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February 6, 2018

VIA HAND DELIVERY AND E-MAIL

Kevin McDonald
Chief
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

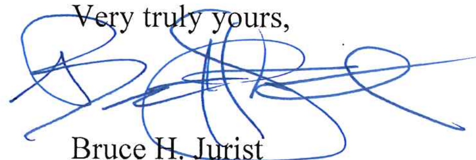
Re: <u>In the Matter of Visiting Nurse Association of Maryland's CON Application to Expand a Home Health Agency in the Lower Eastern Shore</u>
<u>Docket No. 17-R4-2407</u>

Dear Mr. McDonald:

Enclosed please find an original and six (6) copies of our client's, Visiting Nurse Association of Maryland, Response to Interested Party Comments submitted by Peninsula Home Care to be filed in the above-referenced matter.

Please feel free to contact my office should you have any questions or concerns regarding the attached.

Very truly yours,



Bruce H. Jurist

BHJ
Enclosures

cc: Mariama Gondo
William Chan

Ruby Potter
Suellen Wideman, Esq.
Todd Wiebusch
Nancy Bagwell
Peter P. Parvis, Esq.
Molly E. G. Ferraioli, Esq.
Jennifer Kline
Rich Coughlan
J. Craig Stofko, Health Officer of Somerset County
Lori A. Brewster, Health Officer for Wicomico County
Rebecca L. Jones, R.N., Health Officer for Worcester County
Roger L. Harrell, Health Officer for Dorchester County
Barry M. Ray

BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF	*	
	*	
THE APPLICATION OF	*	
VISITING NURSE ASSOCIATION OF	*	**Docket No. 17-R4-2407**
MARYLAND, LLC	*	
	*	
CON APPLICATION TO EXPAND A	*	
HOME HEALTH AGENCY IN THE	*	
LOWER EASTERN SHORE	*	
	*	

* * * * * * * * * * * * *

RESPONSE TO INTERESTED PARTY COMMENTS OF PENINSULA HOME CARE, LLC

Pursuant to COMAR §10.24.01.08F(3), Visiting Nurse Association of Maryland, LLC, ("**VNA**") responds to Peninsula Home Care's ("**PHC**") Interested Party Comments ("**PHC's Interested Party Comments**") filed in opposition to the VNA application for a certificate of need ("**CON**") to expand its home health agency into Dorchester, Somerset, Wicomico and Worcester Counties in Maryland (the "**Lower Eastern Shore Counties**").

A. Response Overview:

VNA's approach to providing home health services has always been, and continues to be, patient centered. Decisions regarding delivery of our services into new markets are analyzed, in order, based on the following considerations: (1) how to best serve the patient population; (2) how to best serve associated referral sources; and (3) how to best meet the needs of our employees. Only once the above noted considerations have been satisfied, does VNA consider whether the project is economically viable and consistent with the financial goals of management. VNA's decision to request approval of its expansion of into the Lower Eastern Shore Counties, came after it determined it could fulfill all four of the above noted considerations.

Additionally, VNA does not subscribe to the notion of attacking other home health agencies in order to justify or validate its own accomplishments (as seems to be the case in PHC's Interested Party Comments). Each agency should, and does, stand on its own merits. VNA believes that the crux of PHC's Interested Party Comments are an attack on the validity of VNA's operations and corporate motivation towards providing home health services in the Lower Eastern Shore Counties. Little, if any, commentary therein addresses the core issues of meaningful

patient choice for high quality services and the attendant effects of such choice on patient outcomes (the cornerstones of determining need). Based on the methodology employed in PHC's Interested Party Comments, VNA believes it has no alternative but to disprove PHC's spurious allegations, and unmask PHC's objections as nothing more than effort to retain its virtual monopoly providing home health services in the Lower Eastern Shore Counties (or at least so much thereof that PHC opts to service). The totality of the PHC Interested Party Comments are a hyper-technical interpretation of the controlling regulations (discounting the specific need parameters in the State Health Plan with respect to home health agencies by reference to more general requirements, typically associated with actual healthcare facilities) peppered with denunciations aimed at VNA; the result of which is a loss of "the forest for the trees", the success of which would act to deny the residents of the Lower Eastern Shore Counties the opportunity to choose among home health agencies, and to determine which provide higher quality choices for their particular needs.

