

Task Force on the Discontinuation of Essential Health Services: Discussion Document

I. Executive Summary

The Fiscal Year 2015 (FY15) budget (see Section 229 of Chapter 165 of the Acts of 2014) established a *Task Force on the Discontinuation of Essential Health Services* (“Task Force”) and charged it with:

- Reviewing current hospital closure processes and all recent examples of full and partial closures within Massachusetts; and,
- Providing recommendations on ways the Commonwealth might best improve processes and policies in anticipation of future closures and market shifts.

To better support the implementation of this legislatively mandated review and report, staff has submitted the following discussion document to the full Task Force to support their conversation and future considerations.

To that end, staff encourages further discussion with regards to several statutory and policy considerations that may better prepare the Commonwealth for hospitals seeking to cease operations or discontinue essential health services. Broadly, these considerations fall into three categories for further discussion – process, planning, and policy – and include:

- Improving the collection and use of critical hospital and health needs data;
- Improving and expanding proactive health planning, including the further development of community health needs assessments to identify services which are “essential”;
- Creating proactive and cross-agency surveillance functions to better identify at-risk hospitals and services;
- Considering policies to reinforce and improve the current essential services process, including greater involvement and coordination of employee supports; and the exploration of opportunities for cross-agency collaboration to assess the impacts of discontinuations and closures; and,
- Considering adjustments to licensure laws and the creation of proactive market incentives and government stimulus to encourage providers to tailor the size and services of delivery models to meet community needs.

MEMBERSHIP & DUTIES OF THE TASK FORCE

Source: Section 229 of the FY15 GAA Budget

Membership:

- Secretary of Health and Human Services (EOHHS)
- Office of the Attorney General (AGO)
- Secretary of Labor and Workforce Development (EOLWD)
- Commissioner of Public Health (DPH)
- Executive Director of the Center for Health Information and Analysis (CHIA)
- Executive Director of the Health Policy Commission (HPC)

Duties:

- Review recent discontinuations of essential health services;
- Review recent hospital closures;
- Investigate the causes and effects of discontinuations and closures;
- Review practices in other states;
- Issue recommendations to improve the notification process; ensure access to services; ensure pro-active identification of hospitals in distress; and to impose regulatory penalties;
- Report to the Legislature by January 31, 2015.

II. Introduction

Complex community responses to recent closures of essential health services preceded a legislative request for a study of current state processes regarding “essential health services,” and how these processes can be improved.

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This request is timely and important: over the last fifty years, nearly half of the Commonwealth's acute care hospitals have closed, with 35 having fully closed since 1980.^{1,2} From a health delivery perspective, some of these hospital closures may have been appropriate due to changing health care needs, delivery reforms, and a transition to community settings, but others have left notable gaps within the Commonwealth's health care system.

All recent hospital closures in Massachusetts have been community hospitals.³ Continued closure of community hospitals underlines the need for conversation on how to better support their appropriate use to drive down costs, while maintaining high-quality and equitable access to needed services. The Commonwealth's focus on cost containment provides an important opportunity for policy makers to ensure increased scrutiny of hospital closures and service discontinuations, and perhaps more importantly, increased discussion regarding the role of health planning and correlating market incentives.

The Department of Public Health (DPH) is statutorily charged with the licensure of these facilities, and has substantial regulatory authority through the Determination of Need (DON) process to oversee hospital proposal to add capacity. However, conversely, DPH has limited authority to review or affect decisions regarding both full hospital closures and the discontinuation of certain defined "essential services" by hospitals that will continue to operate. Often, the final disposition of full closure by a stand-alone hospital is resolved through bankruptcy proceedings and the judicial process.

On November 6, 2014, Quincy Medical Center (a Steward Family Hospital, Inc.) announced its intent to close effective December 31, 2014. On the same day, the state's Center for Health Information and Analysis (CHIA) reported that from 2009 to 2012, statewide inpatient discharges declined by 3 percent.⁴ Whether this trend continues, reverses, or stabilizes, the Commonwealth should anticipate and prepare for possible closures in years to come, and use the insight gained from past experience to better prepare for future health service disruptions.

