Draft Meeting Summary
General Hospital Services Workgroup Meeting
August 25, 2021, 10am-12pm
Maryland Health Care Commission (MHCC)
Virtual Meeting

Workgroup Attendees
Kimberly Cammarata
Ted Delbridge
Erin Dorrien
Kristin Feliciano
Arin Forman
Michael Franklin
Donna Jacobs
Hannah Jacobs
Jamie Karstetter
Ryan O'Doherty
Megan Renfrew (substitute for Allan Pack)
Barry Rosen
Miriam Suldan
Dean Teague
Pegeen Townsend
Renee Webster
Spencer Wildonger
Darleen Won

MHCC Staff Attendees
Courtney Carta
Diana Estefania Estrada Alamo
Eileen Fleck
Zoram Kaul
Stephanie Kersheskey
Paul Parker
Jessica Raisanen
Suellen Wideman

Other Attendees
Pat Cameron, MedStar
Oksana Likhova, Office of Health Care Quality
Sruti Padmanabhan, Johns Hopkins
Unannounced Attendees (4)

Eileen Fleck welcomed members of the workgroup, and attendees introduced themselves. She described the process of updating regulations and mentioned that staff tentatively expect to hold two more workgroup meetings, most likely in early November 2021 and January 2022. After these workgroup meetings, the next step is to develop a draft for informal comment before taking draft regulations to the Commission for consideration as proposed permanent regulations. There is another 30-day formal comment period once the Commission adopts proposed regulations and notice is published in the *Maryland Register*. The Commission considers the formal comments received and staff recommendations before voting on whether to adopt final permanent regulations.

Background Information

Paul Parker described the history of the Certificate of Need (CON) review process and he noted that it has been about 12 years since the State Health Plan (SHP) chapter for surgical services (Chapter) was last updated. Mr. Parker explained that the Chapter is primarily used to address bed capacity for hospitals and the establishment or relocation of hospitals. In Maryland, there has only

been one project to establish a hospital in the last 12 years, but there have been several relocations of hospitals.

Mr. Parker also noted that the Chapter includes standards for the treatment capacity of emergency departments (EDs). EDs are not categorically regulated under the CON review process but changes to ED capacity are often included in hospitals' plans for major capital projects. There are also several other types of services that are regulated by other SHP chapters and that also reference standards in the Chapter.

There are six general criteria for evaluating CON projects: 1) compliance with applicable SHP chapter regulations, 2) need for the project, 3) availability of more cost-effective alternatives, 4) viability, 5) feasibility, and 6) track record in meeting terms and conditions of previous CONs granted. In 2018, a report on CON modernization was issued. Mr. Parker noted that there are plans to update the procedural regulations this year. He explained that a CON modernization effort is underway and the guidance from the CON modernization report suggests less consideration be given to the impact on other service providers. Instead, the report suggests the focus should be on reducing cost and charges. The report also recommended that use of cost effectiveness be re-evaluated. Mr. Parker added that the Commission may want to focus on increasing competition in the market.

Mr. Parker noted the healthcare environment has changed since the last update of the Chapter. He briefly described trends in hospital utilization for Maryland and the United States. Specifically, the Maryland hospital use rate and average daily census have been on the decline since 2010, and there has been an increase in the average length of stay (ALOS). The ALOS in Maryland is slightly higher compared to the average for the United States. Mr. Parker noted that MHCC did not update licensed bed capacity in fiscal year (FY) 2021 and it will remain unchanged in FY 2022, due to the COVID-19 pandemic. The only changes in licensed bed capacity have been for approved CON projects. Mr. Parker stated that average daily census has declined slightly since FY 2020.

