Maryland Hospital Association

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January XX, 2018

Paul Parker
Director, Center for Health Care Facilities Planning & Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Parker:

On behalf of its 64 member hospitals and health systems, the Maryland Hospital Association appreciates the opportunity to respond to the Maryland Health Care Commission's request for comments on Maryland's Certificate of Need (CON) program. Our response includes several key overarching principles related to Maryland's current All-Payer Model and future Enhanced Total Cost of Care Model, as well as direct answers to the questions posed in the MHCC's Comment Guidance questionnaire.

**Background and All-Payer Model Performance**

Since the beginning of Maryland's All-Payer Model in January 2014, Maryland's hospitals have outperformed the hospital spending per capita and the hospital spending per Medicare beneficiary targets. Statewide, hospital spending per capita is growing more slowly than the nation, while Maryland's hospitals continue to maintain a robust range of services that all Marylanders can access. Across the country, hundreds of rural hospitals are at risk of closing, while other hospitals require greater state and local subsidies to ensure access to health care for local communities. As we provide feedback on Certificate of Need, Maryland's unique rate setting system and our All-Payer Model performance remain at the forefront of our positions.

**Key Principles**

There are key expectations that guide hospital positions on CON, the State Health Plan for Facilities and Services (State Health Plan) and related MHCC regulations. These include:

- Maryland will continue to operate under its unique waiver from Medicare's payment systems, transitioning from the current All-Payer Model to the Enhanced Total Cost of Care Model beginning in January 2019
- By 2023, Maryland must guarantee $300 million in annual savings, for both hospital and non-hospital services, through slower growth in total Medicare spending *per beneficiary* than the nation
- The Maryland Health Services Cost Review Commission (HSCRC) will continue to set hospital rates
- Other than normal Medicaid payment schedules, Maryland will not set rates for non-hospital health care providers; should the Centers for Medicare & Medicaid Services

(CMS) grant Maryland the authority to apply a Medicare Performance Adjustment (MPA) to differentiate non-hospital payments, implementation for non-hospital providers would be voluntary
- Though delivery system incentives may influence provider behavior, only hospitals, through the HSCRC's authority, are being held responsible and accountable to deliver annual Medicare savings

**Maryland's All-Payer Model and Enhanced Total Cost of Care Model**
Maryland's hospitals strongly support Certificate of Need under both models. Securing the Enhanced Total Cost of Care Model is a priority for Maryland's regulators and elected officials, and is fully supported by Maryland's hospitals. The models provide unparalleled access to health care services and prevent the cost shifting among payers that occurs in other states.

Both Medicare spending growth per beneficiary and all-payer spending growth per capita, for all services, are bound by the models. The historical waiver (prior to January 2014) only required that Maryland's inpatient Medicare prices grow slower than the nation. The enhanced model that will begin in January 2019 limits *total Medicare* spending growth *per beneficiary*, including price and volume, for all health care services.

Hospital global budgets provide powerful incentives to reduce unnecessary and avoidable use, but this incentive only applies directly to hospitals. Hospitals can indirectly affect non-hospital service use through partnerships and alignment incentives. However, non-hospital service providers are not subject to rate setting or global budgets. **Unlike with Maryland's hospitals, non-hospital revenues grow when service use and volume increase**. Therefore, any unchecked volume growth increases Medicare spending, directly driving up the total spending per Maryland Medicare beneficiary.

The HSCRC can adjust hospital rates to make up for this increase in order to comply with the overall spending limit. Certificate of Need is one of the few tools to regulate the supply of health care services. Under Maryland's current All-Payer Model, significantly eroding or removing Certificate of Need barriers would not be appropriate. Maryland's hospitals, like all stakeholders, are willing to modernize CON and the State Health Plan, but the core principles of CON should remain in place.

**Comment Guidance Responses**
Responses from the hospital field are attached to this letter. In several instances, the responses are based on our understanding of the question, but additional clarification may be needed. In those cases, we explicitly noted how we read the question.

In addition to this feedback, MHA's Certificate of Need and State Health Plan hospital work group is concurrently addressing these important issues. Further responses to the commission's questions are expected to be an outcome of the work group's issue review of these issues. For example, question 8 asks about the strengths and weaknesses of State Health Plan regulations.

