Maryland
Hospital Association

April 4, 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 proposed revisions to the State Health Plan for General Surgical Services. The proposed changes affect the establishment of physician office surgery centers (POSCs) and ambulatory surgical facilities (ASFs).

Proposed Exemptions from CON Review
MHCC staff are proposing several changes to the State Health Plan for ASFs. These changes include a proposal that the commission be allowed to issue an exemption from Certificate of Need (CON) review for surgical capacity for the following:

- An existing physician office surgery center with one sterile operating room that has operated for a minimum of one year may be issued an exemption that permits it to establish an ambulatory surgical facility through the addition of a second operating room
- Two existing physician office surgery centers that each has operated no more than one sterile operating room for a minimum of one year may be issued an exemption that permits it to establish an ambulatory surgical facility through consolidation of the two surgery centers to create a single ambulatory surgical facility with two operating rooms
- When a single-room surgery center proposes to expand to a two-room ASF or two single-room surgery centers combine into a single, two-room ASF, the new ASF may only be located at the current location or an immediately adjacent location. If the applicant demonstrates it is not feasible to for the proposed ASF to be established at the same location, it may propose a nearby location. Also, MHCC is proposing that the proposed ASF operate at optimal capacity, defined as 80 percent of full capacity
- A general hospital that seeks to convert to a freestanding medical facility may be issued an exemption that permits it to establish of an ambulatory surgical facility with two operating rooms on the same campus as the freestanding medical facility, if it seeks such an exemption in conjunction with an exemption to convert to a freestanding medical facility

MHA and its member hospitals and health systems support MHCC's proposed changes to the General Surgical Services State Health Plan as flexibility will help address surgical services capacity against the backdrop of Maryland's All-Payer Model. Hospitals that convert to a freestanding medical facility, by definition, eliminate inpatient capacity. These facilities should be allowed to maintain a portion of outpatient surgical capacity if the service exists at the current hospital, and therefore is "needed" at the current location. Rather than setting optimal capacity at 80 percent, we 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.

Establishing a two-operating room ASF from a POSC may improve surgical services efficiency. We support the existing location requirement for a two-operating room ASF created through a CON exemption and ask that MHCC study the impact of any expansion on total health services spending per Medicare beneficiary, since all providers collectively affect this measure under Maryland's All-Payer Model.

Other Considerations

The work group also discussed the possibility of deregulating up to two hospital-based operating rooms. Hospitals strongly recommend that MHCC consider allowing this approach, particularly when considering a CON exemption process that would allow non-hospital surgical services to expand. 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 HSCRC 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.

Several arguments were raised opposing this possibility, including "the duplicative cost" of building an ASF when hospital space exists. First, this is a business decision. Each hospital will weigh the cost of reducing its global budget and the absence of capital revenue to fund the conversion. Hospitals should have the freedom to do so. Second, hospitals could use the vacated operating room space to improve operating room efficiency or address other space constraints. Finally, if an ASF produces a positive return on investment, even at a lower price, it can contribute meaningful resources to fixed and semi-fixed expenses, such as capital and physician subsidies. Hospitals subsidize physician professional fees, particularly for Medicaid and charity patients, to provide the coverage necessary to operate the hospital safely and effectively 24-7, 365 days a year.

We support efforts by MHCC that encourage standalone POSCs and ASFs to pursue electronic medical record capabilities, and recommend that these facilities be connected to Maryland's Health Information Exchange. MHCC's Policy 7 in the revised State Health Plan reflects this.

MHCC did not recommend changing the charity care policy in its state health plan general standards. Hospital rates are regulated by the Maryland Health Services Cost Review Commission, whose statutes mandate charity care and financial assistance policies for hospitals, with the HSCRC controlling uncompensated care funding via the hospital rate-setting process. With a desire to reduce regulatory burdens, the charity care general standards for hospitals requesting a CON should reference HSCRC's authority and hospitals should not be subject to any further charity care requirements. Hospital charity, uncompensated care and financial assistance policies are heavily regulated by HSCRC and there is no reason MHCC should require this information or place an additional burden on hospitals when requesting a CON.

We appreciate your consideration of our input. Should you have any questions, please call me at 410-540-5060.

Sincerely,

Brett McCone,
Vice President