Draft Decision Matrices for

CCF, Home Health, Hospices, Alcohol and Drug Abuse Treatment Intermediate Care (ICFs), Residential Treatment Centers, Ambulatory Surgery Facilities, Hospitals, and Changes that apply to multiple provider categories

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Comprehensive Care Facilities (CCF)

Issues	Potential Solutions

• Exemptions for certain circumstances /projects
  ○ Allow project development without CON review when occupancy rates in a jurisdiction are above an agreed ceiling.
• Modify needs-based review standards on bed capacity
  ○ Expand waiver bed formula to create stronger 'safety valve'
  ○ CCRCs need flexibility to respond to changing care preferences of residents
• CON does not foster innovation
• Eliminate the requirement to provide a minimum number of patient days to Medicaid patients (the Medicaid MOU).
• CON processes need to align with TCoC
• Post approval processes are excessive or inconsistent
• Identify projects eligible for expedited review process
• Streamline CON exemption process
	1. Establish an exempt process for project development in jurisdictions with occupancy rates above a specified threshold
	2. Permit docketing of apps for new facilities in jurisdictions that have failed MHCC quality standards
	3. Allow changes in bed capacity of more than 10% without needing a CON – expand the waiver bed rules
	4. Permit docketing of apps in jurisdictions that have no need if proposal well-aligned with TCOC demonstration
	5. Allow CCFs to provide home health services to discharges without needing a CON
	6. Eliminate CON requirements for modernizations without volume increase
	7. Modify/eliminate direct admission restrictions at CCRCs for non-community residents into nursing homes if a bed capacity is 10% or less of its independent living units.

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 Solutions

• Modify 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 Solutions

• Outdated scope of CON
  ○ Eliminate both use of capital expenditure thresholds in defining a hospice services project that requires CON approval
  ○ Eliminate requirements that a change in bed capacity by a hospice requires CON approval.
• Standards and criteria are not adequate
  ○ SHP methodologies for defining unmet need assume more hospices produce more choice and use
  ○ Charity care standards do not expand access
  ○ Role of CON in promoting quality is underdeveloped
  ○ Hospice SHF lacks inpatient bed need methodology
 	
• CON limits choice
• SHP does not account for/facilitate TCOC across full care continuum
• CON is not applicable to hospice because it is not supply sensitive
Roles of MHCC and MDH are duplicative
	1. Modify SHP
	  ○ Allow general hospices to expand into a contiguous jurisdiction with expedited review
	  ○ Modify access standards related to charity care – give credit for serving uninsured and Medicaid Duals
	  ○ 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:
	  ○ expanded licensure requirements
	  ○ 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 Solutions

• 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/re-licensure 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 Solutions
• 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 2-3 require statutory action	• Encourage availability and use of residential treatment centers when clinically appropriate • Streamline administrative burden

Ambulatory Surgical Facilities (ASFs)

Issues	Potential Solution
• Scope of regulation is outdated • Use of capital expenditure threshold should be reconsidered • Excessive time and expense required for project review and request for exemption from CON review • Post-CON approval performance requirements are outdated	1. Eliminate CON regulation of ASFs and allow hospitals to develop ASFs (non-rate regulated facilities) without CON approval while maintaining CON regulation of hospital-based OR capacity *-or, alternatively-* 2. Redefine the term "ambulatory surgical facility" in CON law to be an ASF with three or more operating rooms and clarify that hospitals can develop ASFs (non-rate regulated facilities) with one or two ORs 3. Limit full CON review requirements to establishing or relocating an ASF (i.e., an ASF with three or more ORs) or contested reviews 4. Create a consent approval process for all other ASF project categories if not a contested review 5. Develop more rigorous requirements for obtaining interested party status – higher threshold for demonstrating adverse impact 6. Allow Commission to waive CON requirements for ASF projects endorsed by HSCRC as fully aligning with TCOC model