B. Responses with respect to Specific Comments Made by PHC:

(1) In its introductory comments, PHC states that they only serve 3 of the 4 Lower Eastern Shore counties subject to VNA's CON request. This comment is an admission that PHC has no interest in, and should not be considered an interested party, at least in relationship to a CON for Dorchester County.

(2) PHC comments include the statement that in 2017 they provided almost 51,000 visits in the 3 Lower Eastern Shore Counties in which they provide services. Central themes in PHC's Interested Party Comments are the lack of growth in the patient population on Maryland's Eastern Shore, and that the grant of additional CONs in that area will only result in the cannibalization of the existing patient base. PHC's own representation shows this to be untrue, as they themselves have experienced a 21.85% increase in home health services provided over a

three year period. This bears out the forecasts set forth in VNA's CON application that advised of organic growth based on: (a) a population aging place (see the attached Exhibit A); and (b) a greater need and reliance on home based services due to the shortening length of hospital stays. VNA certainly is not accusing PHC of growth by cannibalization of other agencies' patients and staff, rather there has been, and will continue to be, an increase in need for high quality home health services in the Lower Eastern Shore Counties.

(3) PHC notes that it is privately owned and operated, and has local offices in Wicomico and Worcester counties. PHC's comments fail to note that its "local" ownership, includes partial (or possibly predominate) ownership by a private equity firm having its principal place of business in North Carolina. This private equity firm was originally organized in the State or Georgia, and recently reorganized in the State of Delaware, begging the issue of what is local. The degree of control exhibited by PHC's out-of-state private equity sponsor is unknown to VNA due to the opacity of the relationship (from publicly available sources). Thus, PHC's own structure refutes, at least partially, its argument regarding local control and its essentiality to the provision of home health services. VNA believes that all home health operations (by necessity) are local in nature (*i.e.*, local patients and local home health staff); however, management, especially in today's technologically advanced business setting, can be provided from any location (local "bricks and sticks" are a relic of the past, and a cost that needs to accounted and paid for).

(4) PHC contends, as a basis of their argument for being an interested party, that "[a] ***common sense approach*** makes clear that potential patients and staff of PHC will be among those 'captured' by VNA. By virtue of PHC's two physical locations on the Lower Eastern Shore and of its treatment of service area residents, PHC will inevitably lose referrals, and more importantly, valuable staff to, and will suffer financial harm as a result of this project. PHC will clearly suffer

'detrimental impact' ... if the Application is approved and if VNA reaches its annual volume projections." While PHC demands unqualified, statistical proof for every assertion made by VNA in its CON application, a "common sense" approach, regarding possible damage done by the grant of a CON, is the acceptable standard for PHC's own response. VNA readily admits that patient choice (*i.e.*, competition from a provider's standpoint) has market repercussions. What those repercussions are (from a provider standpoint) cannot be known with certainty upon grant of a CON, but will become quantified based on operational results. The only absolute assurance upon grant of a CON is the availability of high quality healthcare options for the home health needs of the residents of the Lower Eastern Shore.

VNA has experienced significant growth in many Maryland counties, and has accomplished its growth principally through the creation of its own relationships with patients, referral sources and local healthcare facilities. This is not to say that VNA is never going obtain patients, establish relationships with facilities and referral sources or hire employees from another home health agency. All of these constituencies are the beneficiaries of enhanced choice, and would be free to make decisions and have opportunities relative to the addition of a new home health provider in the Lower Eastern Shore Counties. Wholesale recruitment from competitive agencies is not, however, the VNA model, as was clearly indicated in VNA's CON application. In its prior market expansions, VNA relocated substantial numbers of home health providers, marketing staff and home care coordinators, to its newly serviced communities, adding to the area healthcare pool of talent, as opposed to merely shifting resources among providers.

(5) PHC's Interested Party Comments state that PHC "fears that VNA wants the CON to provide care in the most densely populated economically advantageous portions of the Lower Eastern Shore, while ignoring the poorer, rural areas that dominate the region. This result will unfairly impact the region's residents and PHC, which has provided needed care to the residents

of these largely poor and rural communities for more than 30 years". Throughout its comments PHC continuously references its commitment to providing services to rural, economically disadvantaged residents in a portion of the Lower Eastern Shore Counties, and that VNA has no interest in doing so[1]. This begs the question, why there so few charity home health visits being provided in the region? Based on the most current available data for the 3 Lower Eastern Shore Counties in which PHC provides services, PHC provided a total of 13 charity visits, out of the then approximately 42,000 visits they provided in those counties. Charitable visits, by all home health agencies providing services in the Lower Eastern Shore Counties, totaled only 97; this out of the almost 109,00 home health visits provided in 2014. Adequate servicing of poor, rural areas requires the provision of charitable and reduced fee visits, something that is not seen in the most recently available home health statistics.

