Draft Meeting Summary
Surgical Services Work Group Meeting
Friday, January 6, 2017
10:00 a.m. - 12:00 p.m.
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees:

Arnaldo Valedon, M.D. (phone)
John Topper (Phone)
Edward Koza, M.D. (phone)
Amar Setty M.D. (phone)
Andrea Hyatt
Donald C. Bartnick
Rose Lambie
Marjorie Blouin, R.N.
Brett McCone
Robert J. Gilbert
Dean Teague
Amy Dilcher
Josh Jacobs
Barry Rosen

Commission Staff Attendees:

Paul Parker
Eileen Fleck
Suellen Wideman
Kathy Ruben
Ose Emasealu

Other Attendees:
Pat Cameron

Introductions

Paul Parker opened the meeting at 10 a.m. He introduced the other MHCC staff in attendance, and then all other attending work group members introduced themselves. Mr. Parker thanked Andrea Hyatt and the Maryland Hospital Association represented by Brett McCone and Nicole Stallings, for helping to put the work group together.

Mr. Parker provided a general overview of the State Health Plan (SHP) chapter for general surgical services, COMAR 10.24.11, and the scope of Maryland Health Care Commission (MHCC) regulatory oversight of surgical facilities. He noted that, in general, establishing freestanding ambulatory surgical facilities (FASFs) with two or more sterile operating rooms (ORs) or adding ORs at a hospital require approval of a Certificate of Need (CON). The SHP also addressed the development of physician outpatient surgery centers (POSC), the most common form of outpatient surgical center in Maryland. A POSC is a freestanding outpatient surgical facilities with no more than one OR. He added that POSCs are not established through a CON review process, but instead an applicant seeks a Determination of Coverage by MHCC staff. A hospital, FASF, or POSC may have any number of non-sterile procedure rooms (PRs).

Purpose of the Work Group Meeting

Mr. Parker stated that the SHP is required to be updated every five years and said that since the current SHP chapter for surgical services was last updated in 2012, it should be updated soon. He explained that the purpose of the meeting is to discuss changes proposed by Commission staff and work group members. He noted that at least one additional work group meeting is planned.

Description of the Current State Health Plan

Eileen Fleck thanked members of the work group who had participated in updating the previous SHP chapter for surgical services five years ago and then proceeded to describe the components of the current SHP chapter. She stated that SHP chapters typically include background information on relevant issues and policies. She explained that the policies are generally intended to provide guidance and articulate the Commission's rationale for the standards used to evaluate projects. She said that the SHP chapter for surgical services incorporates by reference design requirements of the Facilities Guidelines Institute for outpatient surgical facilities. (Hospital licensure rules incorporate these guidelines for hospitals.)

She added that there are general standards in the SHP chapter for surgical service that are used for analyzing many different types of projects in multiple other SHP chapters and also specific project review standards. She noted that the SHP chapter also includes OR capacity standards which will be discussed later.

Presentation on Surgery Trends in Maryland Hospitals and Ambulatory Surgery Centers from 2010 to 2015.

Mr. Parker presented a set of eight power point slides for the period 2010 to 2015 that showed changes in: (1) the number of ORs and PRs in all settings and in ambulatory surgery centers (ASCs); (2) OR cases in all settings, by type (inpatient or outpatient); (3) OR cases per OR in all settings; (4) total case volume (ORs and PRs) in ASCs: (5) PR cases per PR in ASCs, the number of ASCs by type (FASFs and POSCs); and (6) OR cases per OR in ASCs by type (FASFs and POSCs).

Robert Gilbert asked if the data on first slide include cases from POSCs. Mr. Parker responded that surgeries at POSCs are included, and he further explained that ASC refers to both FASFs, which have two or more ORs, and POSCs, which have no more than one OR.