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MHA's work group will first assess the overall purpose of the State Health Plan, and then review each chapter to suggest specific modifications.

We appreciate the commission's detailed and thorough approach to Certificate of Need review and Maryland's hospitals look forward to continuing to provide the commission with feedback on current considerations, potential changes and future impacts.

Thank you for your consideration.

Should you have any questions, please call me at 410-540-5060.

Sincerely,

Brett McCone
Vice President

cc: Robert Emmet Moffit, PhD., Chairman, MHCC
Ben Steffen, Executive Director, MHCC
Kevin McDonald, XXXX, MHCC
Nelson Sabatini, Chairman, HSCRC
Donna Kinzer, Executive Director, MHCC

Enclosure

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**COMMENT GUIDANCE – HOSPITAL**
**MHCC CON STUDY, 2017-18**

Please consider your answers in the context of Maryland's adoption of global budgets for hospitals, its commitment to achieve the goals of the Triple Aim, and its aspiration to bring health care spending under a total cost of care model beginning in 2019. Please provide a brief explanation of the basis for your position(s) in each area of inquiry beginning with the overarching question regarding continuation of hospital CON regulation. All responses will be part of the Maryland Health Care Commission's public record for the CON Workgroup.

**Need for CON Regulation**

Which of these options best fits your view of hospital CON regulation?

☐ CON regulation of hospital capital projects should be eliminated. [If you chose this option, many of the questions listed below will be moot, given that their context is one in which CON regulation would continue to exist. However, please respond to Questions 13 to 15.]

☐ CON regulation of hospital capital projects should be reformed.

☐ CON regulation of hospital capital projects should, in general, be maintained in its current form.

*The Maryland Hospital Association's (MHA) 2015 Certificate of Need Task Force, consisting of hospital CEOs and senior health planning and finance executives, concluded that a CON process is needed to determine the most efficient use of limited resources. The main reasons for this conclusion are that Maryland's hospitals are bound by the All-Payer Model and that Maryland's hospital payments are set by the Health Services Cost Review Commission (HSCRC).*

*As reflected in our cover letter, Maryland's hospitals strongly support CON as both appropriate and necessary under Maryland's unique All-Payer Model and the upcoming Enhanced Total Cost of Care Model (collectively, the model). Maryland's hospitals are the only health care providers accountable for achieving the financial and quality targets reflected in the agreement with the Centers for Medicare and Medicaid Services (CMS).*

*Though hospitals support CON, the group recommended that MHA convene a second work group to assess appropriate statutes and regulations, and recommend specific revisions if needed. Certain aspects of CON require modernization. MHA's Certificate of Need and State Health Plan Work Group held its first meeting on November 8 to begin this work.*

*That work group will discuss MHCC's questions, and it is expected that it will develop responses and recommendations for each. Many will not be complete by the January 13,*

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*2018, deadline, and may not be complete until the middle of calendar year 2018. As consensus is determined on specific responses, MHA staff will share those responses with MHCC on an ongoing basis.*

## ISSUES/PROBLEMS

### The Impact of CON Regulation on Hospital Competition and Innovation

1. In your view, would the public and the health care delivery system benefit from more competition among hospitals?

   *(We read this question as hospitals competing with each other for hospital services.)*

   *In the existing CON environment, there is abundant, healthy hospital competition. There are signs of competition across the state including hospital – physician partnerships, investments in information technologies and facilities and constant advertising. Competition is just as visible as before the All-Payer Model and it exists under in the current CON environment.*

   *At the same time, the model provides incentives for hospital collaboration. Hospital and regional partnerships have been formed to manage the health of the population, and large hospitals systems drive collaboration among their subsidiaries.* ***Since the beginning of the model, Medicare hospital spending per beneficiary has grown more slowly than all other health care market segments.*** *This trend has occurred without modifying CON rules.*

   *Hospitals, particularly in diverse markets, are constantly competing with one another for services. Hospital competition is good. It can drive service innovation and service efficiency, particularly since hospitals are accountable for Maryland's performance.*

