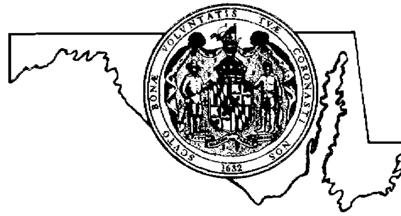
Andrew Pollack, M.D.
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

STATE OF MARYLAND



MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MEMORANDUM

TO: Commissioners

FROM: Eileen Fleck
Chief, Acute Care Policy and Planning

DATE: February 18, 2021

RE: Staff Recommendation for Proposed Permanent Regulations, COMAR 10.24.21, State Health Plan for Facilities and Services: Acute Psychiatric Services

---

Maryland Health Care Commission (MHCC) staff is requesting that the Commission repeal the regulations in COMAR 10.24.07 that address acute psychiatric services and adopt as proposed permanent regulations a new Chapter, COMAR 10.24.21: State Health Plan for Facilities and Services: Acute Psychiatric Services ("Chapter"). The current State Health Plan chapter that addresses acute psychiatric services, COMAR 10.24.07, also includes standards for residential treatment centers for juvenile sex offenders and emergency medical services. Going forward, Staff recommends that the standards for residential treatment centers remain in COMAR 10.24.07, and the standards for emergency medical services be removed. The standards for emergency medical services are outdated and do not apply to Certificate of Need projects that involve hospital emergency departments.

A draft Chapter that only addresses acute psychiatric services was posted for informal public comment on December 17, 2020. Five organizations commented on this early draft. A copy of these informal comments is available on the MHCC website.[1] Staff considered and analyzed the informal comments and recommends certain revisions to the draft Chapter based on these comments and on internal discussions. A summary of the comments received on the draft Chapter and staff's response to these comments is presented first, followed by a summary of the comments. There were also a few additional changes based on further review by staff, which are also noted at the end of this memorandum.

[1] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp.aspx

.03A Issues and Policies

Timely Admission to Acute Psychiatric Services

Luminis Health Inc. (Luminis) suggested that the Commission cite examples of how to increase timely admission for more psychiatric patients. Specific examples were the use of single patient rooms, appropriate and timely medication for psychiatric patients, med-psych specialty units, and increased training of psychiatric nursing staff.

Staff Response

Staff concluded that including examples would provide greater clarity and added them. (see p. 5). Staff notes that the wording changes do not change the standards for review of Certificate of Need (CON) applications and exemption requests.

Timely Discharge Following Treatment

Luminis expressed agreement with the position in the draft Chapter that the lack of affordable community-based care for behavioral health contributes to discharge delays for psychiatric patients and noted that community-based behavioral health services could reduce the need for acute psychiatric services. Luminis commented that providing appropriate financial resources to support community-based services is paramount to the entire system and is the right thing to do for the individuals being served. Luminis suggests that Maryland's Medical Assistance program, Behavioral Health Administration, Governor's Office, and Legislative Branch should support additional funding to incentivize development of affordable, community-based care for behavioral health that can improve timely discharge for patients following treatment.

Staff Response

Staff concludes that emphasizing the importance of funding for community-based services is appropriate. Staff revised the language in this section to note that by increasing funding for community health resources, it should be possible to achieve more timely discharge and more efficient use of acute psychiatric beds and additional State funding should be considered. (see p. 6). Staff also notes that the draft Chapter already included language supporting funding for the development of affordable, community-based services in the Issues and Policies section, specifically following Policy 6 on page 10.

Quality and Safety of Acute Psych Hospital Facilities and Services

In its comments, Sheppard Pratt noted that without a standardized way of measuring acuity, a comparison of facilities using the Inpatient Psychiatric Facility Quality Reporting (IPFQR), or any other tool, is limited. Sheppard Pratt also suggested that the Commission should publish bed capacity and occupancy levels routinely, at the level used for planning purposes. At a minimum, this should include reporting on beds dedicated to children, adolescents, adults, and geriatrics.

Staff Response

Staff concludes that a lack of standardized measurement of patient acuity hinders comparisons of hospitals in Maryland on quality measures. Staff revised the language in this

section to note that standardizing measurement of patient acuity, which may change over the span of the patient's admission, poses challenges to comparing the quality of hospitals.

In response to the request that the Commission publish bed capacity and occupancy levels routinely, Staff concludes that no change is necessary. Staff notes that the Chapter states that the historically underserved needs projections will be updated at least every two years. Licensed psychiatric bed capacity is generally published annually. Physical bed capacity and occupancy levels can be provided by Staff upon request.