(6) PHC asserts that the VNA's approach of not having a satellite office is somehow inferior to PHC's practice of staffing local offices. "While that approach might be sufficient for VNA's more Urban areas of the State (particularly those close to its Baltimore home base) PHC believes that it is vitally important for a successful home health agency on the Lower Eastern Shore to have a well-established presence". First, the idea, in today's world that a "bricks and sticks" facility is the only tangible notion of presence, is beyond ludicrous. Presence is currently best found in direct to home communication, either face-to-face or through various electronic means. This is particularly true with respect to a business that provides **all** of its services in a home setting, and has no need for a storefront, other than to increase costs. The pertinent regulations require no such local office, presumably for this reason. Finally, the "proof is in the pudding" as VNA's methodology has produced superlative Star Ratings, as compiled in CMS's Home Health Compare, for patient outcomes and patient satisfaction (see Exhibits B & C). VNA

[1] VNA already provides services in rural and exurban areas, provides services in disadvantaged communities and provides significant charitable services (342 visits in 2015 and 493 visits in 2016).

shares a similar overall Star Rating with PHC, and similar results with the exception of two vitally important categories: (a) how often home health patients had to be admitted to the hospital, in which VNA enjoys a 10% better results than PHC; and (b) how often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital, in which category VNA scored almost 30% better than PHC. These statistics, rather than antiquated notions, are the essential measurements for achieving the "triple aim" of improving the experience of care, improving the health of the serviced population and reducing per capita costs of health care.

(7) PHC believes that VNA has not made any effort to establish required community links. VNA understands, probably better than most home health agencies in the State, because of the number of counties in which it provides services, the absolute need for working with local communities, physician's offices, hospitals, nursing homes and continuing care communities. VNA has been very successful in cultivating these relationships in its current markets, and if it believed it could not do so in the Lower Eastern Shore Counties, it would not have requested the CON for this expansion. VNA has no desire, incentive or reason to expand into a region in which it could not be successful (both itself and the community it would service). Thus, the real question is at what point should these relationships be formed? VNA believes it is counterproductive and possibly injurious (raising or causing unmet needs) to form relationships with any of these constituencies unless it has authority to operate in the region. It is only with the support of the local communities can one hope to be successful and accepted, and VNA cannot and will not make promises it yet does not have the authority to keep. VNA is confident of its ability to succeed, based on its successes (as indicated by its 4 Star rating for patient outcomes, and 5 Star rating for patient satisfaction) in communities that are every bit as underserved, and as economically challenged as the Lower Eastern Shore Counties.

(8) PHC reproaches VNA for not providing data for the number of visits it provided in "other rural jurisdictions in the State. Specifically, PHC's Interested Party Comments state "VNA could have demonstrated the numbers of home health clients that it serves in Washington, St. Mary's, Calvert, Charles, Kent, Queen Anne's, Talbot and Caroline Counties, and the volume of services it has provided to its authorized four eastern shore rural jurisdictions is insignificant, comprising less than 6% of VNA's total clients in 2014". VNA does not actively provide service in Washington County, and has never asserted so doing. In 2017, VNA provided 11,796 home health visits in Charles County, and another 15,260 visits in St. Mary's County (largely rural Counties). In the aggregate, these visits represent 12.2% of the total visits provided by VNA in 2017, demonstrating significant growth and commitment by VNA outside of central Maryland[2]. In addition, VNA began providing services in Calvert County only in the later part of 2017 (based on a demand for services that were not being adequately provided in the County); VNA anticipates strong service results for Calvert County in 2018. With regard to the Upper Eastern Shore Counties (Caroline, Kent, Queen Anne's and Talbot Counties), PHC's comment is simply disingenuous, as PHC is well aware that the VNA was not awarded a CON for these Counties until the end of July 2017. VNA firmly believes that the success it has enjoyed in St. Mary's and Charles Counties is a function of its experience, tedious planning and tenacious execution, and there is every indication of recurring success in both the Upper and Lower Eastern Shore Counties.

