitals for Psychiatric Patients Not Admitted to a Hospital or Admitted to a Different Hospital Following Boarding.

[https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Items%203\\_4.pdf](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Items%203_4.pdf)

emergency department in order to maintain the child's priority position for a specialized psychiatric bed. For programs that are able to accommodate high acuity patients, the facility may be required to allocate additional staff and place patients in private rooms or alone in a semi-private rooms. This can result in facilities being unable to operate at their full licensed capacity due concerns about staff's ability to manage more patients safely, even if physical space is available. The CAG suggested that programs should have some baseline ability to respond to high intensity needs, similar to the expectations for medical and surgical units, rather than relying on higher staffing ratios.

This chapter of the State Health Plan has also historically required that providers of acute psychiatric services treat involuntary patients, a population identified by the CAG as more likely to have difficulty securing an inpatient psychiatric bed. The Work Group recommended that this requirement continue.<sup>5</sup> Most facilities providing acute psychiatric services are currently able to accommodate involuntary patients in the State of Maryland. However, the infrastructure required to care for involuntary patients is costly; this burden should be equally shared across institutions.<sup>6</sup>

### **Timely Discharge Following Treatment**

Challenges in securing affordable community-based care may contribute to increases in the average length of stay of acute psychiatric patients over time.<sup>10</sup> A 2019 study by the Maryland Hospital Association found that while only three percent of behavioral health patients experience a delay in discharge from acute care, the average length of the delay was 13 days and the prevalence and length of delay was greater for patients with comorbidities. The Maryland Hospital Association also found that about 60 percent of delays in discharge were due to challenges in securing a bed in a preferred placement setting; specific challenges cited included a lack of bed space and delays in processing referrals.<sup>11</sup> The Work Group and CAG suggested that community mental health resources are not adequately meeting the needs of many individuals with mental health conditions. There are limited outpatient treatment options, crisis beds, residential treatment, and long-term care options available. The lack of community resources and discontinuity of care leaves many individuals with mental disorders vulnerable to poor outcomes and shifts an immense burden of care to families.<sup>12</sup> While, outpatient and lower acuity levels of service are not directly regulated through the CON process because development of an outpatient mental health program is not categorically regulated under the CON program, outpatient mental health services can be components of projects that require CON approval.

### **Geographic Access**

In 2017, the Maryland Rural Health Administration's assessment reported that access to behavioral health services was a priority need identified by 13 of the 18 rural counties in

---

<sup>10</sup> *Id.* at 5.

<sup>11</sup> Dillon, K., Thomsen, D. "Delays in Hospital Discharges of Behavioral Health Patients: Results from the Maryland Hospital Association Behavioral Health Data Collection." January 2019. Maryland Hospital Association. Behavioral Health Discharge Delays in Maryland Hospitals. [https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf?sfvrsn=74b0d40d\\_2](https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf?sfvrsn=74b0d40d_2)

<sup>12</sup>Lin, Chih-Yuan. (2003). Ethical Exploration of the Least Restrictive Alternative. *Psychiatric Services*. 54:866-870. <https://ps.psychiatryonline.org/doi/pdfplus/10.1176/appi.ps.54.6.866>

Maryland.<sup>13</sup> In 2016, the Maryland Department of Health convened focus groups and MHCC established a Rural Health Care Delivery Work Group that identified a lack of behavioral health services as one of the largest barriers to health care in rural Maryland, citing a lack of providers and infrastructure, especially for children and adolescents.<sup>14</sup> While community mental health resources are limited across the board, individuals from rural areas may need to travel farther to obtain necessary services and options may be more limited than for patients in more urban areas. Additionally, referrals to rural areas may be more challenging, as more patients are treated in inpatient settings farther from where they reside.<sup>15</sup> Novel approaches to care and expansion of psychiatric telehealth services could be helpful to improving behavioral health systems of care in rural areas.

Commission staff analyzed drive time to acute psychiatric facilities for three age groups: children; adolescents; and adults. The map assembled shows that the largest geographic regions beyond a 30-minute drive time for adults are the counties in the upper Eastern Shore and two counties in Western Maryland, Garrett and Allegany. However, 92% of the adult population has a hospital with acute psychiatric beds within a 30-minute drive time.<sup>16</sup> Drive time analyses show that there are greater travel times for children and adolescents. For children, there are large geographic regions in which residents must drive over 45-minutes to the nearest provider of acute psychiatric services, including residents of Garrett and Allegany Counties in Western Maryland; Charles, Saint Mary's, Calvert, and parts of Prince George's County in Southern Maryland; Cecil, Dorchester, Kent, Queen Anne's, Talbot, and Caroline Counties on the Eastern Shore; and Carroll and Harford Counties in north Central Maryland. For adolescents, many of the same jurisdictions have residents who must drive over 45-minutes to the nearest provider of acute psychiatric services for adolescents, including residents of Garrett and Allegany Counties in Western Maryland; Caroline, Talbot, Queen Anne's, Kent, Cecil, and Dorchester Counties in Eastern Maryland; and parts of Charles County in Southern Maryland.

The health planning regions for acute psychiatric services defined in this chapter of the State Health Plan are defined based on patient origin of psychiatric patients at hospitals with acute psychiatric services and the necessity to have a larger population for acute psychiatric services for children and adolescents. There are five health planning regions that are defined in .06A.