On the second slide, Mr. Parker pointed out the decline in the inventory of ORs and PRs in 2014 and 2015. He explained that the data for 2015 is not yet complete; there are a few outstanding surveys. However, he did not think that the additional data would significantly change the trend shown on the graph. On the third slide showing hospital inventories for ORs and PRs, Mr. Parker noted an increase in ORs and a slight decrease in PRs from 2010-2015. On the fourth slide, Mr. Parker described the outpatient case volumes for ORs, PRs, and total cases for the study period.

On the sixth slide, which included a bar chart of the distribution of outpatient surgery centers, Mr. Parker explained that most outpatient surgery centers were POSCs, established with minimal regulatory oversight through obtaining a Determination of Coverage. He further explained that a Determination of Coverage requires documentation that a proposed facility has no more than one sterile OR, regardless of the number of nonsterile PRs. The graph on the slide showed a slight decline in POSCs from 2014 to 2015. Mr. Parker stated that although new POSCs are still being created, overall, the data indicates that there may be a greater number of POSCs closing down in the last year.

On the seventh slide, Mr. Parker described the number of cases per OR in FASFs compared to POSCs. The charts showed greater throughput of cases for FASFs compared to POSCs. The eighth slide showed a summary of the number of CON applications received, the number of requests for exemptions from CON, and the number of Determinations of Coverage. Mr. Parker stated that in the last four years, MHCC staff has reviewed eight CON applications and one CON exemption request involving surgical facilities. He noted that, in the last four years, there have been two hospital relocations and one hospital expansion which led to a net reduction of one hospital OR. Mr. Parker stated that there were also three new applications reviewed for FASFs, one of which was sponsored by a hospital. He also noted that there were two other smaller facility expansions whereby each facility added a single OR. Statewide, nine ORs were added to outpatient facility settings, through CON or exemption from CON reviews.

Mr. Parker stated that there were 47 Determinations of Coverage issued from 2014-2016. He noted that not all authorized POSCs are established. Mr. Parker then asked if anyone had questions.

Ms. Hyatt wanted to know how many POSCs closed during the past year, and Mr. Parker responded that a few closed, but he did not know the precise number. Dr. Valedon asked if MHCC had data on the number of office based surgical facilities in Maryland. Mr. Parker responded that the Commission does not monitor office based surgical facilities that do not seek licensure from the State.

Josh Jacobs asked if Kaiser Permanente's facilities are considered physician owned or if they fall into the ASF category. Mr. Parker replied that Kaiser Permanente operates licensed ambulatory surgical facilities, and all of their facilities, except for one, have at least two ORs. Mr. Parker further explained that from a regulatory standpoint, HMOs have the ability to develop an ASF without CON review if the facilities are exclusively used by their HMO members.[1]

Donald Bartnick asked what specialties are represented by recently issued Determinations of Coverage. Mr. Parker responded that the Commission receives information on surgical specialties from an annual survey of POSCs and ASFs that these facilities are required to submit

[1] This was a misstatement. While HMOs do have this preferential treatment with respect to CON in the case of most health care facility categories, HMOs are specifically required to obtain CON approval to establish hospitals and FASFs.

to the Commission. He said that over the last few years the biggest specialty increases were in two specialties, orthopedics and pain management, with the greatest increase in pain management. He noted that most of the facilities reporting pain management have only PRs.

Mr. Bartnick also asked, in reference to the first slide in the presentation, whether the increase in OR surgical cases was due to increases in select population groups, such as the elderly. Mr. Parker stated that he did not have a recent analysis of how population use rates are changing by age group. He noted that there would appear to be a long-term trend of an increasing overall surgical use rate given that case counts are increasing faster than one percent per year, which is the approximate rate of annual increase in Maryland's population. He noted that it is difficult to rely on HSCRC discharge databases for accurate information on hospital surgery cases because there has been a pattern of substantial variance between the case counts that can be derived from these data bases and the surgical cases typically reported by hospitals in CON applications or surveys. He said that he would look to provide some perspective on how surgery use rates are changing to share with the Work Group. Barry Rosen commented that the Affordable Care Act and Medicaid expansion may also have had an impact on increasing utilization.

