

Changes to the State Health Plan Chapter for Acute Psychiatric Services (COMAR 10.24.07)

- Codify standards for acute psychiatric services in COMAR 10.24.21
- Maintain the standards for residential treatment centers in COMAR 10.24.07, including for violent juvenile sex offenders
- Delete all standards for emergency medical services

State Health Plan Chapter for Acute Psychiatric Services

- .02D Plan Content and Applicability
 - Establishment of a psychiatric hospital
 - Establishment of a psychiatric unit in a general hospital
 - Addition of psychiatric beds except as permitted pursuant to the annual reallocation of hospital bed capacity*
 - Serving a new age group (children, adolescents, or adults)

*Note: The annual reallocation of hospital bed capacity is permitted pursuant to COMAR 10.24.01.03A(3)(b)(iii) and COMAR 10.07.01.06-1.C.

.03 Issues and Policies

- Policy 1: People should be treated in the least restrictive setting appropriate to their medical conditions.
- Policy 2: Patients should be able to secure timely placement in a psychiatric bed when acute inpatient psychiatric services are required.
- Policy 3: Patients shall be timely discharged from hospitals once acute psychiatric services or other acute care services are no longer needed.

.03 Issues and Policies (continued)

- Policy 4: Acute psychiatric services shall be financially and geographically accessible to all who need them.
- Policy 5: A hospital with acute psychiatric services will continuously and systematically work to improve the quality and safety of patient care
- Policy 6: An increase in the funding and provision of mental health services by the private sector and federal and State government is necessary to meet the needs of Maryland's population adequately.

.04 Procedural Rules

- Acute Psychiatric Services Docketing Rules
 - Does not allow an applicant convicted of a felony, or who pleaded guilty or who entered other specified pleas, when other criteria are also met that pertain to criminal conviction or civil finding of fraud or abuse with respect to State health programs, or Medicare or Medicaid programs, and affiliation of the applicant with the hospital applicant or another hospital.
 - Applicant may show evidence why the rules should not be applied, under some circumstances.
- Acquisition of a Special Psychiatric Hospital
 - Notice is required and rules described above also apply.

.05 Acute Psychiatric Services Standards

- General Standards
 - The Chapter references standards in COMAR 10.24.10, the SHP chapter for general acute care hospitals.
- Project Review Standards
 - Staff received comments on 8 of the 12 project review standards
 - No comments on the following standards: geographic accessibility, support for the project, construction costs, and inpatient nursing unit space.

.05B(2) Need for Acute Psychiatric Services

- A needs determination for historically underserved populations and regional utilization projections is developed by MHCC staff.
 - The historically underserved populations are children, adolescent, patients with mental disorders and one or more developmental disabilities, and patients with mental disorders and a secondary diagnosis of substance abuse disorder.
- An applicant must address both the needs determination for historically underserved populations and regional utilization projections.
- An applicant must also demonstrate the need for acute psychiatric bed capacity proposed through a service-area level assessment.

Needs Determination for Historically Underserved Populations

- Based on trends in psychiatric discharges, emergency department boarding, and the needs assessment developed by local behavioral health authorities and State agencies to identify gaps in the mental health system
- Published for public comment, and potentially revised, before publication as final
- Updated at least every two years

Needs Determination for Historically Underserved Populations

- When a threshold of an identified need for four beds is met, an applicant shall address how its proposed project will meet at least one need identified.
- To justify not meeting any identified needs, an applicant must demonstrate serving any of these patient populations would jeopardize:
 - Financial viability of the hospital; or
 - Ability of the hospital to meet the needs of the broader patient population served
- Alternatively, the Commission may consider evidence from an applicant and find that the applicant is unable to effectively meet the needs of any of the historically underserved populations.

Needs Determination for Historically Underserved Populations

Comments

- Sheppard Pratt and the Maryland Hospital Association (MHA) suggested that it may not be effective to require an applicant to serve at least one historically underserved population.