---

<sup>13</sup>Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester counties are all considered rural areas in the Maryland Code. Md. State Finance and Procurement Code Annotated § 2-207

<sup>14</sup> Maryland Rural Health Association, 2018 Maryland Rural Health Plan. <http://mdruralhealth.org/docs/MDRH-Plan-2018-WEB.pdf>

<sup>15</sup> MHCC. Psychiatric Patient Utilization Patterns by Health Planning Region of Patient Origin and Hospital Location, CY 2017.

[https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Item%203\\_part2.pdf](https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Item%203_part2.pdf)

<sup>16</sup> The drive time is determined by measuring the estimated drive time from the centroid of each Maryland census tract to a hospital located in Maryland with acute psychiatric beds for the age group specified, using ArcGIS software.



## Quality and Safety of Acute Psychiatric Hospital Facilities and Services

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program through the Centers for Medicare and Medicaid Services encourages facilities and clinicians to improve the quality of care of acute psychiatric programs. IPFQR is a pay-for-reporting program in which facilities that do not participate or meet all of the reporting requirements in a fiscal year receive a reduced annual update rate, instead of the standard federal rate.<sup>17</sup> For fiscal year 2021, there were six facilities in Maryland that received full annual payment updates and zero facilities in Maryland were penalized financially.<sup>18</sup>

The quality measures tracked for the IPFQR cover five topics: preventable care and screenings; substance use and treatment; patient safety; follow-up care; and unplanned readmissions. Among these are patient safety measures that should be used to evaluate all Maryland hospitals with psychiatric units. For example, the hours spent in physical restraints for every 1,000 hours of patient care and the hours spent in seclusion for every 1,000 hours of patient care are useful measures of quality. Physical restraints and seclusion should be limited to times where the patient's behavior causes immediate danger because of the risk of patient injury, especially for patients at higher risk of injury such as those who are pregnant or have respiratory conditions.<sup>19</sup>

A third key measure of quality that should be used to evaluate hospitals with psychiatric units pertains to follow-up care. The IPFQR includes a measure for receipt by the patient or caregiver of a patient's complete record of inpatient psychiatric care and plans for follow-up within 24 hours of discharge.<sup>22</sup> This information is essential because another barrier to delivering quality care is access to the patient's medical history and records. Providers who are not familiar with a specific patient may not have a complete history, especially if the patient or their loved ones are unable to communicate where previous treatment was received. The Work Group described the current situation as one in which the Chesapeake Regional Information System for our Patients (CRISP), the State-designated health information exchange, may not be able to share information about a patient's psychiatric diagnoses and treatments with other caregivers including other hospitals without the patient's consent. While it has been transmitting data from all acute care hospitals since 2011, providers may not share information on mental health treatment due to increased privacy concerns; these practices can also differ by institution.<sup>20</sup>

A fourth key measure of quality that should be used to evaluate hospitals with psychiatric units is readmissions rates. The IPFQR includes a measure for 30-day hospital readmission rates. High quality care and discharge planning can decrease the number of patients who need to return to the hospital after a previous admission. Additionally, unplanned readmissions contribute to utilization of scarce resources and increased health care costs. Hospitals should monitor readmission

---

<sup>17</sup> Centers for Medicare and Medicaid Services. Inpatient Psychiatric Facility Quality Reporting Program. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/IPFQR>

<sup>18</sup> Centers for Medicare and Medicaid Services. Annual Payment Update. <https://www.qualitynet.org/ipf/ipfqr/apu>

<sup>19</sup> Recupero et al., 2011. Restraint and Seclusion in Psychiatric Treatment Settings: Regulation, Case Law, and Risk Management. *J Am Acad Psychiatry Law*. 39:465-76. <http://jaapl.org/content/jaapl/39/4/465.full.pdf>

<sup>20</sup> *Id.* at 5.

rates for psychiatric patients and strive to decrease the number of avoidable readmissions that contribute to the lack of availability of inpatient beds.

### **Financing Mental Health Services**

To establish and maintain an effective delivery system for mental health services in Maryland, funding for community-based services must be increased. The availability of community based services can reduce the need for intensive inpatient acute psychiatric care and improve the quality of life for many Maryland residents.<sup>21</sup> However, out-of-pocket costs may present a greater barrier to mental health care than other medical specialty care. Ongoing issues of network adequacy and mental health parity also abound.<sup>22</sup> Funding community-based services will necessarily be a joint effort among federal, State, and local governments and the private sector.

Mental health providers in Maryland point to disparities in reimbursement that they contend disadvantage private special psychiatric hospitals. In Maryland, acute care general hospitals charges are subject to the All Payer Model Contract; revenues are controlled by global budgets. Private special psychiatric hospitals are reimbursed for Medicare and Medicaid patients using rates established the federal government and for privately insured patients by rates established by the Health Services Cost Review Commission. In many cases, private special psychiatric hospitals receive less reimburse for a Medicare or Medicaid patient than an acute care general hospital would receive for a patient with the same diagnosis and treatment. Even at acute care general hospitals reimbursement systems may undervalue and thus disincentivize delivery of behavioral health services. Compared to medical and surgical APR-DRGs, behavioral health APR-DRGs are sparse, leading to broader reimbursement ranges that fail to account for the cost of treating high acuity patients. Of the 315 APR-DRGs, only about 20 APR-DRGs are associated with behavioral health or substance abuse conditions.