Specific Changes Proposed to the State Health Plan Chapter for Surgical Services

Mr. Parker explained that changes in the regulatory process have been considered by staff but not changes in the scope of regulation. He said that based on the State statute, the Commission has some ability to alter the regulatory oversight process currently employed in establishing FASFs with two ORs.

Mr. Parker stated that if a POSC with a single OR demonstrates that it is operating at capacity and wants to add a second OR, Commission staff proposes that instead of going through a CON review process, the POSC be allowed to obtain an exemption from CON review to add the OR. He explained that the exemption review process is different from a CON review in terms of application requirements. Additionally, there are no interested parties in exemption reviews. Thus, the process tends to be quicker. Requests for an exemptions are usually reviewed between 45-60 days after a complete set of information is received.

An exemption from CON review requires a Commission decision, rather than a determination by Commission staff. Mr. Parker further explained that typically, the focus of an exemption review is on three areas:

1. Is the project one that will make for more cost effective and efficient delivery of services?
2. Is it in the public interest?
3. Is it consistent with the State Health Plan?

Mr. Parker further explained that the foundation of CON regulatory oversight of surgical facilities is an evaluation of an applicant's utilization of OR capacity. There is not a need projection methodology for ORs or surgical facilities in the SHP chapter for surgical services. He

explained that the SHP chapter includes assumptions about full capacity use and optimal capacity use of ORs, and once optimal use levels are reached, additional ORs may be justified.

Mr. Parker noted that currently when a POSC wants to expand from one to two ORs, it is required to obtain a CON. However, MHCC staff believe that an exemption from CON review process would be sufficient. Mr. Parker said that the information required for an exemption review would be similar to the information currently required for the CON review process. For example, a POSC would still have to demonstrate that it achieved optimal capacity utilization for its OR. An applicant would also be expected to demonstrate that current and projected caseloads of surgical staff support the need for more OR capacity.

Mr. Parker also proposed that two POSCs that want to consolidate into a single ASF with two ORs should be allowed to obtain an exemption from CON review. Mr. McCone asked if there would be a time constraint on how quickly two POSCS could consolidate to form an ASF. Ms. Fleck responded that the issue has been discussed internally, but no final decision had been reached. However, she said that the annual survey of POSCs and ASFs is a tool that MHCC staff uses to collect information on surgical cases volume at these facilities, and at least data from one survey would likely be necessary.

Ms. Fleck asked if anyone else wanted to share their opinion on the issue raised by Mr. McCone. Ms. Hyatt commented that due to the cost, any facility consolidating to form an ASF with two ORs would want to be comfortable with the volume at each POSC before investing the money required to establish an ASF. Mr. Parker noted that the consolidation could also occur as a result of expansion of one of the two facilities. For example, one site may be getting out of the business while the other facility already has enough resources to expand to operation of two ORs.

Dean Teague commented that there still needs to be a time period, perhaps 30 days, for any interested party to file or contact the Commission before the establishment of an ASF through an exemption process. He said this is necessary because there may be a negative impact related to shifting cases when a larger facility is established in a market those affected should have an opportunity to present their case to the Commission. Ms. Hyatt commented that it is important to also realize that there are other factors that may be driving market shifts. She said that some providers lose patients because payers are insisting that some patients should be served in an outpatient center.

For clarification, Mr. Parker explained that interested parties are part of the process in a CON review, and for someone seeking to establish a POSC, there are no interested parties; only a Determination of Coverage is required, and that will not change. He also explained that when a POSC with one OR decides to add another OR after a certain period of time, the request for approval of the second OR should be considered through an exemption from CON review and that would mean there would be no interested parties.