2. Does CON regulation impose substantial barriers to market entry for new hospitals or new hospital services?

   *(We read "new hospitals" as a newly constructed hospital that did not previously exist, and hospital services as hospital services currently subject to CON.)*

   *Yes, CON imposes a barrier to market entry. We believe this barrier to market entry, either for a new hospital or a new hospital service, is appropriate. A core tenant of CON is to prevent duplication of services, particularly for a new hospital. Certain specialized services – transplant, cardiac surgery, etc. – require CON because there are critical levels of volume to achieve quality standards. The model requires the CON barrier, and the CON barrier supports the desired outcome of the model to reduce total spending per capita. Assuming that HSCRC and hospital rate regulation remain, HSCRC will closely*

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*regulate capital funding in hospital rates to ensure that Maryland meets the model's targets.*

*Hospital and health system operating margins, and the current market environment, from competition for physician resources to the incentives to collaborate, provide additional, inherent barriers to developing unnecessary services. These barriers naturally apply before an organization considers developing a new service that requires CON approval.*

If so, what changes in CON regulation should be implemented to enhance competition that would benefit the public?

*As reflected in our answer to question 1, there is abundant hospital competition in the current environment, and model incentives encourage hospitals to collaborate.*

*The work group is reviewing CON, the State Health Plan and other regulations, and will bring specific recommendations to the commission as the group finishes its review. Preliminarily, hospitals suggest reviewing regulations that are no longer required because they were implemented prior to specialized care standards being established. (E.g., perinatal standards may replace the need for neo-national certificate of need approval.) Any changes should not undermine the core principles of CON. The approach to CON, gathering market and regulatory information that has evolved over the years, should be modernized.*

*Other services might be examined on a case-by-case basis. A CON is not required for neurosurgery, yet it is required for cardiac surgery. Is this appropriate, and if so, why is it different?*

*There is strong market demand for behavioral health services. Hospitals believe that any regulation assessment should begin with behavioral health services given the current market dynamics and the dated state health plan regulations.*

3. How does CON regulation stifle innovation in the delivery of hospital services under the current Maryland regulatory scheme in which hospital rate-setting plays such a pivotal role?

   *As reflected in our answer to question 1, there is abundant hospital competition in the current environment and model incentives encourage hospitals to collaborate. Furthermore, Maryland's hospitals are some of the most innovative health care institutions in the United States. Maryland's All-Payer Model is an example of regulatory innovation designed to achieve the triple aim.*

   *MHCC, HSCRC and the state need to think innovatively about how care can be provided more effectively in lower cost settings, delivered where people need the services. For example, the Freestanding Medical Facility statutory changes in 2016 were designed to make it easier to reduce capacity. In achieving this transformation, the perception is that state regulatory agencies should be much more responsive and flexible to achieve the*

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*intent. The statutes and policies have been changed, but the regulatory burden, either through process or interpretation, has not. More than just the commission, other state agencies are involved. This includes the Office of Health Care Quality and Maryland Institute for Emergency Medical Systems and Services. MHCC, through statute or regulation, could play a leading role to shepherd innovation among all regulatory agencies.*

*Because hospitals are responsible for total cost of care, the commission should recognize the unique position of Maryland's hospitals when revising CON statutes and regulations. MHA's work group is reviewing CON, the State Health Plan and other regulations, and will bring specific recommendations to the commission as the group finishes its issue review.*

**Scope of CON Regulation**

*Generally, Maryland Health Care Commission approval is required to establish or relocate a hospital, expand bed capacity or operating room capacity at a hospital, introduce certain services at a hospital, or undertake capital projects that exceed a specified expenditure threshold. For a more detailed understanding of the scope of CON and exemption from CON review requirements, you may wish to review COMAR 10.24.01.02 - .04, which can be accessed at:*
*http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.24.01.**

4. Should the scope of CON regulation be changed?

*The general scope of CON is appropriate and reasonable. There are adjustments that can and should be made, but these adjustments do not fundamentally alter the CON program.*

*The work group is reviewing CON, the State Health Plan and other regulations, and will bring specific recommendations to the commission as the group finishes its issue review. See responses to question 2 and question 3 for initial reactions. If other regulatory systems are in place, the commission might consider removing certain regulatory requirements.*