The Work Group members raised particular concerns about reimbursement rates for higher acuity patients who require intensive services and resources. They also discussed challenges in staff recruitment and retention because of the inability of many facilities to offer shift differentials.<sup>25</sup> Representatives for several hospitals expressed that reimbursement for acute psychiatric patients is insufficient. The Health Services Cost Review Commission should consider whether and how innovative new models of mental health services may reduce hospital costs and evaluate whether the current hospital-based budgeting approach creates negative incentives for hospitals to serve Maryland residents' acute mental health needs.

### **B. Policies**

The broad policy objectives listed below guide the Commission's regulation of the supply and distribution of acute psychiatric services in Maryland and serve as a foundation for the specific standards of this State Health Plan chapter.

---

<sup>21</sup> *Id.* at 5.

<sup>22</sup> National Alliance on Mental Illness, "A Long Road Ahead – Achieving True Parity in Mental Health and Substance Use Care." <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead>.

**Policy 1: People should be treated in the least restrictive setting appropriate to their medical conditions.**

Treatment in an outpatient setting is preferable to hospital-based treatment for long-term management. Hospitalization should be reserved for individuals with an acute psychiatric condition who cannot be safely managed in the community.

**Policy 2: Patients should be able to secure timely placement in a psychiatric bed when acute inpatient psychiatric services are required.**

Boarding of acute psychiatric patients should be minimized because boarding results in unnecessary utilization of emergency department resources and can result in a patient's decompensation.

**Policy 3: Patients shall be timely discharged from hospitals once acute psychiatric services or other acute care services are no longer needed.**

Discharge delays result in an inefficient use of resources and potentially negatively affect access for other patients. Each hospital should strive to develop or facilitate development of a complete continuum of post-acute psychiatric services in their service areas. Hospitals should develop early and coordinated discharge planning that links patients to appropriate community-based services, facilitates timely discharge, and decreases avoidable readmissions. Additionally, increasing the availability and accessibility of community-based services, including partial hospitalization programs, intensive outpatient treatment, and other psychiatric care options are necessary to facilitate timely discharge from acute care. For some patients with chronic psychiatric conditions, a long-term residential or inpatient program may be the most appropriate option and the lack of availability of these programs is a barrier to discharge.

**Policy 4: Acute psychiatric services shall be financially and geographically accessible to all who need them.**

Hospitals should increase their capacity to care for high acuity patients and vulnerable patient populations to ensure adequate access for Maryland residents. Acute general and private special psychiatric hospitals with licensed inpatient psychiatric units should admit involuntary patients. General hospitals that can feasibly provide acute inpatient and outpatient psychiatric hospital services should provide these services.

**Policy 5: A hospital with acute psychiatric services will continuously and systematically work to improve the quality and safety of patient care.**

This includes planning, implementing, and optimizing the use of electronic health record systems, electronic health information exchange, and telehealth to provide high quality, cost-effective, and patient-centered care.

**Policy 6: An increase in the funding and provision of mental health services by the private sector and federal and State government is necessary in order to meet the needs of Maryland’s population adequately.**

The General Assembly, the Governor, the Department of Health, local government agencies, and health care facilities are encouraged to increase the capacity for mental health services in Maryland through funding community mental health resources and subspecialty inpatient care. Alternative reimbursement models for inpatient services should also be explored.

**.04 Procedural Rules: Acute Psychiatric Hospital Services.**

**A. Acute Psychiatric Hospital Services Docketing Rules.**

(1) The Commission shall not docket an application involving establishment of a psychiatric hospital or changes to an existing psychiatric hospital or inpatient psychiatric service of a general hospital unless the applicant provides an affirmation, under penalties of perjury, that, within the last ten years:

(a) No current or former owner or senior manager of the hospital or of the hospital operator, or of any related or affiliated entity:

(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; or

(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; and

(b) Neither the hospital, its operator, nor a current or former related or affiliated entity:

(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony;

(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; or

(iii) Has paid fines, penalties, or entered a monetary settlement that exceeds \$10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charges or investigation relating to allegations of Medicare or Medicaid fraud or abuse.

(c) The applicant may show evidence as to why this rule should not be applied if each individual involved in the allegations of fraud or abuse that resulted in the monetary settlement, fines, or penalties is no longer associated with the entity, or any of the related or affiliated entities, and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty, monetary settlement, or agreed disposition.

## **B. Acquisition of a Psychiatric Hospital**

Commission staff shall apply the following rules to a person or legal entity seeking to acquire a psychiatric hospital pursuant to Health-General §19-120. If Commission staff finds non-compliance with these rules, it shall not approve the acquisition.

(1) Notice of Acquisition. A person or legal entity seeking to acquire a psychiatric hospital shall provide the Commission with the notice required by COMAR 10.24.01.03A. The notice shall include:

(a) The identity of each person with an ownership interest in the acquiring entity or a related or affiliated entity;

(b) The percentage of ownership interest of each such person; and

(c) The history of each such person's experience in ownership or operation of health care facilities.