	7. Limit completeness review to one round of questions and response – docketing an application will not connote that application is complete 8. Limit required criteria to (1) SHP, (2) project feasibility/facility viability, and (3) project impact on cost and charges 9. Revise SHP so it is limited to standards addressing need for project and criterion (2) and (3) above 10. Establish a standing Project Review Committee of Commissioners to handle consent approval process and contested reviews (eliminate individual Commissioner Reviewers) – allow for public to speak to Project Review Committee
Obstacles • Either alternative requires significant statutory changes • If CON is maintained (*the alternative*) hospitals will still be competitively disadvantaged by being the outpatient surgery setting for Medicaid patients, uninsured patients, and more complex patients • HSCRC must assure that hospital GBRs are sufficiently re-based over time as more surgical care exits the hospital to unregulated settings • Total cost of care could rise if hospital global budgets are not sufficiently adjusted to avoid double payment for surgical services	Benefits • Streamlined administrative burden • Aligning CON to allow more outpatient surgery to move to the lower cost, non-rate regulated setting may reduce the total cost of care for Maryland patients • Enhanced opportunities for hospital and ASF competition • Streamline administrative burden for ASFs • Potential for more direct input from communities and general public to MHCC's regulatory review process

Hospitals

Issues	Potential Solution

• Scope of regulation is outdated – Use of capital expenditure threshold should be reconsidered
• Many CONs do not involve a service that is statutorily subject to CON review
• SHP is outdated and unclear, many standards are unnecessary.
• SHP doesn't align with current hospital payment model and care delivery transformation
• Excessive time required for project review and request for exemption from CON review
• Duplications or external inconsistencies
  ○ Excessive and duplicative information requirements
  ○ Contradiction between HSCRC and MHCC financial submissions. Little value to submit financials without inflation
  ○ Align with HSCRC in capacity planning approach
  ○ Hospital's CON approved projects still needed to request capital in rates
• Alternatives to conventional CON project review are lacking
• Underdeveloped capability to obtain broader community perspectives on regulated projects
	1. Set capital expenditure threshold as a percentage of hospital revenue and only require review and approval if hospital is seeking adjustment of GBR related to the project (when capex is only reviewable aspect of project) - eliminate "the pledge"
	2. Limit full CON review requirements to establishing or relocating hospitals or FMFs, introducing cardiac surgery or organ transplantation, and contested projects
	3. Create a consent approval process for all other hospital project categories if not a contested review
	4. Develop more rigorous requirements for obtaining interested party status – higher threshold for demonstrating adverse impact
	5. Allow Commission to waive CON requirements for projects endorsed by HSCRC as fully aligning with TCOC model
	6. Limit completeness review to one round of questions and response – docketing an application will not connote that application is complete
	7. Limit required criteria to (1) SHP, (2) project feasibility/facility viability, and (3) project impact on cost and charges
	8. Revise SHP so it is limited to standards addressing need for project and criterion (2) and (3) above
	9. Establish a standing Project Review Committee of Commissioners to handle consent approval process and contested reviews (eliminate individual Commissioner Reviewers) – allow for public to speak to Project Review Committee
	10. Remove requirements for charge information, charity care, and quality of care documentation
	11. Delegate financial feasibility to HSCRC
	12. Eliminate ED standards
	13. Hospital renovation projects below the proposed threshold could seek rate relief because the CON is otherwise not needed
	14. Immediately review the Psychiatric Services chapter of the SHP

	15. Eliminate submission of previous CON terms and conditions compliance 16. Remove requirement to identify 2 alternatives when updating general acute care services 17. Remove requirement to identify 2 alternatives
Obstacles	Benefits
• Potential solutions will require significant statutory changes • Potential solutions 1 and 4 may require policy development by HSCRC • Uncertainty about the incentives in the TCOC makes hospitals hesitant to consider major changes	• Reduced administrative burden for both hospitals and MHCC • Potential for better alignment of MHCC and HSCRC objectives • Enhanced opportunities for hospital competition • Potential for more direct input from communities and general public to MHCC's regulatory review process

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 3. Submit one set of financials to agencies
Obstacles	Benefits
• Changes to statue required to implement solutions	• Streamline administrative burden for providers seeking a CON