MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Meeting Summary
General Hospital Services Workgroup Meeting
November 4, 2021, 10am-12pm
Maryland Health Care Commission (MHCC)
Virtual Meeting

Workgroup Attendees
Kimberly Cammarata
Erin Dorrien
Kristin Feliciano
Arin Forman
Kimberly Justice
Donna Jacobs
Jamie Karstetter
Ryan O'Doherty
Allan Pack
Barry Rosen
Dean Teague
Oksana Likhova (fill in for Renee Webster)
Spencer Wildonger
Darleen Won

MHCC Staff Attendees
Courtney Carta
Eileen Fleck
Zoram Kaul
Stephanie Kersheskey
Theressa Lee
Paul Parker
Sarah Pendley
Jessica Raisanen

Other Attendees
Amale Obeid, University of Maryland
Sruti Padmanabhan, Johns Hopkins
Aneena Patel, Johns Hopkins
Unannounced Attendees (3)

Eileen Fleck welcomed members of the workgroup, and attendees introduced themselves. Ms. Fleck mentioned a change in workgroup membership; Kimberly Justice will be representing Atlantic General Hospital. There were no other changes or additions to the roster. Ms. Fleck noted that no one had suggested corrections or changes to the meeting summary for the first workgroup meeting.

Discussion of Policies

Jessica Raisanen led the workgroup through a discussion of the revised draft policy statements. Ms. Raisanen read Policy 2 from Handout #1 and requested feedback from the workgroup. Erin Dorrien asked for a reminder on the reasoning for the new changes. She also commented that Policy 2 reads well. Ms. Raisanen explained that at the last workgroup meeting, workgroup members suggested that access to services should be defined more broadly than just financial and geographic access. Ms. Fleck mentioned that MHCC staff did not want to include an exhaustive list and decided to include specific potential barriers to access suggested at the last workgroup meeting, without limiting the list to the barriers listed. Kristin Feliciano and Ryan O'Doherty agreed with the changes to Policy 2.

Ms. Feliciano also asked how this policy would be considered in relation to hospital at home services given that MHCC determined that a Certificate of Need (CON) would not be required for those services. Ms. Fleck said that the question raised speaks more to project review standards than the application of policies. Ms. Fleck emphasized that if a project is not subject to CON, then CON policies and standards would not be relevant. Ms. Feliciano responded that even if a project is not subject to CON, there should be some regulation. She asked if there might be a way to tie in these policies to other services that were traditionally hospital-based, but no longer are provided in hospitals.

Ms. Fleck responded that normally when there is an exemption from CON, the applicant is still expected to address the standards in the State Health Plan (SHP), but the process is different. In terms of hospital at home, Ms. Fleck was not sure if this State Health Plan chapter would be relevant. Ms. Feliciano commented that at this point, she does not think anyone is sure. Ms. Fleck mentioned that she could ask for guidance from other MHCC staff and attorneys. Paul Parker explained that the Commission had recently endorsed a recommendation to the HSCRC staff that hospital at home is outside the scope of CON. HSCRC staff is in the final stages of drafting a report to the Joint Chairman on this issue.

One of the workgroup members asked when the HSCRC report on the issue will be finalized. Mr. Parker responded that the report was due December 1, 2021, but he believes that HSCRC requested a 30-day extension and plans to get it to the legislature by the end of the year. Ms. Fleck said that since MHCC has said that CON statute would not control hospital at home, then the CON standards would not apply. Another workgroup member asked who has the regulatory oversight of hospital at home. Mr. Parker replied that MDH's Office of Health Care Quality has oversight because the care is provided under the hospital's license. He added that there may need to be some changes in hospital licensure requirements.

Ms. Fleck and Ms. Raisanen asked if there were any other comments about the policies that were presented. Barry Rosen commented that the language in Policy 1 is stronger than many of the other policies because the word "shall" is used, and he favors revising the policy to avoid potential appeals, which are expensive and time-consuming. Ms. Fleck commented that MHCC staff are intentional about using "should" or "shall" when it is appropriate. She asked if removing the word "most" would address his concern, and he agreed that it would.