(9) PHC asserts that VNA has not demonstrated and cannot demonstrate that it's proposal is more cost effective than maintaining the *status quo*. VNA rejects this premise as factually inaccurate. VNA has shown that it has managed to attain superior re-hospitalization

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[2] It should be noted that the central Maryland Counties, where VNA provides substantial home care services, are not homogeneous, and each has significant exurban and rural areas (as opposed to the City of Baltimore which singularly is a urban area).

results and avoidance of emergency room usage as scored by CMS's Home Health Compare. These results are the very essence of cost effectiveness (keeping patients from needing the most expensive healthcare services) and is the principal reason for opening the region for additional CONs. VNA, in particular, regularly delivers these cost effective results across the entire State of Maryland and sees no reason that it will not continue to do so in the Lower Eastern Shore Counties. This is the true measure of unmet need, cost effectiveness, and reducing omnibus health care system costs.

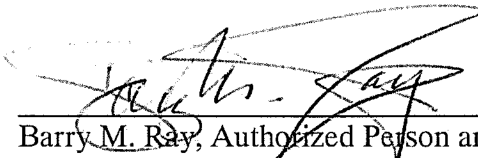
(10) Finally, PHC maintains that VNA has failed to address whether agencies with existing CONs in the Lower Eastern Shore Counties could continue to provide the services that VNA seeks to offer if VNA were granted a CON in that region. PHC by its own admission has experienced significant growth in 3 Lower Eastern Shore Counties in which they provide services, yet they maintain there is no growth and hence no need for additional agencies. Is PHC implying a vested right to any home health patient growth in the 3 Lower Eastern Shore Counties in which they provide services, and that patients in those jurisdictions have no right to have a choice based on criteria important to them? In the entirety of PHC's Interested Party Comments there was hardly a mention of how patients would benefit, only how the agency might be negatively impacted.

In addition PHC has suggested that an award of the CON for the Lower Eastern Shore Counties to VNA would, under applicable regulations, forestall a different, potentially more qualified agency, from applying for a CON in that region for a period of 3 years. VNA finds this argument to be utterly ridiculous. The Maryland Health Care Commission has established a need for additional patient choice in the Lower Eastern Shore Counties, VNA is an eminently qualified provider of such home health services (as all pertinent data indicates), and no other home health agency have been inclined to apply for a CON for this region even though the applications were

being accepted in an open process. Perhaps what PHC is really saying is that they are concerned about the competition in a region in which they have had a virtual monopoly, stripping the residents of those communities of any real home health provider choice. VNA finds it hard to imagine that PHC, which has served the area for 30 years, and certainly has established strong relationships therein, would not have the ability to survive any challenge that VNA might offer. PHC will have to work harder and better, as will VNA, but the beneficiary of such earnest efforts will be the residents of the Lower Eastern Shore Counties.

In conclusion, as noted above, VNA believes that PHC's comments are completely self-serving and the result that they propound works to the detriment of the residents of the Lower Eastern Shore Counties. VNA respectfully requests that the Commission take the forgoing Response to PHC's Interested Party comments into consideration and approve VNA's application for the CON without delay.

Respectfully submitted,

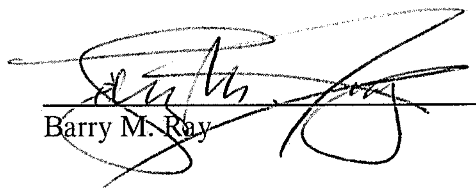


Barry M. Ray, Authorized Person and
Authorized Person and Managing Member of the entities owning VNA Home Health, LLC, the sole member of Visiting Nurse Association of Maryland, LLC

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of February, 2018, a copy of the foregoing Response to PHC's Interested Party Comments was sent by electronic mail and by first class mail, postage prepaid, to:

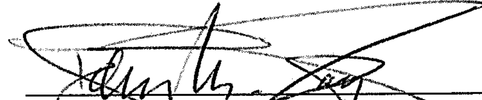
Peter P. Parvis, Esq.
Molly E. G. Ferraioli
Attorneys for Peninsula Home Care, LLC
Miles & Stockbridge
100 Light Street
Baltimore, MD 21202-1153
pparvis@milesstockbridge.com
mferraioli@milesstockbridge.com



Barry M. Ray

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to PHC's Interested Party Comments are true and correct to the best of my knowledge, information and belief.