(2) Information and Disclosures Required. A person or entity subject to .04B of this chapter shall:

(a) Affirm that the services provided will not change as a result of the proposed acquisition;

(b) Affirm that the commitment to Medicaid participation will not change as a result of the proposed acquisition and shall provide information on corporate structure and affiliations of the purchaser, purchase price, source of funds, and other relevant data as requested;

(c) Affirm, consistent with Regulation .04A(2)(a) of this chapter, under penalties of perjury, that within the last ten years no owner or former owner, or member of senior management or management organization, or a current or former owner or senior manager of any related or affiliated entity has been convicted of felony or crime, or pleaded guilty, nolo contendere, entered a best interest plea of guilty, received a diversionary disposition regarding a felony or crime, and that the applicant or a related or affiliated entity has not paid a civil penalty or monetary settlement in excess of \$10 million dollars that relates to the ownership or management of a health care facility.

(3) Disqualification for Acquisition. A psychiatric hospital may not be acquired by an entity with an owner or member of senior management or an owner or member of senior management of a related or affiliated entity who has been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime within the last ten years, unless each individual involved in the fraud or abuse is no longer associated with the entity (or any of its related or affiliated entities) and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty, monetary settlement, or agreed disposition, consistent with Regulation .04A(2)(a) of this chapter.

## **.05 Acute Psychiatric Hospital Services Standards.**

### **A. General Standards**

An applicant for a Certificate of Need to establish acute psychiatric services shall address and meet the applicable general standards in COMAR 10.24.10.04A, in addition to the applicable standards in this chapter.

### **B. Project Review Standards.**

The standards in this section shall apply to Certificate of Need applications and exemption requests involving acute psychiatric services. An applicant for a Certificate of Need must address, and its proposed project will be evaluated for compliance with, all applicable review standards. An applicant for an exemption from Certificate of Need review must address, and its proposed project will be evaluated for consistency with, all applicable review standards.

#### **(1) Geographic Accessibility.**

Sites proposed for a new psychiatric hospital or relocation of a psychiatric hospital shall optimize accessibility through minimizing travel time for the likely population to be served.

(a) Optimal travel time for adult acute psychiatric hospital services is within 30 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region where the facility is located or will be located, has or will have as a result of the proposed project, optimal travel time to a hospital with acute psychiatric inpatient services or if the Commission determines that access will be substantially improved for the population in the applicant's likely service area through a reduction in travel time.

(b) Optimal travel time for adolescent and child acute psychiatric hospital services is within 45 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region where the facility is located, or will be located, has or will have as a result of the proposed project, optimal travel time to a hospital with acute psychiatric inpatient services or if the Commission determines that access will be substantially improved for the population in the applicants' likely service area through a reduction in travel time.

#### **(2) Need for Acute Psychiatric Hospital Services.**

(a) The Commission shall publish, at least every two years, regional acute psychiatric hospital utilization projections for adults, children, adolescents, and the geriatric population using the methodology in Regulation .06 of this chapter.

(b) The Commission shall publish at least every two years a needs determination for historically underserved populations for acute psychiatric hospital services by region.

(i) The needs determination for historically underserved populations will be developed based on consideration of factors that include trends in psychiatric hospital use, trends in hospital emergency department boarding, and needs assessments developed by local behavioral health authorities and State agencies that identify gaps in the mental health system.

(ii) Commission staff shall publish on its website a draft needs determination for historically underserved populations that includes the sources and assumptions used to develop the determination and requests public comment regarding the draft determination. Staff shall also send the notice to each acute general hospital and special psychiatric hospital in Maryland. The Commission shall consider the comments and Commission's staff's recommendations at a public meeting before establishing a needs determination for historically underserved populations that shall apply to a Certificate of Need review and to a request for exemption from CON review for a project that involves acute psychiatric hospital services.

(c) The Commission shall use the regional acute psychiatric hospital utilization projections and the needs determination for historically underserved populations to evaluate the need for a proposed new psychiatric hospital, the proposed introduction of psychiatric services by a general hospital, the relocation of a special psychiatric hospital or a general hospital providing psychiatric inpatient services, and other projects that involve acute psychiatric hospital services. An applicant shall address the need for its proposed project within the context of the regional acute psychiatric hospital utilization projections and the needs determination for historically underserved populations in effect when a CON application or request for an exemption from CON review is filed and shall explain the basis for any inconsistency between the needs determination for historically underserved populations and the bed capacity and patient populations it proposes to serve.

(i) When the needs determination for historically underserved populations indicates a level of regional utilization for a patient population with specialized needs that is sufficient to support four or more beds for one or more historically underserved populations, an applicant shall address how its proposed project will meet the needs of at least one patient population; or

(ii) If the applicant does not currently serve or propose to serve any of the historically underserved populations in need, as identified in the needs determination for historically underserved populations, the applicant shall demonstrate that developing bed capacity or programming to serve any of these patient populations would jeopardize the financial viability of the hospital or would jeopardize the ability of the hospital to meet the needs of the broader patient population it serves.

(d) In addition to addressing the needs determination for historically underserved populations in effect, an applicant shall demonstrate in a service-area level needs assessment that the acute psychiatric hospital bed capacity proposed is needed. The applicant's service area-level needs assessment shall include a forecast of demand for acute psychiatric hospital beds by the population in its projected service area and a zip-code level analysis of the market share that the

applicant expects to capture within the projected service area. The applicant shall demonstrate the reasonableness of its assumptions in:

- (i) Defining the service area of the proposed project;
- (ii) Projecting psychiatric hospital use rates for its service area population;
- (iii) Projecting the market share of applicable psychiatric hospital services of the proposed project within the project's service area; and
- (iv) Projecting the average length of stay in proposed psychiatric beds.

(e) A hospital shall obtain a Certificate of Need to establish acute psychiatric hospital bed capacity proposed to serve adults, adolescents, or children.