A. Are there hospital projects that require approval by the Maryland Health Care Commission that should be deregulated?

*The commission might consider reviewing the capital threshold, possibly on a service-specific basis. Additionally, the commission might consider limiting the scope of services required under CON (NICU example), or creating new classes of CON review, beyond the three levels that exist – determination of coverage, CON exemption and CON approval.*

*Hospital boards are stewards of community resources, and are not going to invest in capital they cannot afford. In our answer to question 2, operating margins and the*

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*health care market are inherent barriers to unchecked service development. The availability and concentration of scarce clinical resources is another inherent barrier to service development, no matter what the community desires.*

B. Are there hospital projects that do not require approval by the Maryland Health Care Commission that should be added to the scope of CON regulation?

*There are a range of services provided at hospitals that are not covered by CON, or can be exempt from CON, if provided outside of the hospital. Diagnostic imaging, infusion and ambulatory surgery contribute significantly to covering the fixed cost and semi-fixed costs required to operate hospitals. Outside of hospitals, when Medicare volumes for services increase, total Medicare spending per beneficiary increases.*

*An alternative under question 4A is to allow hospitals to deregulate outpatient services on an expedited basis. Alternatives might include moving services to unregulated space, or allowing services to be deregulated in place, within the hospital. The latter raises several issues, but all options should be identified.*

*Our work group is discussing this, and how CON statutes and regulations should address this consideration against the backdrop of the model's constraints.*

**The Project Review Process**

5. What aspects of the project review process are most in need of reform? What are the primary choke-points in the process?

   *We recommended that MHCC staff create a detailed process map, with expected average times for each step, noting typical delays. This is not to suggest that commission staff are causing the delays, but merely to get an accurate picture of issues and items that affect the approval process.*

   *CON approval, unless contested, is supposed to be complete in 150 days. Before an application is even docketed, completion questions can cause significant delays.*

   *From the hospital perspective, MHCC regulations governing charity and uncompensated care should be moved to the HSCRC's jurisdiction. This includes the timeline for determination whether patient applies for charity care. HSCRC governs hospital rates, including charity care and uncompensated care provisions. MHCC may continue to request this information from other providers to fulfill certain requirements for CON eligibility.*

   *For hospital projects, the financial projections, including inflation, are reviewed by HSCRC to determine if the results are reasonable. Hospitals that assume a rate increase for financial feasibility will naturally require additional approval steps. They must concurrently file an HSCRC rate application requesting the rate increase reflected in the CON application.*

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6. Should the ability of competing hospitals or other types of providers to formally oppose and appeal decisions on projects be more limited?

   *Yes, the commission should consider limiting interested parties on projects. The model provides incentives to focus on a specific service area, or a specific group of beneficiaries served by the hospital. Unless there is a specialty service provided on a regional or statewide basis, at a minimum, interested parties should be limited to those that are in the hospital's service area. Commission statute limits interested parties, but this issue should be revisited. There are several definitions of service areas that might be considered.*

   *Those seeking to be interested parties to CON proceedings should prove, using data driven analysis, that the organization would be impacted by CON approval of a hospital's (or other provider's) project.*

   Are there existing categories of exemption review (see COMAR 10.24.01.04) that should be eliminated?

   *This issue will be considered by the work group.*

   *The CON exemption review process is arduous, requiring significant time and effort before the commission grants an exemption. The main difference between a CON exemption request and CON approval is the allowance of interested parties. However, a CON exemption request requires much of the same information and many of the same review steps.*

   *The commission might simplify the requirements to grant CON exemptions. These might be considered on a service-specific basis. If the commission is concerned about quality of care, the licensure requirements could be reviewed and augmented.*

   Should further consolidation of health care facilities be encouraged by maintaining exemption review for merged asset systems?

   *The exemption for merged asset systems should continue. The model creates incentives for cooperation and collaboration among hospitals, health systems, and community organizations. We should not erect barriers that prevent hospitals from operating efficiently.*

7. Are project completion timelines, i.e., performance requirements for implementing and completing capital projects, realistic and appropriate? (See COMAR 10.24.01.12.)