To that end, staff have reviewed past essential health services closures and considered regulatory mechanisms used in other states to identify potential opportunities to improve the Commonwealth's processes, planning, and policies. Based on this analysis, staff has identified a number of considerations for further discussion by the Task Force to better protect the public when hospitals intend to close or discontinue essential services.

III. DPH Regulation of Hospital Closures and Discontinuance of Essential Health Services

The Department of Public Health (DPH) licenses 66 acute care hospitals on 80 campuses through the authority of Section 51G of Chapter 111 of the Massachusetts General Laws. Under this section, these hospitals, ranging from large academic teaching hospitals, to the 46 smaller, community and disproportionate share hospitals,⁵ are required to notify DPH 90 days prior to any closure or discontinuation **of any service** they are licensed to provide. This notice must include:

- How many patients are using the service to be closed;
- How the closure might impact patients;

¹ American Hospital Association, Hospital Guide Issue and Hospital Statistics, various years

² Of these 35 closures, four (not including Quincy Medical Center) occurred since the creation of MGL Chapter 111, Section 51G.

³ <http://www.mhalink.org/Content/NavigationMenu/AboutMHA/HospitalDirectory/HospitalClosuresMergersAcquisitionsandAffiliations/default.htm>

⁴ <http://www.mass.gov/chia/researcher/hcf-data-resources/regional-hospital-services/>

⁵ <http://www.mass.gov/chia/researcher/hcf-data-resources/massachusetts-hospital-profiles/introduction-to-hospital-cohorts-list-and-guide.html>

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- Intended date of closure; and
- The names and addresses of all known organized health care coalitions and community groups in the service area.

Following notification of a hospital's intent to fully close a campus *or* discontinue an **essential health service** (see sidebar),⁶ a public hearing must be conducted at least 60 days before the hospital's proposed discontinuance date. In addition, DPH must publish a notice of legal hearing in local newspapers in the service area at least 21 days before the hearing. However, exemptions from the public hearing requirement can occur if another licensee will offer the same service at the same site without interruption, or if the hospital will provide the same service at a new site within five miles of the original site without interruption. In circumstances where the exempted services may in fact be deemed "essential," the Commissioner of Public Health may also require the closure to follow the essential services hearing process.

Thus, if the hospital notifies the Department at the minimum of 90 days before a proposed discontinuation, the Department must publish information about a public hearing within 9 days of notice, and must schedule a public hearing to take place within 30 days of notice to meet the legal timeline requirements. During the public hearing, the hospital must describe the service(s) to be closed and outline plans for alternate access to said service(s). Any interested parties must have an opportunity to comment on the hospital's proposal.

Within 15 days of the public hearing, DPH must determine whether the service proposed to be discontinued is necessary to preserve access or health status in the hospital's service area. This determination is based upon all relevant information available to the Department, and testimony provided to DPH by either the hospital or concerned citizens, including: evidence presented at the public hearing; the current utilization of the service as provided by the hospital; the capacity of alternative delivery sites to provide the service as identified by the hospital; travel times to these alternative delivery sites; and the clinical importance of the ability of the community to access the service. At this time, clinical importance is largely determined by available incidence data, community testimony, and any known statewide capacity concerns. Community level data and needs assessments are not currently part of the review process.

Cases in which a service is not deemed necessary to preserve access and health status in the hospital's service area require no further action by the hospital prior to proceeding with the proposed discontinuation. However, when DPH determines that the service to be discontinued is necessary, the hospital must submit a plan for assuring post-discontinuation access. This plan, which must be submitted within 15 days of DPH's determination, must include:

WHAT ARE ESSENTIAL HEALTH SERVICES?

105 CMR 130.020 provides that Essential Health Services include the following outpatient services:

- Dental;
- Psychiatric and mental health;
- Reproductive health.

