UNIVERSITY of MARYLAND MEDICAL SYSTEM

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VIA EMAIL

Eileen Fleck
Chief
Acute Care Policy
Maryland Health Care Commission
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Dear Ms. Fleck:

Re: Draft State Health Plan for Facilities and Services: Acute Psychiatric Hospital Services, COMAR 10.24.07

Informal Comments Submitted on behalf of the University of Maryland Medical System

Dear Ms. Flex:

I write on behalf of the University of Maryland Medical System ("UMMS") to provide informal comments on the proposed draft State Health Plan for Facilities and Services: Acute Psychiatric Hospital Services, COMAR 10.24.07 (the "Draft Chapter"), which was published for informal review and comment on December 17, 2020.

UMMS generally supports the Draft Chapter and urges the Commission to propose and adopt the Draft Chapter as a permanent regulation with the modifications discussed below.

I. Project Review Standards – COMAR 10.24.07.05B

UMMS provides the following comments to the project review standards set forth at COMAR 10.24.07.05B.

A. Notices Regarding Bed Capacity and Acute Psychiatric Age Programming – COMAR 10.24.07.05B(2)(e)

Project review standard 10.24.07.05B(2)(e) of the Draft Chapter states as follows:

> 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 [*sic*] 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.[1]

Presumably, these provisions were added to the Draft Chapter so that the Maryland Health Care Commission ("MHCC") can track utilization and bed capacity for purposes of the need projections described in the Draft Chapter. However, as written, these notice requirements may restrict a facility's ability to reallocate acute psychiatric beds in order to meet immediate patient demands. An exception to the notice requirements for exigent circumstances should be included. Alternatively, notice to the MHCC should be permitted to take place within a certain number of days following the reallocation of beds across the acute psychiatric patient populations a facility is authorized to serve, assuming the reallocation of beds does not increase total licensed bed capacity of the facility.

In addition to notice of relocation of beds among adults, adolescents, and children, the Draft Chapter requires that a facility notify the MHCC 30 days before establishing a "specialized unit for elderly patients" so long as the facility is authorized to provide acute psychiatric services to adults and the total psychiatric bed capacity is not increased. The term "elderly patients" is not defined and it is unclear whether the Draft Chapter's use of this term is intended to be coterminous with the definition of "geriatric population" – defined as adults aged 65 and over. What constitutes a "specialized unit" should also be clearly defined. A specialized unit could include anything from a locked dementia unit to a unit with additional or specialized staff or equipment.

Finally, the Draft Chapter is unclear how either of the two notice provisions provided in COMAR 10.24.07.5B(2)(e) regarding allocation of acute psychiatric bed capacity will apply upon the annual change to an acute general hospital's licensed bed capacity. Presently, the

[1] UMMS presumes that standard 10.24.07.05B(2)(e)(1) should read as follows: "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."

licensed bed capacity of an acute general hospital is recalculated every year based on 140% of each hospitals' prior year's average daily censes. Acute general hospitals are able to allocate beds across licensed acute care services, including (1) psychiatric; (2) MSGA; (3) obstetrics; and (4) pediatrics. An exception should be permitted to allow acute general hospitals to reallocate acute psychiatric beds within acute psychiatric populations the facility is authorized to serve at the time each facility designates its annual licensed bed capacity without having to provide thirty (30) days' advanced notice to the MHCC.

B. Physical and Programmatic Distinctions Between Acute Psychiatric Hospital Age Groups – COMAR 10.24.07.05B(4).

Standard 10.24.07.05B(4) of the Draft Chapter states that "[a]n 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." Given the Draft Chapter's adoption of an acute psychiatric bed need projection for the "geriatric population" and undefined "historically underserved populations" as well as the Draft Chapter's reference to "specialized units for elderly patients," this standard should be clarified to indicate that it applies to an application seeking to provide acute psychiatric services to two or more age groups for which CON review is required, i.e., adults, adolescents, and children. *See* COMAR 10.24.07.05B(2)(e).

UMMS proposes the following suggested clarification to COMAR 10.24.07.05B(4):

> An applicant proposing to provide acute psychiatric services for two or more age groups <u>for which separate CON review is required</u> shall provide physical separation and programmatic distinctions between the patient groups consistent with Maryland Department of Health requirements.

C. Involuntary Admissions – COMAR 10.24.07.05B(7)

Standard 10.24.07.05B(7)(a) states that "[a]ll special psychiatric hospitals and all psychiatric units operated by general hospitals shall admit involuntary patients, unless exempted by the Commission." The Draft Chapter should be clarified to provide a mechanism and timeline pursuant to which a provider of acute psychiatric hospital services may obtain an exemption from MHCC from the requirement to admit involuntary patients.