   *In general, completion timelines and performance requirements are appropriate. The commission might consider reviewing the impact on total cost of care growth/savings and quality performance.*

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**The State Health Plan for Facilities and Services**

8. In general, do State Health Plan regulations for hospital facilities and services provide adequate and appropriate guidance for the Commission's decision-making? What are the chief strengths of these regulations and what do you perceive to be the chief weaknesses?

   *The chief strength of these regulations is the idea that there should be "standard" criteria to determine the need for a project. However, incentives in the Maryland model directly affect the demand for services. State Health Plan criteria deal with providing an adequate supply of services to meet the demand.*

   *The regulations are static, and most haven't been updated in many years. The inpatient psychiatric services chapter has not been substantially updated in 20 years. Meanwhile, the state closed several state-owned psychiatric facilities. The State Health Plan needs to be updated, and flexible enough to account for changes in emerging technologies like telehealth as well as technologies that don't exist yet, but will shape future health care delivery.*

   *As reflected in our cover letter, MHA's work group plans to begin its issue deliberation by discuss the purpose and goals of the State Health Plan. The work group then plans a chapter-by-chapter review of the plan to suggest revisions and modifications. We expect this process to continue concurrently with the commission's work group.*

9. Do State Health Plan regulations focus attention on the most important aspects of hospital projects? Please provide specific recommendations if you believe the regulations miss the mark.

   *See our response to question 8, in particular the last paragraph of our response.*

10. Are the typical ways in which MHCC obtains and uses industry and public input in State Health Plan development adequate and appropriate? If you believe that changes should be made in the development process for State Health Plan regulations, please provide specific recommendations.

    *The State Health Plan should be more regularly reviewed and updated.*

    *When State Health Plan chapters are revised, commission staff create a stakeholder work group to provide input and feedback. This feedback is then synthesized by commission staff into a series of recommendations, and a revised chapter is drafted. The commission will solicit informal, then formal public comments. These comments receive written responses from staff that are shared with commissioners. However, oral comments are*

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*not considered at the public meetings. The commission should allow stakeholders the opportunity to comment on staff recommendations at the meeting, similar to the HSCRC process.*

*At a minimum, at the end of this review process, when the commissioner-led work group releases its final recommendations for commission action, the full commission should allow presentations and comments before taking action.*

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**General Review**
**Criteria for all Project Reviews**

*COMAR 10.24.01.08G(3)(b)-(f)) contains five general criteria for review of all CON projects, in addition to the specific standards established in the State Health Plan: (1) Need; (2) Availability of More Cost-Effective Alternatives; (3) Viability; (4) Impact; and (5) the Applicant's Compliance with Terms and Conditions of Previously Awarded Certificates of Need.*

11. Are these general criteria adequate and appropriate? Should other criteria be used? Should any of these criteria be eliminated or modified in some way?

    *The MHA work group is reviewing the State Health Plan. Recommendations will be shared with the commission when our process is complete. At a minimum, hospital requirements for charity/uncompensated care are not needed, or, should fall under HSCRC jurisdiction.*

    **CHANGES/SOLUTIONS**

**Alternatives to CON Regulation for Capital Project**

12. If you believe that CON regulation of hospital capital projects should be eliminated, what, if any, regulatory framework should govern hospital capital projects?

    *Maryland's hospitals strongly support the continuation of CON requirements. CON is appropriately required in light of Maryland's All-Payer Model. We are reviewing individual services to determine whether certain regulations are no longer required because other clinical or application standards have been established.*

    *Absent another mechanism to hold non-hospital service providers accountable for achieving model targets, the commission must continue to regulate the supply of services.*

13. What modifications would be needed in HSCRC's authority, if any, if the General Assembly eliminated CON regulation of hospital capital projects?

    *See our response to question 12.*

14. Are there important benefits served by CON regulation that could be fully or adequately met with alternative regulatory mechanisms? For example, could expansion of the scope and specificity of hospital licensure requirements administered by the Maryland Department of Health serve as an alternative approach to assuring that certain hospital facilities and services are well-utilized and providing an acceptable level of care quality, with appropriate sanctions to address under-utilization or poor quality of care? Are there ways (other than those touched on in earlier questions) in which the regulation of hospital charges could be adapted as a substitute for CON regulation?