Mr. Parker then explained that under the current CON process, any person has the opportunity to comment in support or in opposition to a project seeking approval by the Commission. A key distinction of interested party status in a CON review is that interested parties have automatic standing to appeal the CON decision.

Mr. Bartnick commented that it may be in the public interest to find a way to encourage hospitals, health systems, POSCs, and ASFs to work together to decrease the overall cost of surgical care. He stated that surgery should be done in settings where it costs less. Efforts should be made to establish regulations that will force these parties to cooperate instead of coming after each other in legal proceedings.

Mr. Teague and Mr. Gilbert agreed with Mr. Bartnick. Mr. Teague noted that sometimes he is tied up by budget policies adopted by his own hospital. Mr. Gilbert pointed out that the volume will come out of one of the hospital systems. He also said that the patients may need to be moved to out of network facilities that will ultimately cost patients more out of pocket. He added that it would be beneficial to consider where the surgical cases are going to come from and where services will be delivered. He added these issues may force collaboration among interested parties in order to come up with a common solution.

Mr. Bartnick further argued that it will be of interest to consider in and out of network status of ASFs and POSCs. He noted that is a critical piece of determining whether money is being saved or not through shifting where surgeries are performed. Mr. Gilbert added that the payers are now forcing cases to be done at different settings, and a lot of affected facilities are looking to go back in network.

Rose Lambie said the for-profit ASFs may experience a negative financial impact if the cases that shift to them from hospitals are primarily Medicare and Medicaid patients while the hospitals retain the high paying privately insured patients. Mr. Gilbert agreed, but he pointed out that this can go both ways because hospitals may also get cases that are not well reimbursed.

Dr. Valedon asked if there is a benchmark for OR utilization. He also wanted to know if there has been any discussion on the expected utilization over time. Ms. Fleck responded that normally once a project is approved by staff, there is no ongoing oversight. In terms of utilization, she explained that MHCC staff previously looked at the history of CON applications and how much hospitals utilized ORs before and after they increased their surgical capacity. MHCC staff also reviewed survey data on OR utilization.

Mr. Parker added that in the current SHP, there are assumptions about capacity for general purpose ORs that vary by the setting, hospital or outpatient centers. For hospital ORs, full capacity is assumed to be 2,375 hours per room per year. Optimal capacity use is 80% of full capacity which is 1,900 hours per year per room.

The vast majority of ORs in hospitals are mixed-use (inpatient and outpatient cases), general purpose ORs. For a dedicated outpatient OR, full capacity is assumed to be 2,040 hours per room per year, and optimal capacity is 80% of full capacity, or 1,632 hours per room per year. This assumption is based on use of the OR 255 days per year and eight hours per day. This is consistent with operation five days per week with five additional days of non-operation for holidays or other reasons. He added that for a special purpose OR, which would only be in the hospital setting, there is no capacity standard. Applicants are allowed to make a case based on the specific circumstances associated with use of the specialized room.

Mr. Jacobs referred back to Mr. Teague's comments and said that it will be important to consider who gets to use an exemption and when it can be used. He commented that someone could use the exemption process to circumvent the CON by first opening one OR and then another OR shortly afterwards. He wanted to know if there are any criteria as to when a POSC or ASF will be allowed to add an OR through the exemption process. He also wanted to know if there would be a limit on the number of times the process could be used to add an OR to an ASF.

Mr. Parker answered that the exemption process would still use the same criteria for need, the level of OR utilization. If an applicant does not reach the minimum utilization required, then the addition of a second OR would not be approved by the Commission. Also, although a second OR may be approved through an exemption process, a third OR would not be approved through an exemption process. Instead, CON review would be required to add a third OR.

Ms. Fleck stated that, if work group members are concerned about allowing an exemption process to add an OR in certain circumstances, then it would be helpful to hear suggestions on other conditions that must be met in order for someone to establish an ASF through an exemption process. She said that ideas could be discussed at this meeting or a future meeting.