Financing Mental Health Services

Sheppard Pratt expressed agreement with the policy statement that financing mechanisms "fail to account for the cost of treating high acuity patients." Sheppard Pratt also supports higher reimbursement for hospitals to treat these high acuity patients.

Staff Response

Staff concludes that no change is required. As reflected in the draft Chapter, the Commission supports improved financing mechanisms to cover the cost to treat high acuity patients. The Health Services Cost Review Commission is the authority that controls hospital charges and global budgets for Maryland hospitals.

.05B Project Review Standards

(2) Need for Acute Psychiatric Services

(2)(b)

Sheppard Pratt suggested that it would be helpful to clarify how the list of historically underserved populations was developed and requested clarification on when the list of populations included would be updated. Additionally, the University of Maryland Medical System (UMMS) commented that the draft Chapter did not define "historically underserved populations."

Staff Response

Staff recommends no changes in response to these comments. A definition of the "Needs determination for historically underserved populations" is included in .07B(13). The definition provides that the needs determination will be published at least biennially by the Commission for the following patient populations: children; adolescents; patients with mental disorders and one or more developmental disabilities; and patients with mental disorders and a secondary diagnosis of substance abuse disorder. MHCC staff developed this list based on discussions with Work Group members regarding populations that are largely underserved. The list may be updated in future revisions to the Chapter.

(2)(c)

Sheppard Pratt commented that it may not be efficient or effective to require an applicant to serve at least one of the historically underserved populations. Similarly, the Maryland Hospital Association (MHA) suggested that it may not be efficient or effective to require every hospital to serve at least one of the historically underserved populations due to the specialized staff and care required. Instead, MHA suggested regional access should be the focus. MHA suggested that the

Commission create incentives through the CON program or encourage payment policies that make it financially feasible to serve the historically underserved populations.

Staff Response

Staff concluded that the language in .05B(2)(c)(ii) should be revised to allow an applicant to present evidence that it will be unable to effectively meet the needs of any of the historically underserved populations and for the Commission to consider this evidence in determining whether an applicant should not be required to meet an identified need for a historically underserved population. This change addresses the concern raised by Sheppard Pratt and MHA, while still maintaining a strong requirement that hospitals seeking to establish or expand acute psychiatric services consider the needs of historically underserved populations. Staff also notes that the needs of these populations are considered at a regional level. Every hospital that applies for a Certificate of Need or requests an exemption will not necessarily have to incorporate plans to serve at least one historically underserved population. A threshold of need must be crossed and the need determination for historically underserved populations will be updated at least every two years and will account for newly approved capacity and losses of capacity.

(2)(e) Reallocation of Beds

UMMS stated that it is unclear how the 30-day notice provisions regarding allocation of acute psychiatric bed capacity will apply to the annual change to an acute general hospital's licensed bed capacity. UMMS suggests that an exception should be permitted to allow acute general hospitals to reallocate psychiatric beds at the time each facility designates its annual licensed bed capacity without having to provide 30 days advance notice.

Both UMMS and Sheppard Pratt recommend an exception to the 30-day notice required before allocating beds between the three age groups for exigent circumstances or that notice to MHCC should be permitted to take place within a certain number of days following the reallocation of beds.

UMMS and Sheppard Pratt also commented that the term "elderly patients" in (2)(e)(ii) is not defined in the draft, and it is unclear if this term is coterminous with the definition of "geriatric population." Additionally, UMMS suggested that the term "specialized unit" should be defined.

Staff Response

Staff concluded that .05B(2)(e)(i) and (ii) should be addressed in a new Paragraph .05B(2)(f) that acknowledges the annual reallocation of hospital bed capacity permitted under COMAR 10.24.01.03A(3)(b)(iii) and COMAR 10.0701.06-1.C, and that addresses the notification requirement for the reallocation of psychiatric beds among age groups.

Staff also concluded that 30 days advance notice is not consistent with the current practices for annual licensed bed capacity changes and other changes in capacity. Staff revised the language to require advance notice, without specifying that 30 days advance notice is required. In addition, staff revised Section .02D to state that the Chapter applies to increases in psychiatric bed capacity "except as permitted pursuant to the annual reallocation of hospital bed capacity under COMAR 10.24.01.03A(3)(b)(iii) and COMAR 10.0701.06-1.C."