Ms. Fleck stated that staff will likely not be revisiting a discussion of the policies in future meetings because it seemed like consensus was reached. However, she welcomed workgroup members to submit additional feedback via email.

Discussion of General Standards: Information Regarding Charges

Ms. Fleck reintroduced the standard for information regarding charges and directed workgroup members to look at Handout #2. She reminded the workgroup that the federal

regulations require that hospitals post updated charge information annually, and those regulations could be referenced in the SHP chapter for acute care general hospitals. Ms. Fleck suggested eliminating the definition of Representative List of Services and Charges and the language seen in 1A. Ms. Dorrien commented that this standard is duplicative and should be eliminated since there is another regulatory body involved; she also commented that other standards may be duplicative too. Ms. Fleck responded that 1B and 1C are not duplicative of the federal requirements or HSCRC regulations.

Ms. Fleck asked Ms. Dorrien if she agreed with referencing the federal standard. Ms. Raisanen mentioned that the MHCC Hospital Quality Initiatives team will be keeping track of hospital compliance with the federal requirements (e.g. publishing on the website), and verifying compliance should not slow down the CON review process because the information should be readily accessible already; the burden put on programs would be quite minimal. Kim Cammarata echoed MHCC staff's desire to ensure that hospitals are compliant and agreed it should not be difficult to verify compliance. She also emphasized that 1B and 1C go beyond the federal requirements, and this is a good opportunity to ensure that consumers can access this charge information.

Ms. Dorrien asked how MHCC checks that hospitals are properly training staff. Ms. Fleck explained that programs submit the hospital's policy and review the description of staff training and timeliness of responding to requests. She also commented that she believes this standard is not usually a problem for CON applicants. Another workgroup participant asked whether standards that are closely duplicative can be eliminated to streamline the application. Mr. Rosen commented that asking for a hospital's policy seems somewhat pointless, even if asking programs to submit a copy of the policy is not incredibly burdensome. He said that he would support adding a reference to the federal requirement.

Dean Teague emphasized that hospital charges can change frequently; he emphasized the public should be aware that in Maryland, charges can change daily. Ms. Fleck asked if it would be important to include that in the SHP chapter. Mr. Teague said that it is important. Ms. Fleck commented that in addition the SHP chapter for general acute care hospitals, a change could be made through HSCRC's regulations.

Erin Dorrien expressed uncertainty as to whether having the requirement for submitting a policy related to staff training on charges gets to the end goal of ensuring that consumers know what they are going to have to pay. She questioned if a CON application is the right place to do this. Ms. Cammarata agreed that MHCC staff just reviewing a hospital's policy is not particularly helpful. She suggested checking on complaints instead. Kristin Feliciano questioned whether the CON review process was the appropriate time to check on complaints because hospitals are held accountable for those complaints already.

Ms. Fleck went back to Mr. Teague's comment that perhaps not enough is being done to educate the public on hospital charges in Maryland. Mr. Rosen said that CON application is not the place to do this. It might make sense if one of the overall questions in the applications is "please summarize any material complaints about violations in any law" so that the applicant can let us know. Ms. Fleck commented that the expectation is that hospitals would be doing this all the time but sometimes staff do see hospitals complying at one point and then coming back to MHCC with an application and being out of compliance at a later time.

Ms. Fleck stated that it seems like the workgroup is amenable to referencing the federal requirements, but that MHCC should potentially do more to better meet consumer needs. Kristen Feliciano disagreed because in her view a standard like this does not belong in the CON review. Darleen Won agreed. Theressa Lee commented that the CON process is one vehicle that MHCC has to ensure price transparency and expressed support for referencing the federal requirements. She also expressed support for having a check on staff training. Ms. Fleck reminded workgroup members that earlier someone suggested looking into complaints instead of maintaining the current standard. Other workgroup members suggested deleting the standard entirely.

Ms. Dorrien suggested it would be helpful for MHCC staff to provide draft language that references federal requirements, but she would have to think about the process of reviewing complaints and whether it fits with the CON process. Ms. Feliciano commented that CMS has the posting of charge information covered. She recommended deleting standards 1B and 1C, if the language will regularly be brushed over during the CON review process. Another workgroup participant commented that this standard does not add anything to the CON process.