(i) A hospital shall provide 30 days' notice to the Commission prior to the reallocation of acute psychiatric hospital beds from one age group of patients it is authorized to serve to another age group it is authorized to serve change provided that the change does not increase the total acute psychiatric hospital bed capacity of the hospital; and

(ii) This notification requirement also applies to reallocation of acute psychiatric hospital beds to establish a specialized unit for elderly patients, provided that the hospital is authorized to provide adult acute psychiatric hospital services and the project does not increase the total acute psychiatric hospital bed capacity of the hospital

(f) The need for long-term psychiatric hospital beds, in which the average length of stay exceeds 30 days, will be evaluated on a case-by-case basis, considering the needs assessment provided by the applicant. The needs determination for historically underserved populations referenced in Paragraphs (a) through (d) of this standard will only be applicable in the review of psychiatric hospitals providing acute psychiatric hospital care, in which the average length of stay is less than 30 days.

### (3) Patient Rooms

(a) All new patient rooms for acute psychiatric hospital patients will be private rooms designed for single-occupancy. Semi-private patient rooms, which are designed for double-occupancy, shall only be permitted if the applicant provides evidence demonstrating that, under the specified circumstances presented by the proposed project, semi-private patient rooms are appropriate.

(b) Projects that involve renovation or replacement of patient rooms for acute psychiatric hospital patients will, to the maximum extent possible, replace semi-private rooms with private rooms. Renovation or replacement of acute psychiatric hospital patient rooms that retain semi-private rooms shall only be permitted if the applicant provides evidence demonstrating that,



under the specified circumstances presented by the proposed project, semi-private patient rooms are appropriate.

(4) Other Program Requirements

An applicant proposing to provide acute psychiatric services for two or more age groups shall provide physical separation and programmatic distinctions between the patient groups consistent with Maryland Department of Health requirements.

(5) Support for the Project

CON applications and requests for exemption from CON review involving acute psychiatric hospital facilities and service shall document support for the project from entities that serve the population in the applicant's service area, including:

- (a) Local health departments;
- (b) Local community mental health centers;
- (c) The Behavioral Health Administration of the Maryland Department of Health;
- (d) Each local mental health advisory council or agency; and
- (e) behavioral health service providers.

(6) Emergency Services

Special psychiatric hospitals and general hospitals providing acute psychiatric services shall have the ability to provide services on an emergency basis at all times, including the capability to perform evaluations of persons believed to have a mental disorder and brought to the hospital on emergency petition, unless otherwise exempted by the Maryland Department of Health as provided in Health-General §10-620(d)(2). Each such hospital shall also have emergency holding bed capabilities and at least one seclusion room.

(7) Involuntary Admissions

- (a) All special psychiatric hospitals and all psychiatric units operated by general hospitals shall admit involuntary patients, unless otherwise exempted by the Commission.
- (b) A special psychiatric hospital or hospital with a psychiatric unit may not discontinue admissions of involuntary patients without approval from the Commission.

(8) Access to Acute Psychiatric Hospital Services

(a) A special psychiatric hospital or a psychiatric unit operated by a general hospital shall not deny admission to a designated psychiatric unit solely on the basis of a patient's legal status as an involuntary patient or because of a patient's ability to pay for services.

(b) A special psychiatric hospital or a psychiatric unit in a general hospital shall only deny admission if it is unable to provide the appropriate level of care for a patient.

(c) A special psychiatric hospital and a general hospital with a psychiatric unit shall participate in Medicare and Medicaid programs.

(9) Adverse Impact.

(a) A capital project involving psychiatric hospital facilities shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. If the applicant is a Maryland general hospital seeking a capital-related adjustment in its global budget revenue, it shall demonstrate that:

(i) It is an efficient hospital within its peer group as reflected in the most recent integrated efficiency analysis published by Health Services Cost Review Commission;

(ii) If the project involves replacement of physical plant assets, the age of the physical plant assets being replaced exceed the average age of plant for its peer group or otherwise demonstrate why the physical plant assets require replacement to achieve the primary objectives of the project.

(iii) If the project reduces the potential availability or accessibility of psychiatric hospital services by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish the availability or accessibility of the population in the primary service area to acute psychiatric hospital care, including access for the indigent, underinsured, and uninsured.

(10) Construction Cost.

(a) The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any capital-related adjustment of global budget revenue shall not include the amount of the projected construction cost that exceeds the Marshall Valuation

Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

- (b) An applicant shall provide the information necessary for MHCC staff to calculate the construction cost per square foot based on the Marshall Valuation Service® guide.
- (c) An applicant is permitted but not required to submit calculation of the construction cost per square foot based on the Marshall Valuation Service® guide, independent of MHCC staff's analysis.

(11) Inpatient Nursing Unit Space.

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 a rate adjustment. If the inpatient unit program space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any capital-related adjustment in global budget revenue shall not include the amount of the projected 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.

(12) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application or a request for an exemption from CON review must be accompanied by a statement containing each assumption used to develop the projections;

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the acute psychiatric services, unless the applicant demonstrates why future utilization should not be expected to be consistent with observed historic trends for the likely population to be served by the applicant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing

levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

(iv)The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation) if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations, with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate or the Commission determines that overall hospital financial performance will be positive and that the services will benefit the hospital's service area population.