Essential Health Services also include any other campus or service(s) a hospital is licensed for that is not an exempted service.

The "Exempted Services" are:

- Skilled nursing facility service;
- Intermediate care facility service;
- Cardiac catheterization service;
- Chronic care services;
- Hematopoietic progenitor/stem cell collection, processing, and transplant services or clinical transplant programs;
- Trauma services provided in designated trauma centers;
- Primary stroke care; and
- Medical control services.

The Commissioner of Public Health can require a public hearing if he/she determines an exempted service is essential or if all services are being discontinued at a campus.

⁶ Section 51G applies to both closures of essential health services and full hospital closures.

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NOTIFICATION PROCESS:

Source: MGL Chapter 111, Sections 51G and 56; Chapter 105 CMR 130

Days Before Closure/Action Required:

90 Days: Hospital Notifies DPH of a closure or discontinuation of a licensed service. Public Hearing Scheduled and Noticed.

81 Days: DPH must publish public hearing notice.

60 Days: Public Hearing.

45 Days: DPH determination: necessary service?

30 Days: If necessary, hospital submits closure plan for transition.

20 Days: DPH completes plan review, approves or sends back for improvement(s). Hospital replies in a “timely manner”.

0 Days: Closure. DPH begins to monitor post-closure community health needs.

- Information about use of the facility or service to be closed;
- Information, plans, and protocols regarding alternative health services (i.e. where they are, and how patients can access them); and,
- Provisions for continuity of care.

If the plan is inadequate, DPH may request correction, and the hospital is required to reply in a “timely manner.” Following closure or discontinuation, DPH monitors implementation of the hospital’s plan to preserve access, and within one year of closure, prepares a post-closure report that evaluates the impact of closure on access to the necessary health service. Lack of resources for dedicated review, pro-active surveillance, and accurate impact measurement based on comprehensive health planning activities present challenges as DPH assesses continued access.

It should be noted that Section 56 of Chapter 111 of the Massachusetts General Laws (MGL) grants DPH the power to impose fines for failure to comply with section 51G (and other licensing-related sections). The fines are not more than \$500 for a first offense, and not more than \$1,000 for a subsequent offense. Section 56 also authorizes the Department to enjoin

any violation of 51G.⁷ Functionally, it is unclear how DPH might operationalize this section of law beyond the fines themselves.

IV. Recent Examples of Service and Hospital Closures in Massachusetts

Staff reviewed all recent closures of hospitals that have resulted in 1) full closure within the last decade, as well as 2) the discontinuation of essential service lines, all occurring within the last two calendar years. A full description of these closures are submitted as addenda to this report (please see Addendum A and Addendum B).

In summary, over the last decade, four hospitals have proposed closures of their campus. Two were full service acute hospitals, which ultimately ended up becoming smaller facilities with emergency departments (North Adams Regional Hospital or “NARH”, and Hubbard). A third was a specialty hospital whose services were being provided more efficiently elsewhere in the community and was therefore closed completely (Radius). In these cases, the hospital failed to notify the state according to the requirements of statute and the hospital’s license under DPH regulation. The fourth announced its closure date as this Task Force was created; its future is still uncertain (Quincy Medical Center).

⁷ Section 56 also authorizes “imprisonment for not more than two years” as a punishment for a subsequent offense. This power has never been used, and it is unclear procedurally exactly how it would be used.

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In two cases of full closures, some services remained, or were restored at some capacity. In all three completed closures (*Note: outcome of Quincy Medical Center is still pending*), the truncated nature of the notification process prevented the state from conducting thorough reviews, and in the case of North Adams, DPH was unable to conduct a public hearing.

A complete or substantial discontinuation of an essential service within a hospital also triggers the essential services review process. In the last two years, DPH conducted seven hearings in response to notifications regarding the discontinuance of all, or a substantial part of, an essential service.

In contrast to full hospital closures, hospitals proposing a service discontinuation within the last two calendar years complied with the Department's 90 day notice. In some cases, public interest was limited. In other cases – all relating to behavioral health services – the public hearing yielded substantial public interest and comment, ultimately leading to changes in proposed plans by the hospitals in response to this public pressure.