Ms. Fleck noted that hospitals are expected to comply with the standard for charges at all times, and MHCC staff wants to be able to hold hospitals accountable in the CON process. Ms. Raisanen added that one of the main goals of MHCC is to increase accountability and improve access to this type of information. The CON process is one of MHCC's mechanisms of regulating hospitals, and it may be used to improve access to charge information. Oksana Likhova added that if the standard was deleted entirely, the elements in 1B and 1C would be lost because they are not part of the federal requirements; CMS monitors web sites, not staff training. Ms. Fleck agreed. Ms. Cammarata commented that the CON process is a leverage point, and it is an appropriate time to check compliance with federal regulations.

Ms. Feliciano asked if MHCC had the same kinds of requirements for other services and facilities (e.g. home health care, skilled nursing facilities). Ms. Fleck responded that she believes a similar approach is used with other types of services and facilities, and Ms. Feliciano's point is good to keep this in mind. Ms. Dorrien asked if a requirement the workgroup should consider something in the unlikely event that CMS were to rollback requirements. A workgroup member responded that MHCC could update the State Health Plan

chapters later. Ms. Fleck agreed. Ms. Lee suggested that MHCC propose language for the standard to the workgroup in the future. Ms. Fleck agreed that MHCC staff would consider feedback and draft revised language. Donna Jacobs suggested that anything duplicative should be removed and make reference to other regulations.

Ms. Raisanen said that there seemed to be consensus on referencing the federal requirements for posting charge information. However, she was still unsure about the consensus on the standards pertaining to individual requests for charge information and staff training. Ms. Fleck responded that it sounded liked 1B and 1C should be replaced with language around complaints or issues and that workgroup members wanted to see draft language. Spencer Wildonger commented that he would reference the federal requirements or remove the standard entirely. Erin Dorrien commented that she agreed with Mr. Wildonger. She added that if MHCC replaces 1B and 1C, then she would want to consider the proposed language and may or may not support it. Ms. Fleck summarized that there is a mix on opinions on this and that draft suggested language may help to reach consensus.

Discussion of General Standards: Quality

Ms. Fleck reviewed Handout #3. She explained that the current process of reviewing quality measures is to see if the hospital is performing worse than the State average. If so, MHCC staff requests that a hospital explain how it has taken action to improve its performance. She noted that the language in the current standard is outdated because the data are not available in quartiles. Ms. Fleck queried the workgroup about whether the current method of evaluation is appropriate or if another approach should be used to evaluate quality. Ms. Fleck also mentioned that MHCC staff would be open to reducing the number of quality measures that apply across the board for all projects.

Ms. Dorrien stated that the emergency room throughput quality measures give her pause and requested further explanation about how the quality measures are used during the CON evaluation process. Ms. Fleck responded that programs need to provide information about what they are doing to improve. She noted that MHCC staff do not usually turn down CON applications because of poor performance on quality measures. Ms. Dorrien asked which standards MHCC staff are thinking about removing and commented that a CON application might be intended to address some quality issues.

Ms. Raisanen described an example of a time when considering all of the quality metrics might not make sense; if a hospital is applying to open a new cardiac surgery program, it would also have to respond to its performance on all of the measures, including those that do not seem relevant to cardiac surgery (e.g. high cesarean rates). Ms. Feliciano said that if the CON is to expand an emergency department, then discussing quality measures around emergency care be good for the conversation. However, if it will not change the decision of the Commission then it is fine to expect programs to explain actions taken to

address performance on quality measures. Ms. Raisanen responded that she expected the handling of a hospital's performance would be on a case-by-case basis. This gives MHCC staff the ability to judge it based on the actual findings and then make a recommendation to the Commission. The Commission could choose to add a condition to a hospital's CON if quality is a concern.