Mr. Parker agreed and added that procedurally, he has been generally describing staff's proposal for an exemption process to establish an ASF through the addition of a second OR by a POSC. He said that at the next meeting, specific language will be shared and discussed regarding changes to the SHP chapter for surgical services.

Ms. Hyatt said that shifting surgical volumes through the addition of ASFs affects not only the hospitals but ASFs as well because a lot of ASFs that are in the process of getting a CON lose their surgeons because the surgeons leave to open a POSC with a single OR.

Mr. Jacobs asked if we are considering allowing the exemption process to be used to open an ASF initially, without first establishing a POSC with one OR. Mr. Parker responded that MHCC staff was not currently considering that option. He reiterated that the two scenarios already discussed that are being considered for an exemption to establish an ASF are:

1. A single OR facility that wants to expand to have a second OR.

2. Two facilities each with a single OR that want to consolidate to create one facility with two ORs.

Mr. Parker next explained a third scenario for allowing an exemption from CON to establish an ASF, when a general hospital converts to a freestanding medical facility (FMF). He explained that the FMF model was established in Maryland about ten years ago and functions like a hospital emergency department; it provides unscheduled care 24 hours a day seven day a week. An FMF can only be operated by a general hospital as a satellite emergency department. He noted that there are currently three FMFs in Maryland. One is Germantown Emergency Center, operated by Adventist Health Care, as a satellite of Shady Grove Adventist Hospital in Rockville. A second FMF, Queenstown Emergency Center, is operated by Shore Regional Health (SRH), as a satellite of SRH Easton Memorial Medical Center. The third FMF, Bowie Health Center, is operated by Dimensions HealthCare; the parent hospital is Prince George's Medical Center.

Mr. Parker explained that a general hospital cannot simply convert to a FMF without a parent hospital, and the FMF is a key component because it maintains access to emergency services for the community. He also noted that maintaining ambulatory surgical services may be desired on the same campus as the FMF, and some stakeholders view having an ASF as retaining surgical services that the former hospital had already been providing.

Work group members asked if it would be possible to have an FMF on the same campus as an ASF. Mr. Parker explained that an FMF could have a single OR after obtaining a Determination of Coverage. However, if an FMF wanted to establish more than one OR, a CON would be required under the current statue and regulations.

Mr. Parker stated that State statute allows for an amendment to the SHP chapter that would allow a general hospital seeking to convert to an FMF to also establish an ASF with two ORs through an exemption process. The ASF would be licensed and certified by Medicare as an ASF. An ASF on the FMF campus established through an exemption would be limited to two ORs. If the ASF wanted to add a third operating room, it would need a CON.

Ms. Hyatt asked about the maximum amount of time that a patient could be under observation in an FMF. She also asked whether a patient that requires urgent surgery would get surgery at an FMF or be transferred out immediately. Mr. Parker responded that patients can stay up to 48 hours in observation at an FMF. He also said that minor surgeries can be performed at an FMF, in the same way that minor procedures can occur in a hospital ED. Mr. McCone commented that patients who require complex surgeries are transferred to a hospital.

Ms. Hyatt asked if an ASF created on the campus of an FMF that resulted from conversion of a general hospital would be rate regulated or not. Mr. Barry Rosen responded that HSCRC would be setting the rates. Ms. Fleck and Mr. Parker clarified that HSCRC would definitely set rates for the FMF, including observation care, but he thought HSCRC would have discretion on whether to give rates for surgical services at the ASF. Mr. Parker said that other services such as

radiological imaging are not regulated by MHCC. Only the surgical facility will require MHCC approval.

Work group members wanted to know if there are concerns about the financial viability of the three FMFs that currently exist. Mr. Parker responded that there is some concern about financial viability because according to MHCC staff's studies of the three existing FMFs, they have not been generating excess revenue over expenses.

