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STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

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June 18, 2019

George Watson
Vice President, Corporate Development
Mid-Atlantic Health Care, L.L.C.
8501 LaSalle Road, Suite 303
Towson, Maryland 21286

Re: Baltimore Nursing and Rehabilitation, L.L.C.
CON Docket No. 15-24-2366

Dear Mr. Watson:

Staff of the Maryland Health Care Commission ("MHCC") has reviewed the document entitled "Baltimore Nursing and Rehabilitation, LLC, ("BNR") Supplemental Filing to Docketed Certificate of Need Application" dated February 19, 2019. Staff requests responses to the following questions and requests for additional information on this document.

Initially, I want to respond to the "PREAMBLE" provided to the filing. The Maryland Health Care Commission ("MHCC") did not "inform" the applicant "that it would recommend approval if the HSCRC examined the proposal and supported the project." Mr. Ben Steffen informed the applicant, following the 2016 status conference, that a positive recommendation would be made by MHCC staff if the applicant chose to make the changes recommended by staff and enter the required agreements regarding the proposed project." This statement referred to a "Project Status Conference Summary, in which staff stated its willingness "to provide BNR with an opportunity to translate its concept into an actual hospital/CCF partnership, which may provide a basis for recommending approval of this project despite the weak evidence for a generalized need for additional CCF bed supply." Staff went on to state that, "If Mid-Atlantic produces an acceptable signed agreement with UMMC-Midtown and/or other Baltimore City hospitals that fully details both the planned partnership(s) and an appropriate risk-sharing arrangement, staff believes that it may be able to make a positive recommendation on the proposed project, on the basis of advancing more innovative approaches to post-acute care. Such an agreement must offer the likelihood of lowering the Medicare total cost of care for admitted patients/residents. The agreement must include a risk-sharing component in which a hospital partnering with the nursing home is willing to share its Global Budget Revenue. Essentially, the hospital will need to agree to reimburse additional days in the CCF (skilled nursing facility) out of its Global Budget Revenue in order to ensure that there is not increased utilization as a result of the arrangements. Also, the arrangement should not shift cost to Medicaid for residential

services. The Summary concluded by stating that, "Commission staff will share such agreement(s) with HSCRC, the Centers for Medicare and Medicaid Service, and the Maryland Insurance Administration ("MIA") to determine whether those agencies' find the agreement(s) to be acceptable." In subsequent correspondence, Mr. Steffen stated that he was agreeable to sharing the agreement(s) provided by BNR with the Health Services Cost Review Commission and permitting HSCRC to determine whether CMMI ("Center for Medicare and Medicaid Innovation") review is necessary." He stated that, "If BNR plans to admit privately insured patients under an agreement with the University of Maryland Medical Center-Midtown and/or other Baltimore City hospitals, Commission staff will consult with the MIA." He concluded by stating that, "It is acceptable to MHCC staff for Baltimore Nursing and Rehabilitation, LLC to have until November 21, 2016 to file one or more acceptable signed agreements(s) that meet the requirements detailed in the attachment to my August 3, 2016 letter."

PART I

1. Please describe the process, if any, used by the University of Maryland Medical System (UMMS) to decide that a partnership with the applicant was the best approach to achieving its objectives for improving the care of patients discharged from UMMS' Baltimore City hospitals to comprehensive care facilities (CCFs) and reducing the cost to Medicare and other payers of episodes of rehabilitative care in CCFs by these discharged patients. Did UMMS discuss a similar collaborative relationship with any Baltimore City CCFs or solicit bid proposals for collaborative projects of the type proposed in this application? If not, how did UMMS assure itself that the proposed partnership is the best alternative for achieving its objectives?

2. A recent article in the Baltimore Sun indicates that the applicant no longer has an agreement to lease the site identified for this project. (See link below.) Please clarify the applicant's control of this site and its continued status as the proposed site for the project.
http://www.baltimoresun.com/politics/bs-md-rifkin-20190612-story.html

3. Provide more specific information on the success in effective care management of the five Mid-Atlantic Healthcare, L.L.C. ("MAHC") facilities in Philadelphia, as referenced on page 10, that are participating in bundled payment contracts with Einstein Medical Center. Specifically, for each DRG-defined episode of care, provide information on the reduction in cost per episode achieved. Specify the time period covered by this information on reduced cost and quantify, to the extent possible, the contributing factors, i.e., how much was the reduction in cost achieved through "more effective care management," use of "lower cost services settings," "reductions in unnecessary utilization," and "quality of care improvements."

4. Please complete Table J, page 16.

5. Exhibit H states that "short stay residents" at the proposed CCF will include short term observation stays." Please clarify this patient classification or service classification.

PART II

6. Is the "Bed License Purchase" of $500,000 in the Project Budget estimate the same as the $550,000 "Purchase Price" in Part 2.3 of the "Purchase and Sale Agreement" of Exhibit K? Please clarify.

