Draft Meeting Summary
Acute Hospital Services Work Group
January 26, 2022, 10:00am-noon
Maryland Health Care Commission (MHCC)
Virtual Meeting

Workgroup Attendees

Ted Delbridge, M.D.
Erin Dorrien
Kristin Feliciano
Arin Forman
Donna Jacobs
Hannah Jacobs
Kim Justice
Jamie Karstetter
Ryan O'Doherty
Allan Pack
Barry Rosen
Miriam Suldan
Dean Teague
Renee Webster
Spencer Wildonger
Darleen Won

Other Attendees

Pat Cameron, MedStar
Oksana Likhova, Office of Health Care Quality
Sruti Padmanabhan, Johns Hopkins
Aneena Patel, Johns Hopkins
Craig Wheeless, KPMG

MHCC Staff Attendees

Courtney Carta
Eileen Fleck
Zoram Kaul
Paul Parker
Sarah Pendley

Eileen Fleck welcomed attendees to the third work group meeting and introduced herself as the Chief of Acute Care Policy and Planning. She read off names of members and MHCC staff from the list of those registered and asked attendees to mention their affiliation. Ms. Fleck noted that there had been no suggested changes to the draft meeting summary and asked if anyone had changes after reviewing the summary again. There were no suggested corrections or changes, so Ms. Fleck stated that the draft meeting would be finalized without changes.

Ms. Fleck referred attendees to the handouts. She noted that in the discussion guide for the meeting, the first standard to be discussed is adverse impact. She explained that the first handout has draft language modifying the current standard. She noted that there had been statutory changes and changes with HSCRC's rate setting system, which led to modifying the standard. For example, the capital threshold for a Certificate of Need is higher. She asked for feedback on the standard and specifically whether anyone felt strongly that additional changes are needed. Initially no one responded. Ms. Fleck then mentioned a minor change under 4(b), specifically referencing the addition of a service as a change that may affect access and availability of services for the population in an applicant's primary service area.

Kristin Feliciano commented that in light on the disruption due to COVID-19, there is likely to be a significant change in hospital-based care in the future. She anticipated more home-based care and care at alternative locations. She noted that those changes would really affect access and other standards. She asked how standards can be viewed based on anticipating future changes rather than look back at past practices. She asked other work group members for their thoughts.

Ms. Fleck noted that she did not see any hands raised to respond to Ms. Feliciano's question. She mentioned that MHCC staff had recently spoken with HSCRC about the issue of the hospital-at-home model, specifically with respect to the bed need methodology. Further discussion of the bed need methodology is planned for the next work group meeting. She agreed that the issue may be relevant to other standards too. She commented that it is unknown the extent to which a hospital-at-home model may be used in the future. Ms. Fleck noted that if the State Health Plan chapter becomes out of date, there is an opportunity for stakeholders to petition for an update. For regulations frequently used, like the State Health Plan (SHP) chapter for acute care hospital services, staff is very receptive to feedback that an update is needed.

A work group member commented that he agreed with the sentiments of Ms. Feliciano. He asked for an update on the hospital-at-home issue, noting that there was report that was to be issued by HSCRC and MHCC that addresses the hospital-at-home model. He asked if hospital at home should be addressed in the SHP chapter for acute care hospital services and specifically where in the regulations.

Ms. Fleck responded that MHCC staff definitely thinks that use of the hospital-at-home model should be addressed with the bed need methodology. She commented that the HSCR and MHCC report referenced had been discussed at the Commission meeting held in December. She thought the report had been finalized. She mentioned that HSCRC and MHCC agree that hospitals can establish hospital-at-home services without obtaining a CON. She mentioned that should be kept in mind. Allan Pack agreed that the bed need methodology is the most germane. He commented that at this point it is unknown how prevalent the hospital-at-home model will become; forecasting for it is not currently needed. He noted that data fields

in the hospital case-mix data will allow for tracking of the setting where patients receive care, so that it could be accounted for in future bed need projections. He added that he was not sure what should be done in terms of any other standards.

Erin Dorrien commented that the work group should not solely focus on hospital-at-home. She asked Ms. Fleck to confirm that the regulations could be revisited. Ms. Fleck responded that was correct.