Mr. McCone commented that the existing FMFs, two of which were pilot projects, are essentially satellite emergency departments for the parent hospital and were established where emergency services, and other hospital services did not previously exist. He noted that he sees the replacement of a hospital with an FMF as a different situation. He also commented that the HSCRC will need to do its due diligence in making a determination about rates for FMFs created through the conversion of a hospital.

Dr. Setty asked whether an ASF established through an exemption on the campus of an FMF that is replacing a general hospital will be rate regulated. Also, he wanted to know if an ASF will be allowed to have extended patient stays, for up to 23 or 24 hours.

Ms. Hyatt answered that ASFs and POSCs already may keep patients for up to 23 hours. Mr. Parker said that the Department of Health and Mental Hygiene amended its rules to be consistent with CMS rules for ASCs so that patients can stay for up to 23 hours. In response to Dr. Setty's first question, Mr. Parker explained that HSCRC is required by law to regulate rates at FMFs for emergency services and observation. He also noted that HSCRC has the discretion to decide whether or not to provide rates for other outpatient services. Mr. McCone noted that HSCRC plans to make determinations on rates for other outpatient services on a case by case basis. Mr. Parker said that long term financial sustainability would likely be a prime consideration.

Mr. McCone commented that he agreed with Mr. Parker. He noted that it may not make sense for HSCRC to rate regulate a service in some markets, but in another market, geographic or financial access issues may be a concern that results in HSCRC providing rates for a service. Ms. Fleck agreed that access would likely be a key consideration for HSCRC.

Mr. Rosen wanted to know if it will be possible to apply for an exemption to establish an ASF with two ORs rather than going through CON review. Mr. Parker answered that establishing a new ASF with two ORs, when not expanding a POSC, combining two POCSs, or converting a hospital to an FMF with an ASF on the campus, will require a CON.

Mr. Gilbert wanted to know if there will be any restrictions on the cost of an FMF created through the conversion of a general hospital. Mr. Parker said that the cost of an FMF is a separate issue from the surgical facility, which may or may not be included on the campus of an FMF. He added that what is currently being proposed is that the Commission will use the American College of Emergency Physicians' (ACEP) guidance for FMFs. Initially, it was proposed that an FMF is

assumed to fall within ACEP's guidance for a low range hospital emergency department which includes recommendations on the number of treatment spaces and the size of the overall facility. However, Mr. Parker noted that there had been pushback on using the ACEP guidance for a low range hospital emergency department because some FMFs may have higher acuity patients or specializations that result in the need for more treatment spaces or greater space.

Mr. Teague asked if hospitals such as Washington Adventist Hospital and the Cheverly campus in Prince George's County are going to be eligible for FMFs. Mr. Parker responded that in the current plan of Washington Adventist Hospital (WAH), the Tacoma Park campus will continue to be a hospital campus because it will retain acute psychiatric services. He said that WAH is not proposing an FMF and plans to establish an urgent care center that operates 24 hours per day. He also noted that a CON would be required for WAH to create an FMF on the Tacoma Park campus because WAH has not closed. Mr. Parker stated that the Commission has not received any specific plans for the Cheverly campus, and the existing Bowie Emergency Center will continue to have Prince George's Medical Center (PGMC) as its parent hospital after PGMC relocates.

Mr. Teague asked if Laurel Hospital will be replaced with an FMF. He also cautioned that there may be push back in terms of legal steps by interested parties to force the facility administrators to go back to the community. Mr. Parker responded that MHCC staff has not received a detailed plan for Laurel Hospital, but his understanding is that the vision is to replace it with an outpatient campus that includes emergency services available 24 hours per day seven days a week.

Mr. Parker said that the law that establishes the ability of a general hospital to convert to an FMF lays out specific requirements that are not included in the general exemption review requirements. Public meetings are required, and sign off by the Maryland Institute for Emergency Medical Systems Services (MIEMSS) is required.

