SB 337

Department of Legislative Services
Maryland General Assembly
2001 Session

FISCAL AND POLICY NOTE

Senate Bill 337 (Senator Kelley, *et al.*)
Finance

Cardiac Services - Licensing

This bill removes cardiac surgery services from Certificate of Need (CON) requirements. Instead, the Department of Health and Mental Hygiene (DHMH) must license each cardiac surgery program operated by a hospital within the State, beginning January 1, 2004.

The bill takes effect July 1, 2003.

Fiscal Summary

State Effect: DHMH special and general fund expenditures could increase $377,400 in FY 2004, of which $200,000 (special funds) is budgeted. The Maryland Health Care Commission (MHCC) special fund revenues could increase by $243,800 in FY 2004. Future year estimates reflect annualization and inflation.

(in dollars)	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
SF Revenue	$243,800	$261,500	$266,900	$272,500	$278,400
GF Expenditure	133,700	168,200	177,400	187,300	197,900
SF Expenditure	243,800	261,500	266,900	272,500	278,400
Net Effect	($133,700)	($168,200)	($177,400)	($187,300)	($197,900)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The licensure term for a cardiac services program is three years. DHMH cannot license a program or renew a license of a program in which the mortality and morbidity rates for all patients undergoing surgery in the hospital significantly exceed the mortality and morbidity rates for all cardiac surgery patients in the State. Each licensee or applicant for licensure must document: (1) a plan to staff and operate a cardiac services program; (2) adequate operating room capacity; (3) compliance with regulations adopted by DHMH; and (4) the present ability to maintain the required caseload of 350 cardiac surgery cases, 200 cardiac-related procedures, and the establishment of a cardiovascular disease prevention and early diagnostic program. DHMH must adopt regulations to implement the bill's requirements.

By November 30, 2003, DHMH must develop and adopt by regulation a standard data set for the volume and characteristics of inter-hospital transports, to be collected by the Maryland Institute for Emergency Medical Services Systems (MIEMSS). MIEMSS, with the assistance of DHMH and the hospitals providing specialized cardiac care or referring patients for cardiac services, must adopt by regulation protocols to guide the rapid inter-hospital transport of cardiac patients.

MHCC and DHMH must submit a report to the Governor and the Senate Finance Committee and House Health and Government Operations Committee by December 31, 2007 concerning the impact of removing cardiac surgery services from the CON process on: (1) health care costs in the State; (2) the quality of medical care; (3) access to cardiac surgery services; (4) bed capacity and caseload; and (5) the number of inter-hospital transports for cardiac surgery services.

Until September 30, 2005, DHMH must grant a waiver of the conditions for licensure to any cardiac surgery program that holds a CON granted on or before June 30, 2003 and applies for licensure.

Current Law: A CON is the primary method for implementing the State Health Plan and is generally required for capital expenditures, additions, or modifications to existing facilities or services, and new services. The basis for approval of a CON is need, as determined in the State Health Plan.

All hospitals in Maryland must be licensed by DHMH. To qualify for licensure, a hospital must have a CON. Hospitals that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are deemed to have met the State's standards for licensure.

Background: The CON process, employed in most states, is a cost-containment regulatory method that began in the early 1970s. CONs prohibit capital expenditures by hospitals and other health care institutions unless a governmental agency finds a need for the new health care services to be offered. Beginning in the 1980s, some states eliminated CON programs, while others modified the programs and continue to use them in combination with other regulatory programs. Overall, 27 states and the District of Columbia regulate cardiovascular services through a CON process.

In its January 2001 report, *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Phase I, Final Report to the General Assembly*, MHCC recommended that Maryland maintain existing CON regulation for cardiac surgery services citing that the CON program protects against the establishment of cardiac surgery programs with low volumes and ensures that highly specialized resources and personnel are allocated to appropriately meet community needs.

There are nine hospitals in Maryland that have a CON to provide open heart surgery services. Treatment of patients with heart disease ranges from medical therapy, using drugs, to interventional cardiology and cardiac surgery.