Ms. Dorrien asked hospitals to comment on the question raised by Ms. Fleck. She stated that it is a delicate balance with the move toward more regionalization. She stated that she thinks a legislative change would be needed to move to free market for entry because CON still exists. There needs to be a balance between looking at regionalization and the impact of one hospital on another hospital.

Ryan O'Doherty commented that he is opposed to any ideological shift. Free market has not been proven to reduce costs; it probably increases costs for consumers. If the Commission plans to go in that direction, it is not consistent with CON and the Total Cost of Care (TCOC) model.

Mr. Pack asked if the focus is still on the hospital-at-home model or a broader subject. He noted that hospital-at-home services are exempt from CON, but still part of a hospital's budget. Ms. Fleck responded that she had changed the focus to the impact of a hospital's CON project more generally on other hospitals. She explained that the process is sometimes dragged out by having interested parties involved. There is often lots of back and forth on whether an anticipated negative impact is unacceptable, which adds to the time to reach a decision and to the costs for hospitals involved in the CON process.

Ms. Feliciano noted that if there is already a low-cost provider and a new higher cost provider is approved then the cost of care will increase. She agreed with Mr. O'Doherty's position. Ms. Fleck agreed that TCOC is important to consider and whether a decision is cost-effective. She noted that there is an opportunity for interested parties, but as she understands it, there is interest in cutting back on those opportunities. If people feel it is important, then it would be useful to include in the update of the SHP chapter for acute care hospital services. As written, the impact standard is focused on access to care and services. Ms. Fleck asked if people felt that standard was working well. She noted that the changes proposed were to be consistent with statutory changes and included some other relatively minor changes.

Spencer Wildonger commented that there needs to be a balance, a way for hospitals to have a voice in CON projects, but not in a way that is costly and inefficient. He suggested that maybe interested party involvement could be streamlined. He suggested that reviewers be appointed more quickly. Ms. Fleck appreciated the feedback and noted that it is helpful to get

additional feedback on the CON process, even if the way to address the feedback is not the SHP chapter for acute care hospitals. Ms. Fleck asked if anyone else wanted to comment.

Mr. Rosen stated that the standard refers to an unwarranted adverse impact. It is not the case that no adverse impact is acceptable. As Mr. Wildonger pointed out, it may not be the standard that is a problem, but the process that follows. Who can challenge? How fast is the process? Does the challenge take the form of a letter or brief? He suggested that the word "material" could be added to emphasize that a significant impact in unacceptable. He concluded that that is the process that needs to be streamlined, as suggested by Mr. Wildonger. A change of standard is not needed.

Ms. Fleck responded that the focus is on access to services and availability of services rather than the impact on other providers or the larger system. She wanted to get feedback on whether the types of impact that matter should be revised. Ms. Fleck noted that no one seemed concerned about further modifying the standard. She noted that people could contact her if they had additional thoughts. In addition, there will be an opportunity to comment later too, once draft regulations are posted for informal comment.

Ms. Fleck next asked work group members to consider the cost-effectiveness standard. She described the requirements of this standard. She stated that staff has only proposed minor changes the standard becuase from staff's perspective, the standard is working well. She asked for feedback on the standard. Ms. Dorrien asked for an explanation of the rationale for the requirement that a hospital explain at least two alternatives considered. She stated that a hospital already has an incentive to choose a cost-effective approach because it has a global budget. She asked if two alternatives are necessary. She suggested that a hospital may have to come up with an alternative it is not really considering.

Ms. Fleck responded that the cost-effectiveness standard definitely is important when a hospital is relocating. She mentioned that with the Washington Adventist Hospital (WAH) relocation project, there was a question of where the new hospital should be located and which services it would provide. She mentioned that for the relocation of Prince George's Hospital Center, the new location and services to be provided at the new location were also questions. She noted that it was helpful to have those possibilities explicitly considered and to see the impact on the budget for the project and future costs for the hospital. Donna Jacobs commented that she agreed with Ms. Dorrien; two alternatives are needed in every situation. Ms. Fleck responded that with the WAH project, the initial project was turned down due to cost, not cost-effectiveness, but she thinks the cost-effectiveness analysis was helpful.