Lastly, Staff concluded that the references to elderly patients and a specialized unit should be replaced for clarity. The revised standard refers to geriatric patients rather than elderly patients and replaces the term "specialized unit" with designated beds. Unlike other age groups where physical separation may be essential, geriatric patients may be less likely to be physically separated in a unit apart from other adult patients, as implied by the term "specialized unit."

(3) Patient Rooms

Staff received comments from Johns Hopkins Health System (JHHS) and Luminis on single-occupancy patient rooms. Luminis strongly believes that any CON application for a new unit(s) or alteration of existing unit(s) should be single-occupancy and cannot envision a circumstance where, within new or altered space, semi-private rooms make sense; all evidence indicates that single-occupancy rooms greatly reduce altercations between patients and between staff and patients, and decrease the need for seclusion and restraint. JHHS expressed support for some exceptions to a requirement for single-occupancy patient rooms, as allowed in the draft Chapter. JHHS commented that it is crucial that applicants be given the opportunity to "provide evidence demonstrating that, under the specified circumstances presented by the proposed project, semi-private patient rooms are appropriate." JHHS explained transitioning from semi-private to private rooms is not always feasible without reducing capacity, which may be more important.

Staff Response

Staff concludes that no changes are required. Staff will evaluate requests to retain or build semi-private rooms on a case-by-case basis.

(4) Other Program Requirements

UMMS commented that this standard should be clarified to state that it applies to an applicant seeking to provide acute psychiatric services to two or more age groups for which CON review is required (i.e. child, adolescent, adult) and not the "geriatric population."

Staff Response

Staff concludes that no changes are required. The requirement that an applicant provide physical separation and program distinctions between patient groups consistent with the Maryland Department of Health requirements is not limited to the age groups of child, adolescent, and adult. Patient safety is a primary consideration of the Department of Health for all psychiatric patients, including geriatric patients.

(6) Emergency Services

Staff received a comment from Sheppard Pratt stating that it would be helpful to clarify the standard's expectations for special psychiatric hospitals without emergency rooms.

Staff Response

Staff concludes that the reference to special psychiatric hospitals should be removed. The standard applies only to acute care general hospitals, and the standard is included because all psychiatric patients must receive medical clearance in an emergency department before admission to a hospital.

(7) Involuntary Admissions

Staff received comments from Luminis, JHHS, UMMS and MHA that expressed support for a requirement that any new program must accept involuntary patients. JHHS also supports that requirement; however, it strongly opposes the requirement for all existing psychiatric programs to admit involuntary patients. JHHS requested that the Commission revise the Chapter to include an exemption from this requirement for existing programs. Only Luminis commented that a CON for alteration of an existing unit(s) should result in a requirement to accept involuntary patients. MHA commented that the Commission should consider offering incentives to hospitals to accept involuntary patients and suggested that the Commission seek additional input from hospitals that do not accept involuntary patients.

UMMS commented that the draft Chapter should be clarified to provide a mechanism and timeline for a hospital to obtain an exemption from the requirement to admit involuntary patients. Similarly, UMMS commented that the draft Chapter should be clarified to provide a mechanism and timeline for a hospital to discontinue admission of involuntary patients.

Staff Response

Staff concludes that the standard should continue to require existing psychiatric hospitals and units to accept involuntary patients, when the hospital is proposing a project that is subject to the Chapter. However, staff believes that the Chapter should be clarified to address how the Commission will determine whether a hospital is required to accept involuntary patients. Staff revised the language to specify the factors that the Commission will consider in determining whether to exempt a hospital from admitting involuntary patients. These factors include the number of psychiatric beds, access to hospitals that admit involuntary patients for the population to be served, and comments from interested parties or other stakeholders.

Staff notes that the mechanism and timeline for exemptions from the requirement to admit involuntary patients or to discontinue admission of involuntary patients is action by the Commission. The Commission must vote on both types of proposals. The former will be considered as part of the decision on a Certificate of Need or exemption request, and the latter is likely a Certificate of Need modification request. Commission meetings are held monthly with the usual exception of August. Staff has not proposed any change to the existing processes and concludes that no change is needed to address the comments from UMMS.

Staff has concluded that the Commission should not offer incentives for a hospital to serve involuntary patients. Serving involuntary patients is deliberately the default assumption because the responsibility for those patients should be shared by hospitals and health systems. Instead, it is appropriate to provide some flexibility and exceptions from the requirement, as reflected in the revised draft proposed standard, which also aligns with the current standard.