In terms of major changes to CON regulations, for many years specific types of projects required a CON, and there was also a capital threshold. Mr. Parker explained that a couple of years ago, the capital threshold for triggering CON review was eliminated, except for hospitals. For a hospital, as of 2019, the threshold is the lesser of $50 million or 25% of a hospital's global budget revenue. The Health Services Cost Review Commission (HSCRC) also has adopted a capital policy that sets the threshold for allowable extraordinary adjustments in global budget revenue related to capital to a similar threshold. Mr. Parker stated that MHCC staff hope that this will better align CON review with HSCRC policies for rate adjustments and reduce delays in CON reviews.

Mr. Parker explained other recent statutory changes, noting that hospitals are now able to establish small non-rate regulated outpatient surgical centers by getting a determination of coverage rather than a CON. Also, an ambulatory surgery center (ASC) with two sterile operating rooms may be established through a determination of coverage; previously, a proposed ASC with two sterile operating rooms required approval through the CON review process. MHCC is also on

a 120-day deadline[1] for uncontested projects that do not involve establishment of a new facility, relocation of a facility, or that do not involve certain hospital services (i.e. cardiac surgery, percutaneous coronary intervention services, or organ transplant services).

Discussion of New Draft Policies

Jessica Raisanen led the workgroup through a discussion of the proposed policy statements. Ms. Raisanen read through the current and proposed policies included in Handout #1 and requested feedback from the workgroup.

For Policy 3.0, Kristin Feliciano recommended getting rid of words like "the most possible" and suggested replacing this phrase with, "provide services in a cost-effective and safe manner." She noted that the new draft Policy 3.0 did not include "access." She suggested that access should be discussed, and potentially the concept of access should be broader than geographic and financial access; it may be important to encompass diversity and inclusion metrics.

Ms. Feliciano commented that the meaning of draft Policy 3.3 and 3.4 changed compared to the current policies. She appreciated that the new language in Policy 3.4 references racial and ethnic disparities, but she expressed concern that the concept of coordination on a regional basis was removed. She mentioned examples where coordination on a regional basis may be important, such as special pathogen units, trauma services, and cardiac surgery services. Ms. Feliciano also observed that the changes in Policy 3.3 shift from a focus on the availability of data to the provision of care and suggested that the focus should remain on sharing data. Ms. Raisanen asked workgroup members for feedback on the issues raised by Ms. Feliciano.

Michael Franklin commented that the focus of Policy 3.0 should be shifted from the patient to the community, not just patients in the hospital. Ms. Raisanen responded that staff tried to keep policies related to hospitals. She asked if others agreed with Mr. Franklin. Ryan O'Doherty agreed with Ms. Feliciano's comments and commented that if the language is going to be shifted from patient to community, then it is imperative when updating other policies, that other actors are held accountable as well. Ms. Fleck commented that MHCC acknowledges that other players have a role. However, staff must consider what MHCC has the authority to regulate. Ms. Fleck also explained that staff did have the community in mind for Policy 3.0, but she could understand that referring specifically to patients might not reflect a focus on the community. Hannah Jacobs added that the suggested change in language around "healthcare needs of the patient" already broadens the meaning of the policy because even though the Chapter is about acute care, healthcare needs are much broader than hospital care and include community care.

Barry Rosen commented that draft Policy 3.0 is different than other policies in that the wording in other policies includes terms such as "strive" and "work for," but draft Policy 3.0 says "will be." He commented that someone could argue in appellate court that a CON should be denied because it is not the most safe and effective and violates Policy 3.0. Ms. Raisanen responded that she believes that other policies contain similar language (e.g. "shall" in Policy 3.1). She noted that

[1] The 120-day count begins after docketing, and if action is not taken within 120 days, then the project is deemed approved.

the policies are generally used as broad principles that guide the creation of standards. The decision on whether to recommend approval of a project is based on standards, rather than policy statements.

Megan Renfrew commented that HSCRC is interested in encouraging hospitals to focus on their respective communities and upstream health issues so that hospitals invest in ways that keep people out of hospitals. Erin Dorrien commented that she wanted to follow-up on Mr. O'Doherty's points. It is important to limit the focus to access to acute care services.