V. Closure, Service Reduction, and Health Planning Policies of Other States

Staff reviewed state policies regarding both full and partial hospital closures across several states with similar health care environments and policy complexities. The sample included Connecticut, New York, New Jersey, Minnesota, California, Oregon, and Washington.

The surveyed states required notifications ranging from 1 day (Oregon) to 90 days (Massachusetts, Minnesota, New York). Connecticut, New Jersey, New York, and California, along with Massachusetts, require analysis of available alternatives for health access. No other state requires a public hearing, although California requires a public comment period. While New York's Department of Health (NYDOH) indicates that the state can and must approve a closure, NYDOH's regulations regarding closures were recently ruled to be unconstitutionally vague.⁸

Only one state provided enforcement powers to its regulatory agency to assure state laws regarding closure are followed. In Minnesota a correction order can be issued. Failure to comply with the correction order can result in fines. However, notification is only required, and this enforcement power only applies, when patients must be relocated.

Additionally, staff's review determined that, compared to Massachusetts, some other states commit more resources per capita to health needs planning, work similar to what Massachusetts has proposed through the Health Planning Council pursuant to Chapter 224 of the Acts of 2012.

Staff further identified that two nearby states have employee-notification laws of general applicability (i.e., not specifically related to hospitals) that are of interest. New York requires employers to issue a notice 90 days in advance to employees that a layoff is approaching. Failure to issue the notice subjects the employer to a \$500 fine per day, and makes the employer liable for back pay and benefits. In New Hampshire, failure to issue 60 days notice to employees results in a civil penalty of up to \$2,500, as well as a \$100 civil penalty per employee per day for non-compliance, and liability for back pay and benefits.

⁸ <http://online.wsj.com/articles/SB10001424127887323846504579071660590864256>

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Staff review of sample states determined that in some areas, Massachusetts law provides public protections beyond those available elsewhere. While Massachusetts does not have an employee notification law, or the power to assure that state laws regarding closure will be followed, it has proposed a health needs planning process similar to processes used in other states. It also is comparable to other states regarding the timing of the hospital's notice and requirement for analysis of health care alternatives. Finally, among the states reviewed, it has uniquely strong provision for public input concerning service discontinuations and closures.

VI. Considerations for Task Force Discussion

As described, not all closures are similar in size, scope, or impact, and each has its own unique issues in terms of process, planning, and the underlying policies upon which hospital licensure and financing is built. To that end, staff has organized various considerations for Task Force discussion into three categories:

- 1) **Process**, meaning current limitations and steps that can be taken to improve the current "Essential Health Services" review and determination process;
- 2) **Planning**, meaning program linkages, cross-government convening, and data which could be leveraged and potentially wrapped around the essential services process; and,
- 3) **Policies**, meaning potential opportunities for future discussions regarding the sustainability of critical health services within our Commonwealth's communities and how state government can better support and incentivize their continuation.

Process

Context: The state currently has the same process for all cases of service reduction or discontinuation, however, incentives for hospitals to comply with the current essential services process differ depending on each hospital's unique situation. As our review of recent essential services cases highlights, fully closing a hospital is different than closing a service provided by a hospital which will continue to operate. A hospital that is closing in its entirety may not have the resources to continue core operations. A hospital that is fully closing may not have any incentive to maintain positive relationships with regulators, local elected officials, employees, or the community. Conversely, when the hospital plans to remain in operation following a service discontinuation, it is more likely to protect these relationships. Similarly, incentives for a stand-alone hospital which plans to close are different from those for a health system which plans to close a specific hospital but continue operating others in the Commonwealth. This is underscored by the fact that all recent hospital closures have failed to comply with the notice requirement of 51G.