Paul Parker stated that he probably wrote the standard in 2009. He noted that there are six criteria that have been in regulations for a long time that frame the review of CON projects. These include meeting standards in the SHP, need for the project, impact on other providers, viability, an applicant's track record for previous CON applications, and consideration of the

availability of more cost-effective alternatives. The standard in the SHP chapter for acute care hospital services is being used to address the criterion of cost-effective alternatives. Mr. Parker commented that at least two alternatives was chosen, in his view, to limit the discretion of staff, to require all possible alternatives. Staff tried to keep the standard very simple by requesting that an applicant explain the objectives of the proposed project, alternative projects that could meet those objectives, and costs of the alternatives.

Patricia Cameron agreed with Mr. Parker's explanation of the origins of the standard. In her view, the standard focuses too much on background information and not enough on the needs of the whole system. She thought it should be more of a system wide look at alternatives, not a focus on a hospital's decisions on a specific project. Ms. Fleck responded that it is possible to both look at the system needs and the specific project. She commented that she sees value in an applicant considering alternatives, especially for a large project, such as the relocation of a hospital or a new hospital. Ms. Fleck asked if anyone else wanted to comment on the idea of having more of a system wide look at cost-effectiveness.

Ms. Cameron commented that the cost-effectiveness has not made a difference in the approval of a project or modification of a project. It just adds work for an applicant. Ms. Dorrien commented that she understands Mr. Parker's comments. She also again expressed concern that hospitals may propose alternatives for the sake of proposing them, but which are never really considered. Ms. Cameron commented that she has seen that occur. Craig Wheeless commented that for aged facilities that may need to be replaced, an internal review should consider renovation. He suggested that at least one alternative may be sufficient. Another work group member agreed.

A work group member suggested that for a cost-effectiveness standard, it should be known how the cost changes for one location or another in terms of the cost of care for the consumer. He suggested that TCOC should be incorporated into the cost-effectiveness standard. Ms. Fleck asked if Mr. Pack wanted to comment. He stated that the goal of the TCOC model is to achieve savings relative to the rest of the nation and TCOC savings over time. TCOC should be paramount to any adverse impact to the system.

Ms. Fleck asked if HSCRC should have more of a role in analyzing the impact of a project on the system. Mr. Pack stated that he could not comment on that issue. He also expressed doubt that the burden should be taken off an applicant. Ms. Fleck responded that she thought it seemed like HSCRC or MHCC or both agencies together need to do the analysis to get the bigger picture for the health system. Mr. Pack disagreed stating that HSCRC and MHCC could verify the analysis done by the applicant. He stated that is how it works whenever a hospital wants to bring in a new service line. The hospital pitches that TCOC will be lower. Ms. Fleck asked if anyone else wanted to comment.

Mr. Wildonger stated that his understanding is that the cost-effectiveness criterion exists and is not going away; it is just a question of whether there is a standard for cost-effectiveness in the update of the SHP chapter for acute care hospital services. He stated that having a standard is useful in his view. However, staff should be sensitive that in the past, sometimes responses to the cost-effectiveness standard are filler. The emphasis should be on what a hospital wants to do. Applications are quite long and detailed. It can be a distraction to have to explain a project that the hospital has no intention of doing. The value of that information may be questionable at best. Ms. Fleck responded that Mr. Wildonger's feedback was helpful and seemed to align with Ms. Cameron's comments and some others. Ms. Fleck asked Mr. Parker if he wanted to comment.

Mr. Parker stated that often an applicant's response is disappointing, and it appears that an applicant has not really considered other alternatives. Occasionally, it is a clear that a hospital has put a lot of thought into alternatives with detailed comparisons of alternatives and the costs of each. In an ideal world, an applicant would be directed to tell staff about the planning process, what alternatives were considered, and why the project selected is the best choice. He stated that Mr. Wildonger was wrong about not being able to change the criterion. He noted that the procedural regulations (COMAR 10.24.01) are going to be updated and will be posted for informal comment soon. He stated that he agreed with Ms. Dorrien that there has been a major change in the payment model, and some standards may need to change.

Mr. Wheeless commented that in the viability section of a CON application, it refers to the impact on the cost of the health care delivery system. The focus is on the chosen process. Whether to include in the evaluation of alternatives the impact on the health care system, he is not sure.