Ms. Feliciano reiterated that the elimination of the word "access" in Policy 3.0 is troublesome. Ms. Fleck and Ms. Raisanen commented that Policy 3.1 addresses access and asked if that policy was sufficient. Ms. Feliciano commented that Policy 3.1 limits accessibility to financial and geographic access and may be missing something. Another workgroup participant stated that it is acceptable to move access out of Policy 3.0, but she agreed that defining access as only financial and geographic access in Policy 3.1 is not sufficient. Hannah Jacobs and Ted Delbridge mentioned in the chat that they agreed that the discussion of access could be moved to Policy 3.1. Ms. Raisanen asked about what additional language about access that workgroup members would be favorable. Ms. Feliciano commented that other social determinants of health are important and specifically mentioned race, sexual orientation, and ensuring that hospital-based care is accessible and safe. Kim Cammarata commented that gender disparities should also be included. Arin Foreman mentioned in the chat that it may be helpful to require efforts to ensure providers have similar demographics to the patients in the service area.

Ms. Raisanen commented that we tried to address racial and ethnic disparities specifically in Policy 3.4, but she also acknowledged the points raised by workgroup members on Policy 3.0. Ms. Feliciano said that she liked the language used in 3.4 and recommended using the language proposed for 3.4 be moved to 3.1. Ms. Feliciano also commented that the meaning of the original 3.4 was changed; the original policy 3.4 may be important to retain.

Ms. Raisanen explained that staff recommended elimination of the existing Policy 3.4 because some other specialized acute care services are regulated through other chapters of the State Health Plan, and those other chapters address regional availability of specific specialized services. This chapter is more focused on general hospital services broadly, and the standards that will enforce the coordinated regional availability of certain specialized services are located in other chapters. Ms. Fleck responded that there are some specialized services that are not addressed in another chapter, and staff is open to maintaining the original policy 3.4.

Darleen Won suggested in the chat that the proposed policy 3.4 might be combined with Policy 3.1. Mr. O'Doherty said that the current Policy 3.4 should remain. Donna Jacobs agreed that current Policy 3.4 should be retained, and the proposed Policy 3.4 should be integrated into 3.1. Several workgroup members agreed. Kim Cammarata recommended that Policy 3.4 be revised to include gender disparities, instead of only mentioning racial and ethnic disparities.

Ms. Raisanen asked if anyone disagreed with the proposal to retain Policy 3.4, and no one did. However, Mr. Rosen commented that the Commissioners might argue that the current policy 3.4 favors providers who are already providing those specialized services. In part, the goal of

modernizing CON is to reduce the ability of existing providers to keep out new providers that would compete with them.

Ms. Raisanen asked for feedback from workgroup members on Policy 3.3. Ms. Dorrien asked why the language for infection control was removed; she wanted to understand the thinking behind the change. Ms. Raisanen responded that this policy, which is included in other SHP chapters, has been changed in some of those other chapters recently, for example the SHP chapter for acute psychiatric services. She did not recall the reasoning, and asked Ms. Fleck to comment.

Ms. Fleck responded that in terms of electronic health information sharing, it has already been implemented so MHCC staff thought that it might be less important to include. MHCC staff wanted to add telehealth because its use is more widespread and will continue to become more widespread given the pandemic. Ms. Fleck stated that infection control may have been removed to cut down on the wordiness of the policy. Ms. Raisanen commented that reducing infections is captured by the language "working to systematically improve the quality and safety of patient care." Ms. Fleck agreed that staff was not trying to change the intention of the policy but rather to be more concise.