    *From a hospital perspective, the HSCRC serves as the chief hospital regulatory body. HSCRC and the Maryland Department of Health are leading the negotiations to extend Maryland's All-Payer Model. HSCRC has imposed global budgets that create much different incentives to constrain avoidable and unnecessary health care service use. We do not propose that HSCRC set rates or otherwise regulate non-hospital providers, but we would remind the commission that hospitals are already heavily regulated.*

    *Though hospitals support the overarching CON principles, other regulatory requirements might be leveraged to appropriately regulate other health care services. Licensing and/or certification requirements should be explored further.*

    *Changes to regulatory mechanisms, particularly out of MHCC's scope, may require a reallocation of resources away from MHCC to other state agencies.*

**<u>The Impact of CON Regulation on Hospital Competition and Innovation</u>**

15. Do you recommend changes in CON regulation to increase innovation in service delivery by existing hospitals and new market entrants? If so, please provide detailed recommendations.

    *See our response to question 3. Maryland's hospitals are innovators. The hospital marketplace provides an appropriate balance of competition and collaboration. By adopting, supporting and extending the model, the s, through HSCRC, has given hospitals the implicit directive to collaborate and improve the health of the population. Global budgets are driving innovative alignments of hospitals, physicians and post-acute providers.*

    *MHA's work group is reviewing CON, State Health Plan and other regulations to determine specific revisions.*

16. Should Maryland shift its regulatory focus to regulation of hospital and health systems merger and consolidation activity to preserve and strengthen competition for hospital services?

    *No, Maryland should not focus on regulating mergers and consolidation activity. This question suggests that mergers and acquisitions reduce hospital competition. Maryland's hospitals do not support this implied assertion.*

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*In fact, hospital mergers, consolidations and affiliations have strengthened health care service delivery in Maryland. There are several examples of the benefits of mergers and consolidations eliminating fixed costs and generating system savings. Three examples are: the consolidation of hospital services in Alleghany County, the proposed conversion of small acute care hospitals in Easton and Havre de Grace to emergent and outpatient facilities, and eventual redevelopment of hospital facilities in Prince George's county that previously required significant public subsidies (University of Maryland Capitol Region Health.)*

## Scope of CON Regulation

17. Should the scope of hospital CON regulation be more closely aligned with the impact of hospital projects on charges?

    *Without MHA's work group finishing its issue review, we cannot answer this question with certainty. However, the model limits all-payer per capita growth and Medicare payment per beneficiary growth. Any rate increase to cover capital expenditures will affect these growth rates. Therefore, hospitals must reduce avoidable and unnecessary service use to general additional savings, or the HSCRC must regulate hospital payment rates to maintain compliance with the model.*

    *Non hospital providers have the ability to grow volume to pay for capital and operating expansions. Unlike hospitals, these providers are not subject to global budgets, and therefore revenues will increases as volumes increase.*

    A. Should the use of a capital expenditure threshold in hospital CON regulation be eliminated? For example, should hospital capital projects or certain types of hospital project only require a CON if the hospital seeks an increase in its global budget to cover project-related capital cost (depreciation, interest, and amortization) increases? Alternatively, should CON regulation be based on the overall impact of projects on hospital revenues (related to coverage of both capital and operating expenses, which could increase substantially even for low cost projects if new services are being introduced?)

       *Modifying or removing the capital expenditure threshold should be considered by the commission, including increasing or decreasing the threshold for different services.*

       *Unless HSCRC grants a hospital rate increase, no additional revenues are added to the system for approved hospital projects. The hospital provider, or parent health system, is at risk for having the resources to cover capital expenses. Operating revenues may increase from market shift, or, the hospital has the ability to file a rate application.* ***However, Maryland's all-payer per capita growth and Medicare spending per beneficiary growth is ultimately capped by the model and HSCRC regulates hospital revenues to ensure compliance.***

       *A different approach might be to estimate the impact of the project on total cost of care growth, particularly for non-hospital services. This could be done when*

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*evaluating a CON application, or, determining that services should be added or removed from the scope of CON regulations.*

B. Should Maryland's system of hospital rate regulation include capital spending growth targets or capacity growth targets that shape the scope of CON regulation? If so, how would this work? For example, should CON regulation be redesigned to move away from single project review(s) for a multiple hospital system to a broader process of reviewing systems resource development needs and priorities? Such a process could resemble a periodic budget planning process with approval of a capital spending plan that incorporates a set of capital projects for a given budget period.