#### **.06 Methodology for Utilization Forecast for Acute Psychiatric Hospital Beds.**

Adult, adolescent, child, and geriatric acute psychiatric hospital bed utilization is projected using the following methodology.

##### **A. Geographic Area.**

The utilization of acute psychiatric hospital beds is projected on a regional basis. The regions and the jurisdictions that comprise these regions are:

- (1) Baltimore Upper Shore – Anne Arundel, Baltimore, Carroll, Cecil, Harford, and Howard Counties, Kent, Queen Anne's, and Talbot Counties and Baltimore City;
- (2) Lower Eastern Shore – Dorchester, Somerset, Wicomico, and Worcester Counties;
- (3) Montgomery – Montgomery County;
- (4) Southern Maryland – Calvert, Charles, Prince George's, and St. Mary's Counties; and
- (5) Western Maryland – Allegany, Frederick, Garrett, and Washington Counties.

##### **B. Period of Time Covered.**

- (1) The base year from which projections are calculated is the most recent calendar year for which discharge abstract data is available from Maryland and District of Columbia acute general hospitals and special psychiatric hospitals that provide acute psychiatric inpatient services.
- (2) The target year for which projections are calculated is seven years after the base year.

##### **C. Services and Age Groups.**

Use rates, the number of acute discharges per thousand population for the following age groups will be calculated: children (under 13); adolescents (13 to 17); adults (18 and over); geriatric (65 and over). For the use rate calculations of the adult and geriatric population,

calculations will be performed for subgroups within the full range (18-44; 45-64, 65-74, 75 and over), as applicable.

(1) The following assumptions are relied upon in the methodology.

(a) Interstate patterns of migration from states bordering Maryland (Delaware, District of Columbia, Pennsylvania, Virginia, and West Virginia), by age group, will be accounted for in the baseline projection at the regional level, using the most recent population projections developed for official state government use in each applicable state. Discharges and days for patients from non-bordering states, foreign countries, or unidentified locations will be held constant as a proportion of total days from the base year to the target year for each region.

(b) Regional target year discharge rates are calculated as follows:

(i) Calculate the average annual rates of discharges per thousand population by age group for Maryland residents by region for the most recent five-year period available. For residents of border states (Delaware, District of Columbia, Pennsylvania, Virginia, West Virginia), calculate a discharge rate per thousand population based on discharges from Maryland hospitals, for the most recent five-year period available.

(ii) Calculate the statewide average annual rates of discharges per thousand population by age group for all Maryland residents, including Maryland residents from unidentified counties, for the most recent five-year period available.

(iii) Determine the minimum target year projected discharge rate for each age group in each region by choosing the lower of either the five-year average annual discharge rate per 1,000 population calculated for the region or the five-year statewide average discharge rate per 1,000 population.

(iv) Determine the maximum target year projected discharge rate for each age group in each region by choosing the higher of either the five-year average annual discharge rate per 1,000 population by the projected population for the region or the five-year statewide average discharge rate per 1,000 population.

(v) Both the minimum and maximum target year projected discharge rate for residents in each age group from bordering states will be the five-year average annual discharge rate per 1,000 population.

(vi) Regional target year average lengths of stay (ALOS) is calculated by, first, calculating the average length of stay for each of the most recent five years of data by dividing the total number of days by the total number of discharges by geographic location and age group. Then add the calculated ALOS for each group for all five years and divide by five.

(c) Regional bed capacity is calculated by summing the total number of licensed acute psychiatric hospital beds allocated by age group and region.

#### **D. Data Sources.**

##### (1) Acute Psychiatric Hospital Discharges by Age Group.

(a) Patient discharges coded as MDC 19 in HSCRC or District of Columbia hospital discharge abstract data for general hospitals are counted as acute psychiatric hospital discharges and all discharges from special psychiatric hospitals in Maryland, and if available special psychiatric hospitals in the District of Columbia.

(b) The data source or data fields used to count acute psychiatric hospital discharges may change, as needed, to achieve an accurate count of acute psychiatric hospital discharges, to account for errors in data reporting, and to account for changes in the discharge data. Notice of changes in the data sources or fields used to count acute psychiatric discharges will be published on the Maryland Health Care Commission's website and in the *Maryland Register*.

##### (2) Population.

(a) Base year population data, by area of residence and age, is obtained from the following sources.

(i) Maryland population is obtained from the most recent Maryland Department of Planning projections; and

(ii) Population in other states is obtained from the most recent projections prepared by respective state agencies charged with preparing the projections, or from the U.S. Census Bureau.

(b) Projections of future target year population, by area of residence and age, are obtained from the following sources:

(i) Maryland population is obtained from the most recent Maryland Department of Planning projections; and

(ii) Population in other states is obtained from the most recent projections prepared by respective state agencies charged with preparing the projections, or from the U.S. Census Bureau.

#### **E. Method of Calculating Utilization.**

(1) Adjusted Utilization for In- and Out-migration of Patients Across Regions. The minimum and maximum projected number of days for each region shall be adjusted for utilization patterns by multiplying the number of days projected for each age group and geographic location

by the proportion of days that are attributable to each region in the base year, for each age group and geographic location.

(2) Calculation of Minimum Psychiatric Bed Days. Multiply the target year ALOS by the minimum discharge rate and projected population in the target year, for each age group and geographic location (regions and bordering states).