Mr. Parker commented that he wanted to introduce MHCC staff's thoughts on an exemption process for establishing an ASF and get into further discussion of the details in the next meeting. Mr. Parker asked Ms. Fleck to cover the next three agenda items, regarding specific aspects of the current SHP chapter for surgical services.

Ms. Fleck asked if there are other issues that people want to discuss first. Mr. McCone commented that from a hospital's perspective, in the general standards, it might be good to state that if a hospital files an application for a CON, it should be consistent with the HSCRC charity care policies, rather than the current language included. He explained that the charity care policies are regulated and audited by HSCRC and should not be part of the CON process.

Suellen Wideman asked if Mr. McCone was proposing that MHCC staff delete the language regarding a determination of probable eligibility with a certain number of business days. Ms. Wideman noted that HSCRC regulations do not include that provision. She explained that

hospitals sometimes would put off making a determination of eligibility, which resulted in patients going to another hospital.

Mr. McCone commented that the HSCRC regulations should include that provision not MHCC's CON regulations. Ms. Fleck explained the charity care standard, and Mr. McCone noted that the issue is not limited to the SHP chapter on surgical services. Ms. Fleck asked if anyone else wanted to bring up other issues.

Mr. Gilbert asked whether the charity care policy only becomes applicable when a POSC with one OR adds a second OR. Ms. Fleck confirmed that POSCs are not held to the charity care standards, only CON applicants seeking to change the surgical capacity at a hospital or establish an ASF.

Secondly, Mr. Gilbert asked what the practice is for moving ORs from hospitals to communities. He asked whether regulations would address that issue. Ms. Fleck responded that relocating capacity would be treated as establishing a new ASF and would require CON review.

Mr. McCone noted that recently a commercial insurance company demanded that certain surgical services be provided in unregulated space. He said that an affected hospital proposed moving two ORs from the hospital to an ASF on the campus of the hospital without rates. Mr. McCone asked whether relocating ORs from a hospital to an ASF on the campus of the hospital should potentially be permitted through an exemption, rather than requiring CON review.

Ms. Fleck asked if anyone else wanted to comment on Mr. McCone's remarks. In response to some comments, Mr. McCone clarified that he proposed relocation of ORs on the hospital campus as a project that should be allowed through an exemption, but not creating an ASF on another site. Mr. Jacobs agreed that it is a good idea to allow an exemption for a hospital to move two ORs from the hospital to an ASF on the campus of the hospital, and he asked why a hospital should be limited to moving only two ORs. Mr. McCone noted that the law would not permit establishing an ASF with more than two ORs through an exemption.

Dr. Setty asked if there is any concern that including surgery services as part of an FMF would change the concept of the FMF and the motivation to have one. Mr. Parker explained that he expected surgery would not really be included in the FMF, and there would be separate regulatory processes for the FMF and ASF. Ms. Fleck added that licensure regulations for FMFs limit the ability to integrate surgical services within an FMF.

Mr. Bartnick asked for more clarification on the concept of a hospital closing two ORs and moving them into the community. He said that partnering with an existing facility may be the best use of resources rather than construction of new facilities. He suggested that the Commission look at ways of encouraging the effective use of resources in a strategic way Statewide.

Ms. Fleck asked if there are any other comments on allowing a hospital to move ORs to an ASF through an exemption. Dr. Valedon said that it may be a good idea to have some time to think about that and then discuss at the next meeting.

Mr. Parker said that a survey will be sent out to determine the next meeting date. He also explained that the typical process is to use a work group to help develop a new draft of the SHP chapter and then request informal comments on the draft SHP chapter. The informal comments received are then used to develop a revised draft SHP chapter for consideration by the Commission as proposed regulations. He also explained that under the standard procedural process, the proposed regulations will be posted for formal comment, and then MHCC staff requests that the Commission adopt final regulations. Ms. Fleck added that normally there is a 30 day period for comments, and staff will keep work group members updated on the regulatory process.

The meeting was adjourned at noon.