Specialized cardiovascular services to diagnose and treat heart disease are a major component of the acute care hospital system in Maryland (see **Exhibit 1**).

Exhibit 1

Region	Licensed Acute Care Hospitals	Diagnostic Catheterization/ OHS/Angioplasty	Diagnostic Catheterization/ C-PORT Study	Diagnostic Catheterization Only	Hospitals Providing Cardiac Care
Western MD	5	1	0	3	4
Metro DC	13	2	4	2	8
Metro Balto.	22	5	4	9	18
Eastern Shore	7	1	1	1	3
MD Total	47	9	9	15	33

Source: State Health Plan, updated by Maryland Health Care Commission

Five hospitals that offer open heart surgery are located in the Metro Baltimore region: Johns Hopkins, St. Joseph, Sinai, Union Memorial, and University Hospital. In the Metropolitan Washington area, two hospitals provide open heart surgery: Prince George's and Washington Adventist. Peninsula Regional Medical Center in Salisbury provides open heart surgery on the Eastern Shore. Sacred Heart Hospital in Cumberland opened an open heart surgery program in Western Maryland in 2000. In late 2002, an

additional hospital, Suburban Hospital in Bethesda, received a CON to provide open heart surgery. MHCC has emphasized minimum volume thresholds associated with optimal health outcomes and cost efficiency in awarding CONs for open heart surgery.

The large majority of angioplasty procedures are performed as elective procedures. The State Health Plan requires that hospitals performing elective coronary angioplasty have on-site cardiac surgical backup. This policy reflects American College of Cardiology and American Heart Association guidelines.

Nine Maryland hospitals with cardiac catheterization laboratories but without cardiac surgery services are currently providing primary angioplasty services as participants in the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) study. MHCC is using data from the C-PORT project to review and update planning policies governing the co-location of coronary angioplasty with cardiac surgery services. This review is being conducted with the assistance of MHCC's Advisory Committee on Outcome Assessment in Cardiovascular Care, composed of representatives from Maryland cardiac care programs as well as individuals with regional or national expertise in the collection and analysis of cardiac care data.

State Fiscal Effect: DHMH expenditures could increase $377,429 in fiscal 2004, which accounts for a 90-day start-up delay. The proposed fiscal 2004 budget includes $200,000 in special funds which could be used for the data collection required by this bill. It reflects $133,656 in general fund expenditures for the cost of a physician and research statistician within the Office of Health Care Quality (OHCQ) to conduct licensure inspections and analyze data on cardiac surgery morbidity and mortality. It also reflects $243,773 in special fund expenditures for MHCC, which includes $200,000 to collect, develop, and assess data that must be reported to the Governor and General Assembly as well as the cost of one health policy analyst to conduct statistical analysis on data collected. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits (OHCQ)	$121,206
Salaries and Fringe Benefits (MHCC)	38,395
MHCC Data Collection	200,000
Other Operating Expenses	$17,828
Total FY 2004 Expenditures	$377,429

Future year expenditures reflect: (1) full salaries with 4.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

MIEMSS could adopt protocols to guide the rapid inter-hospital transport of cardiac patients using existing budgeted resources.

MHCC is specially funded through fees imposed on payors and providers. As a result of the increase in expenditures, MHCC would raise payor and provider fees by an amount to exactly offset the increase in expenditures. DHMH advises that it would not charge cardiac programs for licensure. Accordingly, general fund revenues would not be affected.

Additional Information

Prior Introductions: Similar bills, SB 735 and HB 1132, were introduced in the 2001 session. SB 735 was reported unfavorably by the Senate Finance Committee. HB 1132 was not reported by the House Environmental Matters Committee.

Cross File: HB 236 (Delegate Donoghue) – Health and Government Operations.

Information Source(s): *An Analysis and Evaluation of Certificate of Need Regulation in Maryland* (January 1, 2001), Maryland Health Care Commission; Maryland Institute for Emergency Medical Services Systems; Department of Health and Mental Hygiene (Office of Health Care Quality, Health Services Cost Review Commission); Department of Legislative Services

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ncs/jr

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