- **Consideration (1):**⁹The Task Force should consider mechanisms to allow needed flexibility to redesign policies to recognize the differences between the closure of a stand-alone hospital, the closure of a hospital operated by a health system, and the discontinuation of a service by a hospital which will continue operation. In each instance, these policies should maintain requirements for advance adequate notice, but with sufficient regulatory powers to make sure compliance is both incentivized and met.

⁹ Note: Numbering of considerations is provided only for the purposes of facilitating discussion and does not imply a priority order.

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- **Consideration (2):** The Task Force should consider developing a system of financial supports which could be made available to hospitals to incentivize and assist good policy and management outcomes, including the safe and appropriate transitioning of patients to accessible, appropriate services, as well as of staff to accessible jobs. In considering the topic of financial supports and incentives, staff recommend the Task Force look at a variety of policy structures, including, but not limited to: decommissioning funds, existing relevant funding streams for support for community hospitals, EOLWD layoff aversion programs, modified and incentivized receivership policies, amendments to charitable status provisions, and other policy mechanisms that might accomplish the goals of patient safety, safe and appropriate closures, and where possible, early interventions.
- **Consideration (3):** The Task Force should review the state's authority to issue fines or civil penalties if hospitals do not comply with the essential services process as defined by statute and regulation. This could include review of processes for using existing power to impose civil penalties for violations of section 51G, such as establishing adjudicatory procedures for imposing such fines. The Task Force should consider whether legislation to increase the sizes of those fines is warranted and whether additional authority to issue fines or civil penalties is needed.
- **Consideration (4):** The Task Force should consider requiring hospitals to post bonds or otherwise finance an orderly decommissioning fund, or support other such financial sureties that will serve to ensure the safe "winding-down" of services and operations. A measure worth further discussion may be the consideration of current or future receivership mechanisms. The Commonwealth's recent interventions in municipalities may serve as a model for further study.
- **Consideration (5):** The Task Force should consider requiring state approval before a hospital can legally discontinue a service, perhaps by making continued provision of certain services a condition of licensure where appropriate. The Task Force should also consider requiring hospitals to submit robust, data-driven analyses demonstrating why the services they intend to discontinue are not essential. The Task Force should also consider augmenting DPH's authority, staff expertise, and cross-agency collaborations to request and analyze relevant information. As part of this consideration, the Task Force should discuss provisions for ensuring that certain non-public information remain confidential and exempt from disclosure under the state's records law.

When sufficient notice is provided, patients, regulators, employees, and communities have more time to plan for post-closure. However, when inadequate notice is provided, government agencies are restricted in their ability to review and respond to a closure, while employees and the community may be unable to communicate concerns until the facility has already closed.

- **Consideration (6):** The Task Force should consider extending notification requirements beyond 90 days for hospitals, both in cases of full closure and the discontinuance of essential services. The notification requirements could also include a requirement for advance notifications to employees and the community prior to a formal submission to the Department. This could be accomplished by requiring an "intent to file" notification to the Department prior to the formal submission, with outreach occurring to employees and the community following this preliminary notification.
- **Consideration (7):** The Task Force should consider amending the current essential services process to formally include the Health Policy Commission (HPC). Hospitals contemplating a closure or

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discontinuation of essential services should be required to provide notice to the HPC, in addition to DPH, and the HPC should be given the opportunity to provide comments to DPH concerning the potential impacts of closures and essential services discontinuations. To support such comments, the HPC should be able to request fact-specific supplemental information, including non-public information which could remain confidential and exempt from disclosure under the state's public records laws. These changes would increase opportunities for the HPC to support DPH in working together to robustly assess the impacts of service changes on costs, quality, and patient access to care.

- **Consideration (8):** The Task Force should consider amending the current notification process to formally include the Executive Office of Labor and Workforce Development (EOLWD). Currently, EOLWD is notified 60 days in advance of a closure, according to the federal Worker Adjustment and Retraining Notification (WARN) Act. Notification further in advance would align with notice given to other state agencies, and provide that office with additional time to engage with the hospital and with union representatives. Policy makers may also want to consider requiring hospitals to submit plans for employee transition to EOLWD, allowing that office sufficient time to review and make recommendations to encourage a smooth transition for employees.
- **Consideration (9):** The Task Force should consider creating a website for dissemination of information relating to pending closure processes, with links to existing job and resume posting boards, such as the Commonwealth's JobQuest website, along with additional useful information, such as the number and type of jobs affected by the closure, to allow employers to pro-actively reach available workers.