Staff Recommendation

- Staff modified language in .05(2)(c)(ii) in response to these comments.
- The revised Chapter provides an opportunity for the Commission to consider evidence from an applicant and find that the applicant is unable to effectively meet the needs of any of the historically underserved populations.

.05B(2)(e) Reallocation of Beds

- Requires a CON to establish acute psychiatric hospital bed capacity for adults, adolescents, or children
- Requires notice to the Commission and Maryland Department of Health for reallocations of beds among age groups the hospital is already authorized to serve

Comments and Staff Recommendation

- University of Maryland Medical System (UMMS) questioned the 30-day notice requirement;
- Staff changed the standard to require only notice and eliminated the conflict with annual reallocation of beds permitted for general hospitals.

.05B(3) Patient Rooms

- All new patient rooms for acute psychiatric patients shall be single occupancy private rooms unless the Commission finds that an applicant demonstrated that private rooms are needed.

Comments

- Johns Hopkins Health System (JHHS) and Luminis support this requirement.
- Luminis noted that semi-private rooms are impossible to justify.
- JHHS stated that allowing for exceptions is essential.

Staff Recommendation

- No changes recommended

.05B(4) Other Program Requirements

- An applicant proposing to serve two or more age groups shall have physical separation and programmatic distinction between patient groups consistent with Maryland Department of Health requirements.

Comments

- UMMS suggested clarification of the standard to state that it only applies to child, adolescent, and adult populations.

Staff Recommendation

- Staff recommends no change. The requirement is consistent with MDH requirements and is not limited to the age groups proposed by UMMS.

.05B(6) Emergency Services

- General hospitals must have the ability to provide emergency services at all times, unless exempted by the Maryland Department of Health; each hospital shall also have at least one seclusion room.

Comments

- Sheppard Pratt requested clarification on the requirements for a special psychiatric hospital

Staff Recommendation

- Staff revised the standard to reference only general hospitals because the purpose of the requirement is for psychiatric patients to receive medical clearance in an emergency department before admission.

.05B(7) Involuntary Admissions

- A psychiatric hospital or a psychiatric unit of a general hospital shall admit involuntary patients, unless exempted by the Commission.
- A psychiatric hospital or psychiatric unit of a general hospital may not discontinue admissions of involuntary patients without written approval from the Commission.

.05B(7) Involuntary Admissions (continued)

Comments

- Luminis, JHHS, UMMS, and MHA support a requirement that new programs accept involuntary patients.
- JHHS requested modification of the standard to remove any potential opportunity for an existing program to be required to admit involuntary patients.
- MHA suggested that the Commission offer incentives for hospitals to accept involuntary patients and seek input from hospitals that do not accept involuntary patients.
- UMMS asked for clarification on the mechanism and timeline for the requirements.

.05B(7) Involuntary Admissions (continued)

Staff Recommendation

- Staff concludes that the standard should not eliminate the opportunity to require an existing psychiatric hospital or unit to accept involuntary patients when the hospital is proposing a project that is subject to the Chapter.
- The Commission should not offer incentives for hospitals to serve involuntary patients because the responsibility should be widely shared by hospitals and health systems.
- Staff notes that the mechanism and timeline for exemptions from the requirement to admit involuntary patients or discontinue admission of involuntary patients is action by the Commission.

.05B(8) Access to Acute Psychiatric Hospital Services

- This standard requires that a psychiatric hospital or psychiatric unit in a general hospital only deny admission of a patient, if the hospital is unable to provide appropriate care.
- Admission cannot be denied due to a patient's ability to pay for services or status as an involuntary patient, unless the hospital has received an exemption from serving involuntary patients.
- The standard also requires participation in Medicare and Medicaid programs.

.05B(8) Access to Acute Psychiatric Hospital Services (continued)

Comments

- JHHS requested that the order of standards .05B(8)(a) and (b) be switched.
- JHHS suggested that “psychiatric unit” be replaced by “psychiatric program.”

Staff Recommendation

- Staff changed the order of standards for clarity but did not replace “psychiatric unit” with “psychiatric program.”