(3) Calculation of Maximum Psychiatric Bed Days. Multiply the target year ALOS by the maximum discharge rate and projected population in the target year, for each age group and geographic location (regions and bordering states).

#### **F. Calculation of “Other Psychiatric Bed Days.”**

Multiply the proportion of psychiatric bed days in the base year that account for residents from unknown or foreign locations or non-bordering states by the projected number of psychiatric bed days for each age group in each region in the target year.

#### **G. Utilization Projection.**

(a) Before including the calculated “Other Psychiatric Bed Days,” multiply the minimum projected number of days for each age group and patient location by the proportion of discharges from each location that were served in each region in the base year. This is the minimum adjusted projected number of psychiatric bed days.

(b) Before including the calculated “Other Psychiatric Bed Days,” multiply the maximum projected number of days for each age group and location by the proportion of discharges from each location that were served in each region in the base year. For each age group, if the out-migration for residents of the region is greater than 50 percent, and the discharge rate is below the statewide average, then the maximum projected days for those residents should be multiplied by the overall statewide average percentage of residents who receive care in the region in which they reside. For each region add the respective calculated “Other Psychiatric Bed Days” to the total projected days by age group. This is the maximum adjusted projected number of psychiatric bed days by age group.

(c) Calculate the range of gross bed utilization for acute psychiatric hospital services by dividing the minimum and maximum adjusted projected number of bed days from both (5)(a) and (5)(b) above by the total number of days in the target year and then dividing by the minimum occupancy standard, for each region and age group. The minimum occupancy standards are determined by the number of psychiatric beds at a facility, by age group, and are shown below.

**Bed Capacity Minimum Average  
Annual Psychiatric Bed Occupancy Rate**

Less than 20 beds	70%
Between 20 and 39 beds	75%
Over 39 beds	80%

(d) Calculate the range of net bed utilization for acute psychiatric hospital services for children, adolescents, and adults by subtracting the licensed bed capacity allocated to programming for each of these age groups and any beds approved through Certificates of Need that have not yet been developed, for each region from the range of gross bed utilization for the relevant age group, unless it is known that the licensed bed capacity of a facility is different from its physical bed capacity. In that instance, the physical capacity will be used instead of licensed bed capacity for the calculation of gross bed utilization. For the geriatric population, the net utilization will be based on the difference between the base year utilization and the target year utilization.

(e) The gross and net bed utilization by region and age group will be published as a notice in the *Maryland Register*. This need projection will be applicable to the evaluation of bed need in certificate of need projects reviewed by the Commission, as outlined in the bed need standard in this chapter.

**G. Mathematical Formula.**

The utilization projection methodology described in .06 is shown here in mathematical form.

(1) Definition of Terms. Terms used in .06I(2) are defined as follows:



<u>Term</u>	<u>Definition</u>
i	Area of residence, where 1, ...5= Maryland HPRs and other = non-Maryland states or unknown origin
j	HPR of care, where 1, ..., 5 = Maryland HPRs
k	Age group: children (under 13), adolescents (13-17), adults (18 and over); geriatric (65 years and over)
y	Year
byr	Base year (one year prior to base year is byr-1 . . .)
BPD	Base year patient days
TPD	Target year patient days
BPOP	Base year population
TPOP	Target year population
BJRATE	Base year HPR discharge rate
TJRATE	Target year HPR discharge rate
RRATE	HPR use rate
maxTJRate	Maximum HPR discharge rate
minTJRate	Minimum HPR discharge rate
NONMDPD	Patient days originating outside Maryland, other than border states, or of unknown origin
TNONMDPD	Target year patient days originating outside Maryland, other than border states, or of unknown origin
GUTIL	Gross bed utilization projected
INV	Inventory beds
NUTIL	Net projected bed utilization in excess of current inventory
NMIGPD	Net migration patient days
NMIGUTIL	Net migration bed utilization
AUTIL	Adjusted bed utilization

(2) Formula. Utilization for acute psychiatric beds in each HPR is calculated as shown in the following table:

- i. When  $i=1 \dots 5$ , the base year HPR discharge rate by age group  

$$BJRATE_{ki} = BPD_{ki}/BPOP_{ki} * 1000$$
, where  $k$ =age groups: under 13, 13-17, 18 and over, and 65 years and over.
- ii. Average statewide discharge rate by age group  

$$SRATE_{ky} = (PD_{ky}/POP_{ky} * 1000)/5$$
, where  $y = byr, \dots, yr-4$
- iii. Average HPR discharge rate by age group  

$$RRATE_{ky} = (PD_{ky}/POP_{ky} * 1000)/5$$
, where  $y = byr, byr-1 \dots, yr-4$
- iv. Maximum Target year HPR discharge rate by age group  

$$maxTJRate_{ki} = RRATE_{ki}$$
, if  $SRATE_{ky}$  is lower than  $RRATE_{ki}$
- v. Minimum Target year HPR discharge rate by age group