PART III

7. Does the applicant currently own the two Pennsylvania facilities listed in Exhibit I? There are no Delaware facilities listed in Exhibit I, although page 19 refers to Delaware facilities owned and operated by MAHC. Are there former MAHC facilities missing from Exhibit I?

PART IV

8. With respect to COMAR 10.24.08.05A(2) and COMAR 10.24.01.08G93)(e), MAHC developed a CCF in Charles County, Restore Health Rehabilitation Center, which opened in 2015 and, like the project that is the subject of this application, was designed to focus on short stay patients needing a course of rehabilitation following discharge from the hospital. The facility executed a memorandum of understanding with the Maryland Medicaid program agreeing that Medicaid patients would account for no less than 44% of total patient days at the facility. In FY 2017, the facility was reported to have fallen far short of this commitment, with Medicaid accounting for only 26% of total patient days. Why should MHCC view the response to COMAR 10.24.08.05A(2) and the Compliance with Previous CONs criterion as credible, given this track record for MAHC's last Maryland project and the only project for which MAHC previously received a CON?

9. With respect to COMAR 10.24.08.05A(7):

   A. Can the "hard-to-place" patient "cohort" be identified and counted in the hospital discharge data base, using the data fields for discharges to CCFs or other fields, or are estimates by case managers the only feasible approach?

   B. Can the number of unnecessary hospital patient days associated with "hard-to-place" patients, specifically those identified in Exhibit S, be quantified more precisely than the "1-3 week" report of caseworkers applied to all such patients on page 54?

   C. What is the basis for believing that "low acuity patients such as wound care and cancer patients requiring light levels of care" are "hard-to-place patients?"

   D. Cohort 3 is said to represent "a new volume of patients not currently served by nursing homes." How was an average length of stay ("ALOS") of four days determined to be an appropriate assumption for this patient population? Isn't this effectively creating an "observation" service in the SNF setting?

10. With respect to COMAR 10.24.08.05A(9), please provide more context for the MHAC "experience in the Philadelphia market" outlined on page 32.

A. Over what time period was the five-day length of stay reduction achieved? What was the length of stay prior to the reduction?

B. Was any success achieved in reducing the rate of 30-day all cause readmission of patients discharges to skilled nursing facilities (“SNFs”)?

C. What is the current ALOS in SNFs of Medicare patients discharged to this level of care from UMMC and UMMC-Midtown? How does this ALOS compare with other hospitals in the Baltimore area and with other hospitals in the state?

D. What is the current 30-day all cause readmission rate of Medicare patients discharged from UMMC and UMMC-Midtown to SNFs? How does this rate compare with other hospitals in the Baltimore area and with other hospitals in the state?

E. More generally, can the applicant provide more specific information on the “up-side” potential for the proposed project? Can it be shown that positioning itself to primarily serve patients coming out of UMMC and UMMC-Midtown will align it to serve a patient population that clearly has a higher proportion of inappropriate hospital days awaiting discharge to a SNF, a higher ALOS in SNFs, and a higher rate of readmission to the hospital than is seen in other parts of Maryland or in the state as a whole.

11. With respect to COMAR 10.24.08.05B(1):

A. The application states, on page 33, that “Nursing home volume for Baltimore City residents has increased” and “Available bed capacity for comprehensive care in Baltimore City has declined.” However, Figure 7 on page 35, shows that the “Number of Available Beds” in Baltimore City (CCF beds) was 19% higher in FY 2016 when compared to FY 2012 and that the “Average Daily Census” of CCFs in Baltimore City in FY 2016 was 4.6% lower than the same figure for FY 2012. How can these contradictory statements be squared?

B. The applicant cites “out-migration” for nursing home care from Baltimore City as a basis for finding a need for this project. However, MHCC’s analysis of the nursing home data sets available to it indicate that, in 2016, over half of the state’s jurisdictions experienced net out-migration of patient days (i.e., more patient days experienced by home jurisdiction residents out of the home jurisdiction than in-migrating patient days in the home jurisdiction experienced by residents of non-home jurisdictions). In some cases, the proportional amount of net out-migration relative to the size of the market was greater than that experienced by Baltimore City (Howard, Prince George’s, Queen Anne’s) or similar to that experienced by Baltimore City (Calvert and Worcester). In a geographically compact state and with respect to urban and suburban jurisdictions, is there a sound basis for finding a need for more bed capacity in a particular jurisdiction based on such patterns, given that the bed occupancy rates in these jurisdictions do not differ greatly and are not particularly high? Wouldn’t such reasoning, if used in regulating supply, inevitably lead to

excessive numbers of facilities and bed capacity in an attempt to counter patterns of patient migration?

Please submit six copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov).

All information supplementing the application must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, please contact me at (410)764-3261.

Sincerely,

Paul E. Parker
Director, Health Care Facilities Planning and Development

cc: Jennifer Coyne, Esquire
Kevin McDonald
Ruby Potter