Planning

Context: The efforts of DPH, CHIA, the HPC, and other government agencies to gather important hospital and health needs data in Massachusetts is improving as the Commonwealth continues to invest in its ability to predict and prepare for – as well as diagnose and respond to – problems in the health care marketplace. For instance, the Health Planning Council's behavioral health state health plan has provided DPH with important and relevant data to be leveraged the next time a behavioral health service is threatened with closure or relocation. However, while important progress has been made, there is additional data and analysis which might further assist DPH and state government.

- **Consideration (10):** Government agencies should continue to collaborate, invest in, and share relevant data, working together to further develop collaborative information technology solutions.
- **Consideration (11):** The closure process would be improved by expanded and improved data submissions by hospitals, allowing DPH and state partners to better analyze the current state of affairs. This should include, among others, financial data and a community health needs assessment..
- **Consideration (12):** The essential services process should be better supported by creating linkages and access to data and analyses from other DPH programs, the State Health Plan, the Determination of Need program, CHIA, and HPC, among others.
- **Consideration (13):** As improved data is gathered and shared, policy makers should review that data alongside current definitions of "essential health services." This should achieve a definition that represents

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those services (inpatient and outpatient) that both 1) reflect evolved best treatment practices, and 2) directly respond to disease prevalence and community health needs (statewide and community-based).

- **Consideration (14):** The Task Force should encourage regular in-depth assessments of the health needs of Massachusetts communities. Policy makers should continue to support state health planning efforts beyond behavioral health and should consider the mechanism and amount of support provided by other states. The Task Force should revisit the optimal location and sustainable mechanism and amount for health planning activities, in order to align it with related planning efforts, such as the HPC's community hospital study, and other state data collection and analytic efforts. The Task Force should evaluate the strengths and weakness of similar efforts in other areas of state government for guidance, such as regional planning for transportation and the work of ISO-New England in planning for electric system reliability.
- **Consideration (15):** Policy makers should consider creating a proactive surveillance function within state government. Consideration should be given to such things as formalizing a cross-agency task force providing semiregular analysis and discussion of downstream "at-risk" hospitals. In doing so, policy makers will need to balance the goal of better informing government, communities and employees of the financial state of hospitals, with the risk that releasing unfavorable information could put specific hospitals at further financial risk.
- **Consideration (16):** Policy makers may want to consider providing pro-active employee services, through EOLWD, whenever a hospital's situation suggests the discontinuation of services or a hospital closure might be a possibility. Design of this program should take into consideration the potential impacts on the hospital's viability of this intervention, and be carefully designed and messaged to mitigate those impacts.

Policy

Context: DPH licenses 66 hospitals on 80 campuses. As valued community institutions, employers, and delivery agents of health services, these hospitals should continue to be supported in their efforts to serve the needs of their communities.

- **Consideration (17):** Policy makers should encourage future discussions and analysis on whether current state hospital licensure models may establish a size and service minimum that may not allow for potentially important flexibility for hospitals and communities to "right size" a delivery model to reflect actual health needs.
- **Consideration (18):** Policy makers should continue to support innovative efforts to help hospitals deliver services more efficiently. In this, policy makers should explore efforts to develop successful market incentives to drive health systems to better respond to community and statewide health needs more directly. These incentives should allow health systems to see the provision of needed services to be "healthy choices" for all – not just patients.
- **Consideration (19):** Policy makers should explore opportunities to provide a sustained funding stream to programs such as the Healthcare Workforce Transformation Fund, which provides funding to healthcare providers for tailored programs to develop their workforce to meet the needs of an evolving healthcare industry.