$\min TJRate_{ki} = RRATE_{ki}$ , if  $SRATE_{ky}$  is higher than  $RRATE_{ki}$

- vi. Base year patient days for each HPR of residence by age group  
 $BPD_i = \sum_k BPD_{ki}$
- vii. Minimum target year patient days for each HPR of residence by age group  
 $TPD_i = \sum_k (1 + \min TJRate_k)^7 * TPOP_{ki} * ALOS_k$
- viii. Maximum target year patient days for each HPR of residence by age group  
 $TPD_i = \sum_k (1 + \max TJRATE_k)^7 * TPOP_{ki} * ALOS_k$
- ix. Ratio of patient days originating outside Maryland, other than border states, or of unknown origin to the base year patient days originating in the same HPR of care by age group  
 $R_{jk} = \text{NONMDPD}_{jk} / BPD_{jk}$
- x. Target year patient days originating outside Maryland or of unknown origin by age group  
 $TNONMDPD_{jk} = R_{jk} * TPD_{jk}$
- xi. Bed utilization by age group  
 $GUTIL_j = (TPD_j + TNONMDPD_j) / 365$
- xii. Net bed utilization by age group  
 $NUTIL_j = GUTIL_j - INV_j$
- xiii. Net migration patient days among Maryland HPRs in base year by age group  
 $NMIGPD_{jy} = \sum_{i=1, i \neq j}^5 PD_{jiy}$
- xiv. Net migration bed utilization among Maryland HPRs by age group  
 $NMIGUTIL = NMIGRPD / 365$
- xv. Adjusted bed utilization by age group  
 $AUTIL_j = NUTIL_j + NMIGUTIL_j$

## H. Update, Correction, Publication, and Notification Rules.

(1) The Commission will update acute psychiatric hospital bed utilization projections by age group at least every two years and publish the projections in the *Maryland Register*. The most recent inventory of psychiatric hospital beds in Maryland will also be published along with updated projections.

(2) Updated projections published in the *Maryland Register* supersede any previously published projections in the *Maryland Register*.

(3) Published projections remain in effect until the Commission publishes updated acute psychiatric hospital utilization projections.

DRAFT

## **.07 Definitions.**

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “Acute psychiatric hospital services” refers to a psychiatric hospital or psychiatric unit in a general hospital.

(2) “Certificate of Need-approved (CON-approved) beds” means those beds for which a Certificate of Need has been awarded by the Maryland Health Care Commission, consistent with COMAR 10.24.01, but that are not yet licensed.

(3) “Charity Care” means care for which there is no means of payment by the patient or any third-party payer.

(a) Charity care does not mean uninsured or partially insured days of care designated as deductibles or co-payments in patient insurance plans, nor that portion of charges not paid as a consequence of either a contract or agreement between a provider and an insurer, or a waiver of payment due to family relationship, friendship, or professional courtesy.

(b) Charity care does not include bad debt.

(4) “CMS” means the federal Centers for Medicare and Medicaid Services.

(5) “Geriatric population” means the population aged 65 and older.

(6) “Legal entity” means an organization that has an identity separate from its members that possesses rights and responsibilities under the law.

(7) “Likely service area” means the zip code areas for the population that a provider has historically or more recently served or which a new provider is likely to serve, based on market share research or analysis of similar providers, with adjustments based on specific current or projected market conditions.

(8) “Jurisdiction” means any of the 23 Maryland counties or Baltimore City.

(9) “Licensed” means a facility that has received approval to operate from the Office of Health Care Quality of the Maryland Department of Health.

(10) “Local behavioral health authorities” means the local organizations in Maryland that are responsible for the planning, development, monitoring and evaluation of publicly funded behavioral health care services.

(11) “Major Diagnostic Category” (MDC) means a set of 25 mutually exclusive categories for principal diagnoses from the ICD-9 and ICD-10 coding systems.

(12) “Medicaid” means the Maryland Medical Assistance Program administered by the State under Title XIX of the Social Security Act to reimburse comprehensive medical and other health-related care for categorically eligible and medically needy persons.

(13) “Needs determination for historically underserved populations” refers to the need determination, by region, published at least biennially by the Commission for acute psychiatric hospital services by the following patient populations: children, adolescents, patients with mental disorders and one or more developmental disabilities, and patients with mental disorders and a secondary diagnosis of substance abuse disorder, in accordance with the process set forth at .05B(2).

(13) “Peer group” means the hospitals determined by the Health Services Cost Review Commission to be similar with respect to cost, volume, and types of services provided.

(14) “Person” means an individual, receiver, trustee, guardian, executor, administrator, fiduciary, or representative of any kind and any partnership, firm, association, limited liability company, limited liability partnership, public corporation, or private corporation, or other entity.

(15) “Psychiatric bed days” means the number of days spent in a hospital where records are coded as MDC 19 or from a psychiatric hospital regardless of the MDC code associated with the discharge.

(16) “Psychiatric discharge” means a discharge from a hospital that is coded with MDC 19 or discharge from a psychiatric hospital regardless of the MDC code associated with the discharge.

(17) “Projected service area” means a geographic area, defined at the zip code area level, that consists of the zip code areas whose resident populations account, in the aggregate, for a given proportion of the total patients projected to be served by a health care facility or proposed health care facility. It consists of zip code areas, ranked by their proportional projected contribution of patients to the facility or proposed facility, until the desired given aggregate given proportion of total patient is reached.

(18) “Region” means one of the five geographic regions of the State used in this chapter for purposes of bed utilization projection. Regions may be used in scheduling Certificate of Need project review cycles. These regions are: Baltimore Upper Shore, Lower Eastern Shore, Montgomery County, Southern Maryland, and Western Maryland.

(19) “Related entity” means any parent or subsidiary, or affiliate and includes any business, corporation, partnership, limited liability company or other entity in which the applicant, a parent or a subsidiary or affiliate holds 50% or greater ownership interest, directly or indirectly.