.05B(9) Adverse Impact

- A capital project cannot have an unwarranted adverse impact on total cost of care, availability of acute psychiatric services, or access to acute psychiatric services.
- A general hospital must demonstrate that it is an efficient hospital
- Peer hospitals' capital costs, capacity, and age of physical plant shall be used to evaluate a proposed project.
- If project will likely reduce access to psychiatric hospital services, an applicant must demonstrate that the impact on access will not be excessive.

.05B(9) Adverse Impact (continued)

Comments

- UMMS suggested removal of references to global budgets and peer group comparisons, and that if peer group comparison is maintained, then it should apply to special psychiatric hospitals too.
- UMMS expressed concerns that MHCC is overstepping HSCRC's authority and that references to HSCRC standard or methodologies will quickly become outdated.
- Sheppard Pratt and UMMS requested that the potential for adverse impact on an existing provider be addressed.
- Sheppard Pratt suggested that an adverse impact on the financial viability of existing providers be considered.

.05B(9) Adverse Impact (continued)

Staff Recommendation

- Staff recommends no changes in response to most UMMS comments.
- The Commission's reliance on information provided by HSCRC to evaluate projects is appropriate.
- The standard in .05B(9)(a) appropriately references only general hospitals.
- The Chapter will be periodically updated and may be interpreted to preserve the intent of a standard or deem a standard inapplicable.
- Staff concludes that the Chapter should include an adverse impact standard that addresses the potential for a negative impact on existing providers. The draft Chapter now states that a project cannot jeopardize the financial viability of an existing provider.

.05B(12) Financial Feasibility

- A hospital capital project shall be financially feasible and not jeopardize the long- term viability of the hospital.
- Specific information must be documented by an applicant.
- There is an exception to the requirement that a hospital generate excess revenue over total expenses, under certain circumstances.

.05B(12) Financial Feasibility (continued)

Comments

- UMMS suggested that the standard only apply to capital projects subject to CON review because merged asset systems should have greater flexibility.

Staff Recommendation

- No changes are necessary. All capital projects should be financially feasible, regardless of whether a project involves a single facility or is within a multi-facility system.

.06 Methodology for Utilization Forecast

Geographic Planning Regions

Baltimore Upper Shore: Anne Arundel, Baltimore, Carroll, Cecil, Harford, Howard, Kent, Queen Anne's, and Talbot Counties, and Baltimore City

Lower Eastern Shore: Dorchester, Somerset, Wicomico, and Worcester Counties

Montgomery: Montgomery County

Southern Maryland: Calvert, Charles, Prince George's, and St. Mary's Counties

Western Maryland: Allegany, Frederick Garrett, and Washington Counties

.06 Methodology for Utilization Forecast (continued)

Comments

- MedStar, MHA, and Luminis recommended that Prince George's and Montgomery counties be included in the same health planning region.
- Luminis suggested a different health planning region that includes just Kent, Queen Anne's, and Talbot Counties or combining the Upper and Lower Eastern Shore counties.
- MHA expressed concern with merging the Upper Shore into the Baltimore region.
- MedStar suggested the Commission consider maintaining a regional approach for only children, adolescents, and special populations, while treating adult psychiatric services as a service that should be available in every jurisdiction.

.06 Methodology for Utilization Forecast (continued)

Staff Recommendation

- No changes are required. An applicant must provide a service-area level analysis and address regional utilization projections.
- The health planning regions were determined based on population size and patient care-seeking patterns.
- Grouping rural counties together in smaller regions will likely result in the special populations in those counties continuing to be underserved.

.06 Methodology for Utilization Forecast (continued)

Comments on Calculation of Other Psychiatric Bed Days

- UMMS suggested that the methodology should account for delays in psychiatric patient placement and data could be provided through MHCC surveys or surveys by MHA.

Staff Recommendation

- No changes are recommended. Staff believes that data on boarding is captured as part of the discharge abstract record.
- An applicant is not precluded from presenting additional information relevant to an evaluation of need for additional acute psychiatric services.

Other Comments and Changes

- Please refer to the Staff Memo for comments not related to specific standards in the draft Chapter and additional changes by staff.