Mr. Wildonger commented that this might be a time when other chapters in the State Health Plan for more specialized services could be leveraged; including these metrics in this general hospital chapter might not make sense. He continued that often when hospitals submit applications, they are responsible for responding to standards in multiple chapters. Ms. Fleck asked for Mr. Wildonger's opinion on having quality measures that always apply (e.g. infections). Mr. Wildonger responded that he was open to having metrics that were included as hospital-wide metrics. Ms. Fleck noted that patient satisfaction may also be relevant across the board. Another workgroup member mentioned that patient satisfaction, patient safety, and infection performance measures are representative across all hospital services and the other performance measures are more specialty specific. Ms. Fleck noted that other chapters often reference back to this chapter and do not currently mention the quality metrics because it is organized to reference the SHP chapter for general hospitals.

Ms. Lee asked if the quality measures could be broken into two sections such that there are certain metrics (i.e. patient satisfaction, patient safety, and infections) that are applied across the board and others that are project specific. Ms. Lee suggested that MHCC staff reserve the right to look at additional measures that are appropriate for the project. She aked if that approach would be too vague for regulations. Ms. Fleck ask for feedback from the group and commented that it would be helpful to have documentation of which specific elements would be considered for a specific type of project.

Ms. Raisanen commented that her understanding is that the quality measures change over time and that the flexibility that Ms. Lee described may be beneficial. She suggested language such as "the applicant will adjust its response based on MHCC's current quality report and in the Maryland Hospital Consumer Guide that is on the Hospital Performance section of the website." Ms. Lee agreed. Ms. Fleck commented that the implementation of a standard like this might be difficult. Ms. Raisanen disagreed.

Ms. Fleck asked if workgroup members thought that evaluating programs based on performing below the statewide average is acceptable. A workgroup member asked for more information. Ms. Fleck explained that on the MHCC website, it shows whether a program is better or worse statistically than the statewide average; below average is a statistical measure. The workgroup member requested clarification on whether the performance metrics consider a hospital's improvement in comparison to other hospital or only at a hospital's current performance on those metrics. Ms. Fleck and Ms. Raisanen confirmed the latter is true. Ms. Raisanen suggested that workgroup members review the MHCC website to see how the

information is presented and summarized. She added that how a hospital performed compared to the national average is provided for most measures.

Ms. Fleck also asked if it was important to include a quality standard about reducing disparities. Ms. Lee responded that she thought that having a general quality standard was important and suggested looking at overall performance in that area over time. She also suggested that it may be beneficial to be general. Ms. Raisanen clarified that Ms. Fleck's question was related to race/ethnicity or other factors related to Policy 2 that was discussed earlier. Ms. Fleck commented that it may be difficult to have a quantitative standard, and she asked if workgroup members would favor a standard that requires hospitals to provide information on disparities. She mentioned that MHCC is interested in looking at disparities and that a section of the website related to this is under development. Ms. Dorrien commented that the review standards should reflect the policies and that the quality reporting that is done should lead the CON standards. Ms. Lee suggested that the State Health Plan chapter could require hospitals to explain their efforts to address health disparities.

Dean Teague commented that the workgroup has discussed adding a lot into the CON process, and the Maryland Quality Reporting has more elements than CMS requires. He suggested that the goal should be to streamline CON. He also urged MHCC staff to consider how expensive the CON process is for hospitals who hire consultants and attorneys. Ms. Lee agreed that Mr. Teague's point was a good one, but she emphasized that requesting hospitals to explain their efforts to address health disparities will not be costly because an elaborate response is not required. Allan Pack commented that so long as MHCC maintains flexibility to look at evolving measurements for health disparities, the proposed approach should be fine. He noted that health disparities are currently a major policy priority for HSCRC. Ms. Lee again emphasized that addressing health disparities is a priority and needs to be articulated in the work of MHCC.

Ms. Fleck asked Mr. Pack if MHCC should reference HSCRC metrics and other metrics in addition to the quality metrics that are part of MHCC's public quality reporting. Mr. Pack was amenable to this and noted that they are mainly one in the same. Ms. Lee agreed. Ms. Fleck commented that there are metrics that are specific to HSCRC and the agreement with CMS. Mr. Pack confirmed. Ms. Lee suggested that it may be helpful to draft regulations that allow for other State metrics to be evaluated as well. Mr. Pack said that it minimizes burden because HSCRC scores those metrics too and can provide MHCC and applicants with the metrics quite easily.

