Comprehensive Care Facilities (CCF)

Issues	Potential Solution
• Exemptions for certain circumstances/projects • Needs-based review standards on bed capacity • CON & innovation • Medicaid access & MOU requirement • Aligning/streamlining process	1. Permit docketing of apps for new facilities in jurisdictions that have failed MHCC quality standards 2. Allow changes in bed capacity of more than 10% without needing a CON – expand the waiver bed rules 3. Permit docketing of apps in jurisdictions that have no need if proposal well-aligned with TCOC demonstration 4. Allow CCFs to provide home health services to discharges without needing a CON 5. Eliminate CON requirements for modernizations without volume increase
Obstacles	**Benefits**
• Potential solutions 2, 4, 5 require statutory changes • What constitutes TCOC alignment has not been defined by the State or hospitals • Lack of sufficient qualified personnel and knowledge of the home health environment for CCFs to expand into home health	• Encourage availability and use of skilled nursing facilities instead of acute care when clinically appropriate • Increase competition among providers (on a limited basis) to improve patient alternatives for care • Streamline administrative burden

Home Health Agencies

Issues	Potential Solution

• Needs-based review and other standards
• CON in promoting quality of care by staff
• Current charity care requirements are not meaningful
• Aligning info requirements and review process with type/scale of project
• CON's role in reducing CCF utilization or promote appropriate home health utilization
	1. Modify SHP
	  ○ Provide greater flexibility for existing providers to expand into additional service areas by replacing filing requirements or creating an exemption
	  ○ Modify access standards related to charity care – provide credit for serving uninsured and Medicaid Duals
	2. Exempt facilities already subject to CON from obtaining a CON to provide home health services to their patients (for hospital, CCF, and hospice)
	3. Limit CON review standards to a review of the provider's history/quality of previous services
	4. Eliminate CON
	  ○ Establish a rigorous licensure/re-licensure process at MDH

Obstacles	**Benefits**
• Statutory changes required to implement solutions 2, 3, and 4 • Lack of sufficient qualified personnel and knowledge of the home health environment for other providers to expand into home health	• Encourage availability and use of home health instead of acute care or skilled nursing facilities when clinically appropriate • Increase competition among providers (on a limited basis) to improve patient alternatives for care • Streamline administrative burden

Hospice

Issues	Potential Solution
• Outdated scope of CON • SHP does not account for/facilitate TCOC across full care continuum • Charity care not aligned with need • SHP methodologies for unmet need • Role of CON in promoting quality • Missing inpatient bed need methodology • Not all of CON is applicable to hospice • Duplicative role of CON and MDH • Need clear/appropriate guidelines for awarded CONs in jurisdictions of unmet need	1. Modify SHP a. Allow general hospices to expand into a contiguous jurisdiction with expedited review b. Modify access standards related to charity care – provide credit for serving uninsured and Medicaid Duals c. Update SHP to reduce review criteria/standards 2. Eliminate CON for changes in bed capacity at inpatient hospices 3. Remove hospice from the scope of CON oversight and establish: a. expanded licensure requirements b. allow MDH to limit # new licensure apps approved within a given time period
Obstacles	**Benefits**
• Previous modifications to State Health Plan have been resisted by providers. • Change 2 and 3 would require statutory changes	• Streamline administrative burden • Expand availability and use of hospice when clinically appropriate • Increase competition among providers (on a limited basis) to improve patient alternatives for care

Alcohol and Drug Abuse Treatment Intermediate Care (ICFs)

Issues	Potential Solution

• Review whether minimal financial requirement adds to current cost
• Exempt ICF from CON processes, leaving monitoring to licensing
• Expand use of existing regulation for emergency CON (opioid crisis)
• Consider adding definition of "quality of care" to COMAR
• Scope only touches a narrow part of treatment spectrum
• Address increased need for inpatient treatment space
	1. SHP Changes
	  ○ Streamline CON processes for Track 2 providers
	  ○ Eliminate relocation and change in bed capacity requirement for existing Track 2 ICFs
	  ○ Update SHP to reduce review criteria and standards for all providers
	2. Eliminate all CON requirements for Track 2 ICFs
	3. Eliminate criteria and standards for Track 1 ICFs, with exception of impact and financial access for reviews involving establishment/expansion
	4. Eliminate all CON regulation of alcoholism and drug abuse services
	  ○ Expand licensure/relicensure authority at BHA