Standard 10.24.07.05B(7)(b) provides that a "[a] special hospital or hospital with a psychiatric unit may not discontinue admissions of involuntary patients without approval from the Commission." The Draft Chapter should be clarified to provide a mechanism and timeline pursuant to which a provider of acute psychiatric hospital services may receive approval to

discontinue admission of involuntary patients, including when all acute beds in the facility are occupied.

D. Adverse Impact – COMAR 10.24.07.05B(9)

With respect to capital projects involving acute psychiatric services by an acute general hospital, the Draft Chapter states, among other things: "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[.]"

Presumably, this standard was adopted with guidance from the Health Services Cost Review Commission ("HSCRC"), which had two members participate in the MHCC's Psychiatric Workgroup. In the recent past, State Health Plan Chapters that have adopted current HSCRC standards as project review standards have quickly become out-of-date due to changes in HSCRC rate or capital-related adjustment methodologies as well as adoption of the Global Budget Revenue/Total Cost of Care Model between the State of Maryland the Centers for Medicare and Medicaid Services. Approval of applications for capital-related adjustments to an acute general hospital's global budget revenue is within exclusive purview of the HSCRC – not the MHCC. This provision should be eliminated from the Draft Chapter; whether to grant a capital-related adjustment to global budget revenue should be left to exclusive authority of the HSCRC.

The standard on adverse impact should also include a requirement that a proposed capital project involving psychiatric hospital services not have an adverse impact on existing providers of such services, consistent with existing CON application forms. Finally, current standards 10.24.07.05B(9)(a)(ii)-(iii) in the Draft Chapter, if retained, should apply equally to both special psychiatric hospitals and acute general hospitals providing acute psychiatric services.

In summary, UMMS proposes the following modifications to COMAR 10.24.07.05B(9):

~~(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, or existing providers of services affected by the proposed project. ~~If the~~ An 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~~.~~; and

(ii~~i~~) 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.

E. Financial Feasibility – COMAR 10.24.07.05B(12)

Standard COMAR 10.24.07.05B(12), states that "[a] hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital." Because the Draft Chapter is also applicable to CON exemption requests, this standard should be clarified to require that hospital capital projects "subject to CON review shall be financially feasible . . ."

Further, subject to certain notice requirements to the MHCC and a demonstration of consistency with the applicable State Health Plan Chapter(s), pursuant to COMAR 10.24.01.04A, a health care facility in a merged asset system may relocate, change bed capacity, and change the type or scope of health care services if part of a consolidation or merger of two or more health care facilities. The Draft Chapter should continue to permit merged asset systems to maintain flexibility with respect to relocation of services, beds, and the type or scope of health care facilities made as part of a consolidation or merger of two or more health care facilities and in order to meet the needs of the populations served by the merged asset system.

Accordingly, UMMS proposes the following changes to 10.24.07.05B(12):

(12) Financial Feasibility.

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

* * *

(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. Applicants seeking an exemption from CON review as part of a merger or consolidation of two or more health care facilities must demonstrate that relocation of an existing health care facility, a change in bed capacity of an existing health care facility, or a change in the type or scope of health care services offered by a health care facility will benefit the merged asset system's service area population and not jeopardize the long-term financial viability of the merged asset system.

II. Methodology for Utilization Forecast for Acute Psychiatric Hospital Beds

The Draft Chapter includes a detailed methodology for calculating acute psychiatric bed need for four age groups: (1) adults under age 65; (2) adolescents; (3) children; and (4) the geriatric population aged 65 and over. The base year of the projections is the last calendar year for which discharge data is available for acute hospitals in Maryland and the District of Columbia and special psychiatric hospitals. The target year for which projections are made is seven years after the base year.

The methodology for calculating acute psychiatric utilization and bed need includes discharges per cohort per thousand population for the statewide average and each of five identified regions. The Draft Chapter indicates that the MHCC will calculate "[r]egional target year average lengths of stay using 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." This target year ALOS will be used to calculate the minimum and maximum number of psychiatric bed days, and ultimately, the number of projected beds need for each age group by region.

In background commentary, however, the Draft Chapter notes that:

> 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.

Because the Draft Chapter's methodology for calculating acute bed need by region and age cohort relies upon the most recent five-years of discharge data, the methodology may undercount need for psychiatric beds as reflected in the MHA's findings unless patient days spent in an acute hospital bed or Emergency Department are factored into the methodology. The Draft Chapter's methodology should account for delays in psychiatric patient placement, including by adjusting the ALOS or "Other Psychiatric Bed Days" under COMAR 10.24.07.06(F), to account for days that a patient spends an acute general hospital awaiting placement at in an acute psychiatric bed in an appropriate facility. Data on such patient days could be provided by hospitals pursuant to MHCC surveys or in coordination with the MHA.

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

Sincerely yours,

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