Mr. Wildonger commented that he was not sure if language in the criterion for all CON reviews would be in the scope of the work group. Mr. Parker stated that it is not. He was just noting that there is an opportunity to change the criterion for all CON reviews. Mr. Wildonger added that changes to the criterion could influence comments on the SHP chapter for acute care hospital services. Mr. Parker commented that feedback on the cost-effectiveness standard could influence what is recommended for the procedural regulations.

Ms. Fleck noted that for a simple project of limited scope, there is not a requirement to consider alternatives. Another option to consider is adding to the types of projects that do not require consideration of alternatives instead of just eliminating the cost-effectiveness standard.

Mr. Rosen commented that in the cost-effectiveness standard, a sentence could be added to address positive effect on hospital charges, availability of services, or access. With respect to the idea of one alternative or two alternatives, he asked if doing nothing is an alternative. He expects at least one alternative should exist and that doing nothing is an alternative. He commented that he is not surprised that some people have said sometimes a

second alterative is just made up. Mr. Parker responded to Mr. Rosen's question by stating that doing nothing is not an alternative. The standard requires addressing the objectives of the project. Ms. Fleck commented that she and Mr. Parker considered how to change the standard to get better responses, but ultimately made only a few minor changes.

Ms. Fleck next asked work group members to consider the efficiency standard. She noted that staff did not propose any changes to the standard. She asked if anyone wanted to comment on how well the standard has been working.

Mr. Wildonger asked if MHCC staff found the responses to the standard to be useful and whether the information was covered elsewhere in an application. Mr. Parker responded that it is mixed in terms of the usefulness of the responses. He stated that it is a reasonable expectation for hospitals seeking to modernize facilities to lower the unit cost. If staffing ratios are increasing in projections, that suggests lower efficiency. MHCC staff asks hospitals to explain the changes. Sometimes the explanation is case-mix; patients are sicker, so efficiency cannot be improved. MHCC staff is satisfied when a hospital addresses the standard and can explain changes. The CON standards are about accountability. Hospitals are being treated as businesses making business decisions. Ms. Fleck asked if anyone else wanted to comment on the efficiency standard. There were no other comments.

Ms. Fleck next asked work group members to consider the construction cost standard. She noted that staff is not proposing changes to the standard. She reviewed the standard with the work group. She noted that the Marshall Valuation Service benchmarks are used to look at the reasonableness of construction costs. She also noted that Mr. Parker had said that the standard for non-hospital space had not been used very much. Ms. Fleck asked if the standard was working well and served a useful purpose. She asked if anyone has suggested changes.

Mr. Wheeless asked about the need for shell space. He asked whether there should be more leniency with approving shell space, especially in light of the pandemic. Ms. Fleck noted that there is a separate standard for shell space. Mr. Parker stated that the Commission has been receptive to approving shell space, and many major CON projects include it. He did not think it was usually strongly questioned. His perspective is that there has been a shift to approving shell space more readily, which occurred many years ago. The Commission has not been restrictive in his view. There were no other comments on the construction cost standards for hospital and non-hospital space.

Ms. Fleck asked work group members to consider the standards for emergency department space. She noted that the standard references benchmarks in the book, *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians ("ACEP Guidelines"). Staff uses it to evaluate the number of spaces proposed by an applicant. The standards describe the information an applicant needs to provide, including historic trends, the number of hospital emergency service providers in the

applicant's primary service area, and the number of underinsured and uninsured in the hospital's primary service area.

Ms. Fletcher commented that the standard is reasonable. She asked about how behavioral health patients, who often wind up in holding area with long stays, are accounted for in planning. She also suggested that having space for patients with infectious conditions is another concern. Those things will increase the cost of the space. She suggested that it is important to allow for those things. Ms. Fleck thanked Ms. Fletcher for her comments. Mr. Wheeless commented that there is more space needed for behavioral health visits. Ms. Fleck asked if hospitals should be asked to specifically address the handling of certain populations, such as infectious patients and behavioral health patients.

Ms. Fletcher commented that it would be better for some behavioral health patients have their needs met elsewhere. Ms. Dorrien commented that some hospitals have been building out specific space in the hospital's emergency department for behavioral health patients. Some hospitals are handling it differently. Patients show up because of a failure in the rest of the system. She commented that criteria do not need to be added to require that a hospital have specific space for behavioral health patients.