Obstacles	Benefits
• Changes 2-4 require statutory action • Providers argue that bad actors from other states poses a threat to quality of care for patients in Maryland • Significant level of abuse in this sector compared to other sectors	• Encourage availability and use of alcohol and drug abuse treatment intermediate care facilities when clinically appropriate • Increase competition among providers (on a limited basis) to improve patient alternatives • Streamline administrative burden

Residential Treatment Center (RTC)

Issues	Potential Solution
• Challenges of evaluating need for juvenile services • Should RTC be included in scope of CON, given the way in which demand for services has changed	1. Eliminate relocation and change in bed capacity requirement for existing RTCs 2. Remove RTCs from the scope of CON regulations 3. Require MDH to license RTCs that are supported by state juvenile agencies and MDH
Obstacles	**Benefits**
• Changes to statue and regulations required to implement solutions	• Encourage availability and use of residential treatment centers when clinically appropriate • Streamline administrative burden

Ambulatory Surgical Facilities (ASFs)

Issues	Potential Solution
• CON rules differ depending on the number of ORs planned and the ownership arrangement of the applicant • Current rules development of small, potentially inefficient and low quality operations • Post-CON approval performance requirements are unrealistic and outdated • Approach to ASF development does not align with the incentives in TCoC	1. Create an expedited review process for ASF and hospital OR inventory changes (approve if existing OR well-utilized) 2. Give MHCC ability to waive CON requirements for capital projects endorsed by HSCRC as contributing to safe and effective control of TCOC 3. Eliminate all CON regulation of ASF development a. Provide authority and finding for broader and more rigorous ASF regulation by MDH
Obstacles	**Benefits**
• Changes 2 and 3 require statutory changes in Maryland law • Acute hospitals may be left with complex patients and uncompensated care as ASFs receive increased surgical volume • Medicaid underpayment is a disincentive to ASFs serving Medicaid beneficiaries • Total cost of care could rise if hospital global budgets are not sufficiently adjusted to avoid double payment for surgical services	• Streamline administrative burden • A low-cost alternative to surgery in hospitals may reduce the total cost of care for Maryland patients

Hospitals

Issues	Potential Solution
• Portions of SHP are outdated/unclear • SHP doesn't align with current hospital payment model • SHP does not facilitate care delivery transformation • Too many unnecessary standards in SHP • Lack alternatives to conventional CON review • Underdeveloped capability to obtain broader community perspectives on regulated projects	1. Restrict the rounds of completeness questions and allow certain project to be approved through a consent approval process if other parties do not object 2. Eliminate fixed dollar amount for capital expenditure and replace with one based on revenue 3. Eliminate review of applications "reserving the right" for extraordinary GBR adjustment at a later date will be allowed ○ Eliminate capital expenditure (eliminate pledge, allow HSRC to choose approval) 4. Eliminate requirement for review of bed capacity changes 5. Eliminate hospital CON regulation with exemption of: establish new hospital or freestanding medical facilities, relocating hospitals/FMFs, intro cardiac surgery/PCI/organ transplant
Obstacles	Benefits
• Changes 2 through 5 require statutory changes • Uncertainty on the part of hospitals on changes that align with the TCOC	• Streamline administrative burden for both hospitals and the MHCC • Increase competition among providers (on a limited basis) among selected services to improve patient alternatives

Cross-Cutting Recommendations

Issues	Potential Solution
• Current requirements for CON not being appropriate/purposeful • Compatibility of CON with TCOC • Effective use of quality metrics & public data • Exemptions for certain circumstances/projects • CON process does not support the goals of TCOC • CON & innovation • Effective use of quality metrics & public data • Aligning/streamlining process • Excessive time needed to docket an app and complete review (Aligning/streamlining process)	1. Eliminate capital threshold, with exception of hospitals where the thresholds should be linked to revenue 2. Streamline and clarify exemption requirements
Obstacles	Benefits
• Changes to statue and regulations required to implement solutions	• Streamline administrative burden for providers seeking a CON