Ms. Won suggested that including the term "clinical data" in the proposed policy is an important element to add because we are not where we need to be in terms of data sharing and data systems. That change may address the question raised. Dr. Delbridge commented that the policy should describe the desired outcomes instead of processes. Ms. Fleck responded that the policies are intended to be broad principles that inform the standards. The policies are intended to be broad instead of addressing specific outcomes. Ms. Renfrew mentioned, in reference to both Dr. Delbridge's comments and Ms. Won's, that data is important to HSCRC for promoting care transformation and healthcare reform. She personally agreed with Dr. Delbridge's suggestion to focus on the outcomes to be achieved, rather than how those outcomes will be achieved.

Ms. Dorrien agreed that including the word "clinical data" is important and also raised the question of whether telehealth should be included because it is a method of providing a service instead of a tool to improve the service. She recommended that telehealth should be eliminated from Policy 3.3 because the policy is focused on patient safety. Ms. Raisanen next read comments included in the chat box. Pegeen Townsend commented that the issue for telehealth use is whether it is a reimbursable service. Ms. Feliciano commented that the new Policy 3.3 should be tweaked and steered away from service provision through telehealth. Ms. Won agreed that perhaps telehealth does not fit in Policy 3.3.

Ms. Feliciano asked if there might be an additional policy that describes how the hospital-based setting is going to change over the next 10 to 20 years. Ms. Renfrew commented that those kinds of questions could be addressed in the need standard for CON reviews instead of the policy statements. Ms. Fleck noted that MHCC should be updating the State Health Plan every five years or so.

Ms. Dorrien asked about where the workgroup landed on the access policy question and if there is a process for providing additional feedback. Ms. Raisanen responded that MHCC staff will

review some of the comments from the recording and then redistribute changes for comment, either via email or in the next meeting.

Ms. Raisanen then asked if there should be additional policies about discharge delays or boarding in emergency departments or other topics. Ms. Dorrien commented that the problem with having those types of policies written into a SHP chapter is that the discharge delays are not necessarily caused by anything that the hospitals can ameliorate; discharge delays speak to issues with community-level services and are beyond control of the hospital. The best way to address is to make sure that non-hospital providers have the resources they need to meet patient needs. Ms. Renfrew mentioned that Centers for Medicare and Medicaid Services (CMS) is eliminating one measure related to ED boarding time that will make it hard for HSCRC to monitor; if there is a standard related to ED boarding, measurement may be an issue. Ms. Dorrien also concurred that CMS is eliminating ED boarding time from inpatient quality reporting. Ms. Fleck reminded participants MHCC staff is not pushing for the inclusion of these policies but simply included them as an example.

Dr. Delbridge commented that he is not sure about how to craft a policy to address hospital efficiencies because it is not necessarily the hospital's responsibility to design post-discharge care in the community. He suggested it might be important to craft a policy that includes the goal of improving the efficiency of care and treating patients in the appropriate setting. He did not favor including specific metrics because those could change over time. Ms. Raisanen commented in the recent update of the SHP chapter for acute psychiatric services there was a push to include policy statements that reflect a more ideal system. That is why the issue was raised for this workgroup. Dr. Delbridge suggested that it is reasonable to expect a proposed CON project to address the project's influence on efficiency in the hospital or for the health care system. Ms. Feliciano agreed with Dr. Delbridge's comments, but she did not have a specific policy suggestion given declining ED volumes and increased ED lengths of stay for patients in recent years.

Ms. Cammarata suggested that it is important to consider containing health system cost overall. Ms. Fleck agreed that it a good point, she responded that MHCC staff tried to capture idea in Policy 3.5. Ms. Cammarata stated that HSCRC's fiscal goals may be interpreted as HSCRC's goals as an entity, but perhaps it should be reworded such that it clearly references the goals that HSCRC sets for Maryland as a whole. Ms. Fleck clarified that the intent was to be broad so that it would not become outdated over time. Staff did not ask HSCRC's attorneys to look at this specifically and is open to modifying the policy. Ms. Fleck commented that the workgroup may need to come back to the topic of ED boarding in a subsequent meeting.