Ms. Fleck responded that it doesn't necessarily have to be a space requirement. She noted that part of the standard requires that a hospital consider the impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department. The regulations could be modified to include a requirement that a hospital address what it has done in the past and what it is planning to do in the future with respect to behavioral health patients. Ms. Fletcher commented that she disagreed with that suggestion. She just wanted to acknowledge the burden of the behavioral health population that is not necessarily accounted for in emergency department design standards.

Dr. Delbridge commented that the standards convey that the emergency department is a bad place. A hospital is expected to prove it has done a lot to minimize use of its emergency department. In his view, that is wrong. Maryland does not do well on metrics of emergency department wait times. He suggested the standard should focus on efficiency and allowing the addition of space. He explained that his perception is that the regulations treat the ACEP Guidelines as absolute standards rather than guidance. He also commented that emergency departments are not being used like in the 1980's. There are many more demands on emergency departments. More diagnosis occurs in emergency departments. The regulations should reflect how a hospital gains efficiency with adding emergency department space and managing patients there instead of elsewhere in the hospital. In his view, it is not the hospital's job to divert people. Emergency departments are a great public health success, and the regulations should reflect that reality. The regulations should not make it hard to build emergency department capacity. Ms. Fleck asked if any work group members felt the standard for emergency space had been a barrier to getting CON approval.

Pat Cameron said that Dr. Delbridge is right. His approach is forward thinking and should be considered by MHCC staff. Mr. Parker commented that the standard sounds more prescriptive than it actually has been. MHCC has regularly allowed hospitals to exceed the in the ACEP Guidelines. He added that there is a lot of opportunity to explain why more emergency department space is needed. The ACEP Guidelines are used as guidelines. The few cases where staff has requested a hospital scale back the space, most recently for a hospital relocation. There has been a large increase in emergency department capacity from the 1990's to 2010, due to increasing visit volume. The trend has changed, and there is a throughput problem that will not be solved by adding more capacity, in his view. He agreed that it should be clear that the ACEP Guidelines are used as guidelines, not ridged standards. He stated that specialized emergency department capacity has not been opposed by MHCC staff. He does not see a conflict between those changes and ACEP Guidelines. Ms. Fleck asked if anyone had other comments on the standard. There were no additional comments.

Ms. Fleck noted that the material she had planned for discussion at the meeting was covered. She noted that the agenda included topics for the next work group meeting and suggested that work group members contact her if they felt anything should be added. Ms. Fleck noted that the bed need methodology is planned for discussion at the next meeting. She asked Ms. Dorrien if that topic had been considered by MHA members. She responded that it had not been discussed yet. She asked to see a side-by-side list of all current standards and changes to them. She noted that there needs to be a balance between reviewing CON applications and the time the process takes. She stated that a long process is detrimental to everyone.

Ms. Fleck explained that there had been a statutory change to reduce the time allowed for review of CON applications, with some exceptions for specialized services like cardiac surgery and CON reviews that included an interested party. She explained that, apart from some exceptions, after docketing a CON application, a decision is required within 120 days. If the Commission does not take action within that time period, then the CON project will be automatically approved. Ms. Fleck stated that theoretically that change should speed up the CON review process.

Ryan O' Doherty commented that he agreed with Ms. Dorrien's comments to consider the totality of the changes, alignment with the TCOC model, and streamlining the CON process. Ms. Fleck noted that another change to statute affecting the CON process is the ability to open an ambulatory surgery center with two sterile operating rooms through the determination of coverage process rather than the CON process. Ms. Fleck stated that the comments of Ms. Dorrien and Mr. O'Doherty were helpful. She added that she looked back at the CON Modernization report and comments submitted by hospitals as part of the development of recommendation to changing the CON process. Mr. Rosen agreed that considering the big picture is helpful, as suggested by Ms. Dorrien and Mr. Doherty.

Ms. Fleck encouraged work group members to share any thoughts about potential changes to the bed need methodology in advance of the next meeting, so that staff can potentially execute different variations on the current bed need methodology and share how changing certain aspects of the methodology affects the results. She noted that MHCC staff has already starting work on this and plans to discuss potential changes with HSCRC staff.

Ms. Fleck thanked everyone for their participation and noted that she expects the next meeting will be virtual too. She then ended the meeting at approximately 11:45am.