(8) Access to Acute Psychiatric Hospital Services

JHHS requested that the order of standards .05B(8)(a) and (b) be switched. JHHS also suggested changing the language in the standards, specifically replacing the phrase “psychiatric unit” with “psychiatric program.”

Staff Response

Staff concludes that changing the order of the standards .05B(8)(a) and (b) and revising the standard adds clarity. However, Staff concludes that replacing the word "unit" with "program" is unnecessary, and the word "unit" more accurately reflects the physical space for involuntary psychiatric services in hospitals.

(9) Adverse Impact

Sheppard Pratt and UMMS sought revisions to the draft Chapter that address the potential for an adverse impact on an existing provider. Sheppard Pratt specifically requested that the Commission include a provision that considers adverse impact on the financial viability of existing providers because existing providers may be delivering behavioral health services at razor thin, or even negative, margins.

UMMS suggested the removal of the global budget revenue statement and peer group comparison referenced because HSCRC holds exclusive authority over the decision on whether or not to grant a capital-related adjustment to global budget revenue. UMMS also suggested that if wording of the adverse impact standard is retained, rather than deleted as proposed by UMMS, then the requirement for a general hospital to demonstrate that it is an efficient hospital within its peer group should apply to special psychiatric hospitals. Finally, UMMS expressed concern about references to HSCRC standards and methodologies quickly becoming outdated.

Staff Response

Staff recommends that the Commission consider the potential adverse impact of a proposed acute psychiatric services project on the financial viability of an existing provider. The specific language proposed by Staff is shown below.

> (a) A project involving acute psychiatric services shall not have an unwarranted adverse impact on existing providers of acute psychiatric services. An unwarranted adverse impact is one that jeopardizes the financial viability of an existing provider.

Staff concludes that no changes are required to address UMMS concerns that MHCC is overstepping its authority by including the language in .05B(9)(a). This standard indicates that the Commission will rely on information provided by HSCRC in its evaluation of a hospital project, which is appropriate and consistent with the approach taken to reviewing other types of proposed hospital CON projects.

Staff also concludes that the standard in. 05B(9)(a) appropriately references only general hospitals. Reimbursement for special psychiatric hospitals differs from general hospitals, and special psychiatric hospitals are not comparable to each other or general hospitals for purposes of determining efficiency, in accordance with the policies of the HSCRC.

With respect to UMMS concern that references to HSCRC policies and methodologies may quickly become outdated, staff notes that regulations are updated as appropriate or in some cases may be interpreted to preserve the intent of the standard or deemed inapplicable. However, Staff also concludes that the appropriate approach is to be more general in referencing HSCRC policies

and methodologies. After consulting with HSCRC, MHCC staff has revised the language to refer to efficiency policies rather than specifically integrated efficiency analysis.

(12) Financial Feasibility

UMMS commented that, because the draft Chapter is also applicable to CON exemption requests, this standard should be modified to require that only hospital capital projects "subject to CON review" shall be financially feasible. UMMS explained that a merged asset system should have greater flexibility. Specifically, UMMS proposed that the wording in .05B(12)(b)(iv) be modified to include the following statement.

> Applicants seeking an exemption from CON review as part of a merger or consolidation must demonstrate that relocation of an existing health care facility, a change in bed capacity of an existing health care facility, or a change in the type or scope of health care services offered by a health care facility will benefit the merged asset system's service area population and not jeopardize the long-term financial viability of the merged asset system.

Staff Response

Staff concludes that no changes are necessary to allow greater flexibility for a merged asset system. 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 for Acute Psychiatric Hospital Beds

A. Geographic Area

MedStar Health (MedStar), MHA, and Luminis requested modification of the health planning regions, specifically each suggested defining a region consisting of Prince George's and Montgomery Counties. MedStar explained that Prince George's County is more closely aligned with the District of Columbia metropolitan area than with Saint Mary's, Calvert, and Charles counties. MHA commented that this change would better reflect patient care-seeking patterns.

MHA and Luminis also suggested changes to the health planning regions that include counties on the Eastern Shore. Luminis suggested that Kent, Queen Anne's, and Talbot Counties serve as their own region or be combined with the Lower Eastern Shore because Cecil County is more effectively attached to Harford County and the northern Baltimore area. MHA expressed concern that merging the Upper Shore into the Baltimore region may artificially inflate the number of available beds for Shore residents and noted the benefits of treating psychiatric patients locally.