Discussion of General Standards: Information Regarding Charges

Ms. Fleck introduced the standard about information regarding charges and stated that that the last update was in 2009. Ms. Fleck mentioned that the recent CMS requirement regarding charges may be viewed as burdensome. She also explained that the intent for this standard is to have charge information available to patients and asked workgroup members if MHCC should retain a standard related to charges.

Ms. Renfrew stated that MHCC standards should align with the federal standards for price transparency. Ms. Renfrew also mentioned that the law recently changed to require that hospitals provide notice on facility fees as well as an estimate or range of what the patient will pay. Mr. Rosen commented that the CON application is a cumbersome and expensive process and suggested that this standard could be eliminated because the CON application review process should be the time when price transparency is assessed. Ms. Fleck stated that this is the expectation all of the time, and it is not tied to the CON decision but rather a check to make sure that a hospital is following the regulations.

Ms. Cammarata commented that there is a lack of resources to make sure programs are engaging in price disclosure, so when a hospital is trying to expand or create a new facility, it is appropriate for MHCC to evaluate compliance with the standards for price transparency. She also mentioned that the No Surprises Act requires a lot of transparency, and the requirements are coming in January 2022. She agreed that it is important for MHCC's standards to align with the federal rules. Ms. Fleck suggested that the standard could reference complying with federal rules for price transparency. Ms. Townsend stated that MHCC's standard is duplicative at this point and should be eliminated. Ms. Raisanen asked others to comment on this point.

Ms. Dorrien stated that it depends on how the standard is applied during a CON review. She agreed that the standard is duplicative. Ms. Cammarata stressed the importance of maintaining a standard related to price transparency. Mr. Rosen asked if it should be MHCC's responsibility to enforce the fire code or look into fraud and abuse or determine if upcoding is occurring; he stated that MHCC is not a policing mechanism. Ms. Fleck commented that normally hospitals provide a link on the hospital's web site, and MHCC staff check this. Ms. Dorrien agreed with Mr. Rosen. Ms. Renfrew commented that she believes that CMS is starting to enforce the price transparency rules. Ms. Raisanen commented that the CMS website mentions an audit of a sample of hospitals and a mechanism for investigation of complaints. Ms. Won stated that if a link to the website is sufficient to show compliance with the standard, then it seems unnecessary.

Michael Franklin supported the idea of having language about evidence of good standing with the Joint Commission or other federal laws and regulations. Ms. Fleck commented that the Chapter has another section that specifically addresses quality and whether a hospital is in goodstanding with the Joint Commission. Mr. O'Doherty commented that Mr. Rosen's points are important and that the workgroup should be mindful of the burden on CON applicants. Ms. Cammarata emphasized MHCC's main goal is to promote availability of charge information to consumers. Evaluating hospitals' compliance with standards for information on charges is directly in-line with the mission of MHCC.

Hannah Jacobs asked if wording could be changed to say "in good standing with current CMS and HSCRC price transparency requirements." Ms. Refrew said that the concept is fine, but the wording needs to be refined. Ms. Cammarata asked how "in good standing" would be defined. Ms. Raisanen agreed with Ms. Cammarata that it is unclear how compliance would be evaluated if the term "in good standing" is used. Ms. Raisanen stated that she favors being more explicit in the standard, especially since it is not clear what the audits and evaluations will look like from CMS.

Ms. Raisanen then asked about the frequency of updating information on the website, as charges can change quite frequently throughout the year. Ms. Cammarata commented that a hospital should update information on charges to at least meet the minimum requirements of CMS. Mr. Franklin stated that hospital rates may fluctuate up to ten percent either higher or lower, and there may be variation in rates from quarter to quarter. He posited that this fluctuation could support a position to repost regularly or that publication of the annual rate order from HSCRC might be favored instead.

Ms. Fleck concluded the workgroup meeting and encouraged workgroup members to reach out with additional comments. She reiterated that the next meeting would likely be held in November 2021.