Discussion of Project Review Standards: Patient Safety

Ms. Fleck asked if it was important to include the current patient safety standard, which requires an applicant to describe how the planning process took patient safety into account in the design of the project. Ms. Lee suggested that there are other standards or

regulations related to this. Ms. Raisanen reframed Ms. Fleck's question; she asked if workgroup members would support MHCC continuing to require that programs describe the design features that improve patient safety as part of the CON application process. Ms. Dorrien said that the standard seems more germane to a CON because it is the physical plant; she recommended that the standard be maintained.

Ms. Dorrien also suggested that perhaps the workgroup should consider the standards as a whole to decide which are the most important to include during the CON application. Mr. Rosen agreed and added that the policies should guide the standards. He noted that because safety is addressed in one of the policies, then it is appropriate to include a CON standard. He commented that in contrast charge transparency is not an identified reason why the CON process exists. Ms. Fleck responded that promoting price transparency aligns with ensuring financial access. She agreed that it is a good idea to keep the policies in mind when making decisions about the standards. Ms. Fleck agreed that it is germane and summarized that workgroup members seemed to support including a patient safety standard in the SHP chapter for acute care general hospitals.

Discussion of Project Review Standards: Geographic Accessibility

Ms. Fleck read the standard aloud and asked if 30 minutes is the right amount of time to consider as optimal travel time. Ms. Fleck also asked if MHCC staff should consider revising this standard to better align with suggested changes to Policy 2, which broadened the definition of access to explicitly include barriers such as race or ethnicity. Ms. Feliciano commented that the standard as written makes sense, but that it is important to think about how other factors might impact patient care seeking patterns. She mentioned that payers, HSCRC, and other factors may impact this; she gave the example of Kaiser Permanente patients being expected to drive more than 30 minutes to get to a Kaiser facility. Ms. Fleck explained that this standard is applied when evaluating a CON applicant's proposed location for a facility and how the proposed location could impact access.

Ms. Raisanen commented that she believes consideration of health disparities falls more within the quality standard as discussed earlier. Ms. Fleck mentioned that the quality standards might be an indication that there is an issue with access, but that this standard can focus on whether a hospital is doing anything to address access barriers. Ms. Fleck acknowledged that this is a hard question because it is easier to express an ideal in a policy statement than to write a project review standard that aligns with the policy. A workgroup member suggested including a requirement that programs address health literacy. Ms. Dorrien commented that different areas of the state face different challenges; non-geographic barriers to access could vary. Donna Jacobs suggested requiring hospitals to address access barriers other than geographic access that have been identified. Ms. Fleck asked if the language in the regulations should be kept general. Ms. Lee responded that the standard included in the SHP chapter for acute care general hospitals could be kept general, but also

give examples (e.g. transportation, health literacy, use of community health workers); this would allow a hospital to demonstrate an understanding of the needs of the community served by the hospital.

Ms. Fleck reflected that on some of the standards, workgroup members have pushed to eliminate requirements that are not helpful, but she has not heard comments like that on this standard. She asked if that was a criticism that people would have that here too. No one expressed criticism.

Discussion of Project Review Standards: Adverse Impact

Ms. Fleck included a draft proposed impact standard in Handout 4. She mentioned that it is mostly consistent with the current language. She pointed out section (d) and asked if the standard should reflect that access could be reduced through adding services not just eliminating, downsizing, or otherwise modifying a facility or service. The wording did not previously reference adding a service. Erin Dorrien mentioned that the workgroup needs more time to discuss this. Ms. Fleck agreed that the workgroup should discuss the standard at the next meeting.

Ms. Fleck encouraged workgroup members to reach out with additional comments and reiterated that the next meeting would likely be held in late January 2022. She added that she expected that MHCC staff may also hold a workgroup meeting in February 2022. Staff will consider additional meetings too, if needed.