MedStar commented that, if it is the Commission's goal that most hospitals should offer at least a general acute psychiatric service, as stated in Policy 4, or that the general adult psychiatric services should be available in most Maryland counties, then the Commission could consider general adult psychiatric services to be a service that should be available in all Maryland counties and Baltimore City. For other age groups and special populations, MedStar suggested that the need for acute psychiatric services could still be defined at a regional level.

Staff Response

Staff concludes that no changes are required. As described in .05B(2)(d), an applicant for a CON or a request for exemption from CON review will perform a service-area level needs assessment that includes a forecast of demand for acute psychiatric hospital beds by the population in its projected service area and a zip-code area level analysis of the market share that an applicant expects to capture within the projected service area. While the Commission will publish utilization projections by region, when evaluating an application, the service area level needs assessment will be critical to the Commission's evaluation of a project. The health planning regions are primarily relevant to assuring regional access to acute psychiatric services for historically underserved populations.

The health planning regions were determined based on population size and patient care-seeking patterns. Specifically, combining Prince George's and Montgomery counties would result in one region with a very large population, while the population in the three rural counties may be more likely to be underserved because the needs for special populations will not reach a critical threshold that compels development of additional acute psychiatric services. Staff has similar concerns regarding the Eastern Shore and changes suggested by Luminis.

F. Calculation of "Other Psychiatric Bed Days"

UMMS suggested that the methodology should account for delays in psychiatric patient placement, by adjusting the ALOS or "Other Psychiatric Bed Days" under .06F, to account for days that a patient spends in an acute general hospital awaiting placement in an acute psychiatric bed or in another appropriate facility. Data on such patient days could be provided by hospitals pursuant to MHCC surveys or in coordination with MHA.

Staff Response

Staff's understanding is that time spent boarding at a hospital to which the patient is later admitted is counted as part of the number of inpatient days in the HSCRC discharge abstract data relied upon by MHCC staff. For a patient who is transferred to a different hospital after boarding in an emergency department, the time spent boarding is captured in the outpatient data through the date fields. Staff agrees that collecting additional more detailed data on boarding in emergency departments would be useful. However, the value of this information should be considered against the potential burden of additional information collection. Staff also notes that the draft Chapter does not include a bed need forecast; instead, an applicant is required to address a utilization projection. In addition, an applicant is required to provide a service area analysis for review by the Commission, as described in .06F(2)(c), and the applicants own analysis of the need for a project is a primary consideration for the Commission. An applicant is not precluded from presenting additional relevant information in its evaluation of the need for a project.

Other Comment 1

Staff received comments from JHHS questioning whether a Certificate of Need (CON) should be required for any existing Maryland hospital to open or expand psychiatric beds.

Staff Response

Staff concludes that no change is required. Statutory change would be required to remove psychiatric hospitals or changes in psychiatric bed capacity from the scope of CON regulation. Staff notes that the revised draft Chapter eliminates many standards, and the general CON process has been modified to reduce the burden on applicants.

Other Comment 2

Luminis commented that Maryland's General Assembly needs to address "Assisted Outpatient Treatment" or involuntary outpatient commitment to court ordered services in a community. Luminis also commented that involuntary outpatient commitment is already working well in 47 states and would allow patients to receive appropriate services outside of a hospital setting.

Staff Response

Staff concludes that no changes are required. Staff notes that involuntary outpatient commitment is a contentious issue that must be addressed through the legislative process. This topic was not discussed during the Work Group meetings convened by Commission staff.

Additional Changes by Staff

For clarity, staff revised the language regarding acquisition of a psychiatric hospital in .04B(2)(c) and .04B(3).

To reduce the burden on an applicant, staff revised standard .05B(5), the project review standard that requires documentation of support for a CON project or exemption request. Staff removed the Behavioral Health Administration of the Maryland Department of Health from the list of several entities from which an applicant must seek support because staff should contact BHA directly rather than adding to the burden on an applicant.

For the project review standard for adverse impact, staff revised subparagraph .05B(9)(iv) to redefine the relevant population as the population within the optimal drive time standard and the population in the health planning region where a facility is located, rather than the primary service area of the applicant because the primary service area for the hospital may not align well with the population in need of acute psychiatric services expected to be served by the hospital.

For clarity, staff revised the project review standard for financial feasibility, specifically subparagraph .05B(12)(iv).