



Maryland
Hospital Association

August 23, 2017

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 the Maryland Hospital Association's 64 member hospitals and health systems, we appreciate the opportunity to comment on the Maryland Health Care Commission's (MHCC) July 20, 2017, revisions to the State Health Plan for General Surgical Services. The proposed changes significantly differ from MHCC's April 20, 2017, draft.

Proposed Exemptions from CON Review

MHCC staff propose the commission be allowed to issue an exemption from Certificate of Need (CON) review for surgical capacity for the following:

- The office of "one or more health care practitioners or a group practice," as defined in section 1-301 of the Health Occupations Article, seeking to establish an ambulatory surgical facility with two operating rooms
- A general hospital with two or more operating rooms seeking to establish an ambulatory surgical facility with two operating rooms, in conjunction with conversion of the hospital to a freestanding medical facility; the ambulatory surgical facility would share a campus with the freestanding medical facility or be immediately adjacent to the freestanding medical facility, if it seeks such an exemption:
 - In conjunction with an exemption to convert to a freestanding medical facility; or
 - After the issuance of an exemption to convert a general hospital to a freestanding medical facility and prior to the closure of the general hospital
- A general hospital seeking to establish an ambulatory surgical facility with two operating rooms in conjunction with the closure of two dedicated outpatient or mixed-use operating rooms

Issues for Consideration

These proposed changes differ significantly from previous considerations for CON exemption. In earlier staff proposals, a CON exemption to open a two-room ambulatory surgical facility (ASF) could only be pursued if the two-room ASF was the result of expanding from a single room physician outpatient surgery center (POSC) to a two-room ASF, or, the combination of two, single room POSCs into an ASF. There were also geographic restrictions to open such a facility.

The July 20 draft allows health practitioners, or a group practice, to pursue a two-room ASF without having to go through the CON process, despite not having an existing POSC or being subject to any geographic limitations. Hospitals may also pursue a CON exemption to open a two-room ASF, but only by closing two hospital-based operating rooms.

First, there are several unanswered questions about this proposal:

- Are hospitals considered “practitioners or a group practice” as defined by section 1-301 of the Health Occupations Article? (In reading section 1-301, we conclude that hospitals are not defined as a “practitioner or a group practice,” but would appreciate if MHCC would confirm.)
- If a health system has a physician services subsidiary that meets the definition of “group practice” in section 1-301 of the Health Occupations Article, would this subsidiary be permitted to pursue a two-room ASF under a CON exemption?
- May a hospital engage in a joint venture with a practitioner or group practice to pursue a two-room ASF? If so, must the hospital be a minority owner?
- May hospitals establish a two-room ASF, with the closure of two outpatient or mixed-use hospital operating rooms, at any location, or must it be on the hospital’s campus (provided that all other general standards are met)?

Second, the proposal creates a double standard for different types of service providers to pursue a two-room ASF under a CON exemption. As reflected in our April 2017 comment letter, we supported allowing hospitals to pursue an ASF by closing two hospital operating rooms. But under this revised proposal, non-hospital providers can increase overall system capacity under an exemption, yet hospitals can only exchange capacity under the same exemption. A practitioner or group practice, often a physician or group of physicians backed by a larger stakeholder, may request approval for a two-room ASF where no such facility existed before.

It seems more logical to allow a CON exemption in a capacity *exchange* rather than a capacity *expansion*, as the most recent draft proposes. If restrictions are loosened to create ASFs from the non-hospital market, then hospitals and health systems should be permitted to do the same. Hospitals recognize that if permitted to deregulate operating rooms, they would face financial and operational decisions because the Health Services Cost Review Commission would reduce the hospital’s global budgeted revenue cap. Under the All-Payer Model, hospitals and health systems are evaluating ways to operate more efficiently and effectively to reduce health care spending.

Third, under Maryland’s All-Payer Model, including the Model’s proposed progression plan, hospitals are the only service providers that can be held accountable for total cost of care growth. However, under this proposal, other stakeholders would be granted a less onerous path to expand capacity, but cannot be held explicitly accountable for the revenue growth generated by that capacity. We appreciate that applicants must demonstrate the need for new surgical capacity, but

additional capacity could lead to supply-induced demand and unchecked growth in total cost of care. If supply induced demand causes revenue to grow without reducing hospital or other surgical provider volume, spending per capita increases, yet the “new” provider would be exempt from CON approval. We believe the proposed revisions should demonstrate consistency with Maryland’s All-Payer Model and its total cost of care constraints.

Finally, we reference our April 2017 letter for two additional considerations. Maryland’s hospitals continue to support the ability to seek an exemption for a two-room ASF in conjunction with the conversion of general hospital to a freestanding medical facility. Affording a health system the flexibility to maintain existing outpatient services, including outpatient surgery, will be critically important to communities if a general hospital converts to a freestanding medical facility. We also support flexibility for MHCC staff to determine optimal capacity on a case-by-case basis. Operating efficiently might require the facility to operate below 80 percent capacity, as ASF staff could be more productive when using two operating rooms.

Conclusions

We appreciate the MHCC staff’s thoughtful approach to revising the Surgical Services chapter of the State Health Plan and understand that delivery system evolution requires innovation and flexibility from all parties, particularly under Maryland’s All-Payer Model. Thank you for your consideration of our feedback.

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

Sincerely,



Brett McCone,
Vice President

cc: Eileen Fleck, Chief, Acute Care Policy and Planning, MHCC
Robert Emmet Moffit, PhD., Chairman, MHCC
Ben Steffen, Executive Director, MHCC
Katie Wunderlich, Director Engagement and Alignment, HSCRC