*We do not support this approach. The hospital market balances competition and collaboration. The commission should review each project on its individual merits and should not pre-determine capital projects for a given period. This would stifle innovation and the ability of the market to determine the most efficient use of capital, which exists under the current CON regulatory umbrella. We do not support deregulation of CON, and we do not support the commission usurping health system management and planning functions.*

*Maryland's rate regulation system should provide hospitals adequate capital funding. When the rate setting system was developed, monies were not placed in rates for future replacements. Rather, HSCRC would review and approve hospital rate increases to cover the cost of capital at the time of replacement. Under a fixed revenue system, HSCRC might consider revising the historic Capital Facilities Allowance that provided hospitals with a benchmark for capital funding. MHA's work group may explore this issue further.*

18. Should MHCC be given more flexibility in choosing which hospital projects require approval and those that can go forward without approval, based on adopted regulations for making these decisions? For example, all projects of a certain type could require notice to the Commission that includes information related to each project's impact on spending, on the pattern of service delivery, and that is based on the proposals received in a given time period. The Commission could consider staff's recommendation not to require CON approval or, based on significant project impact, to require the hospital to undergo CON review.

*This area is worth further pursuit by the commission. Ideally, the commission should strike a balance between flexibility and clear, unambiguous rules. The commission might consider adopting policy principles in regulation to establish this flexibility. These policy principles should be reviewed from time-to-time with respect to Maryland's performance under the future Enhanced Total Cost of Care Model. The policy principles may reference incentives to expand or contract types of service providers, steered by having the flexibility to determine which providers or projects require CON approval.*

*If granted flexibility, a key determinant should be a data-driven analysis of a project's impact on total cost of care. This analysis should be prepared by the potential applicant, and validated by MHCC and HSCRC staff.*

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19. Should a whole new process of expedited review for certain projects be created? If so, what should be the attributes of the process?

    *The previous MHA CON Task Force discussed a "fast track" approach for projects with no interested parties. Other possible include no assumption of hospital rate increases or the project demonstrating significant cost savings.*

**The Project Review Process**

20. Are there specific steps that can be eliminated?

21. Should post-CON approval processes be changed to accommodate easier project modifications?

22. Should the regulatory process be overhauled to permit more types of projects to undergo a more abbreviated form of review? If so, please identify the exemptions and describe alternative approaches that could be considered.

    *See our response to question 19. This question is somewhat duplicative.*

23. Would greater use of technology including the submission of automated and form-based applications ion improve the application submission process?

    *Questions 20 through 23 will discussed by the MHA work group.*

    *In general, the commission should identify steps that add little or no value to the CON approval process. Several areas should be considered, including the charity care policy, cost per square foot benchmarks, etc. The commission should ask whether an incentive that created the CON requirements is still valid, or, has the incentive been superseded by other regulatory actions, innovation or market forces. Commissioners and the legislature should not hesitate to eliminate steps that are no longer necessary, but have not changed because there has been no real incentive to change. We agree with commission staff that "rules matter." It's time to review the rules and eliminate those that are unneeded.*

**Duplication of Responsibilities by MHCC, HSCRC, and the MDH**

24. Are there areas of regulatory duplication in the hospital capital funding process that can be streamlined between HSCRC and MHCC, and between MHCC and the MDH?

25. Are there other areas of duplication among the three agencies that could benefit from streamlining?

    *MHA's work group will discuss these questions and provide specific responses to the stakeholder work group. Questions 24 and 25 are broader than CON and state health plan review. However, responding to these questions provides MHA's work group the opportunity to comment more generally on MHCC and its mission.*

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*In our response to question 11, the general standard for charity care for hospitals should be moved to the HSCRC's authority.*

**Thank you for your responses. Remember that it will be helpful if you provide a brief explanation of the basis for your position(s) and /or recommendation(s) in each area of inquiry**.

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