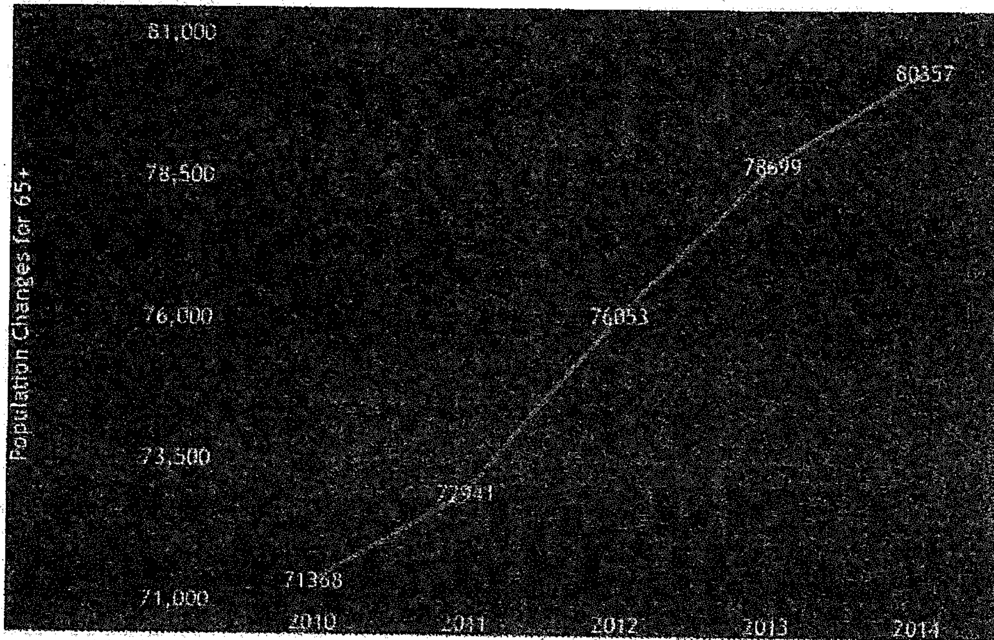


Barry M. Ray, Authorized Person, and
Authorized Person and Managing Member of the entities owning VNA Home Health, LLC, the sole member of Visiting Nurse Association of Maryland, LLC

Exhibit A

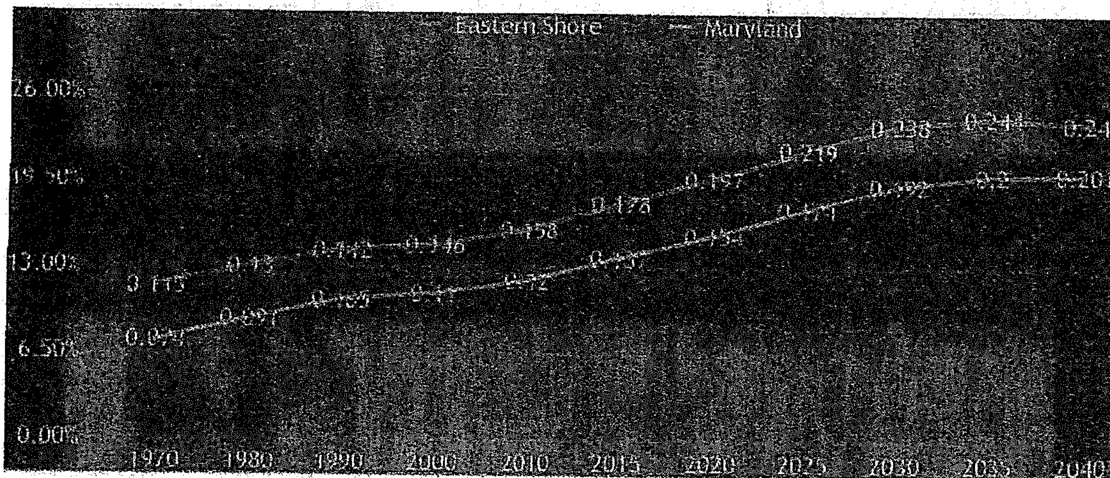
Preparing for our Gra

Figure 1: Total Population for Persons 65+ for the Nine Counties of the Eastern Shore, 2010 to 2014



Source: U.S. Census Bureau and the *Maryland* Department of Planning

Figure 2: Percent of Population Ages 65 and Over, Historical & Projected



Source: U.S. Census Bureau and the *Maryland* Department of Planning

SHORE

By MEMO DIRIKER

The Eastern Shore of Maryland is graying as the average age of our population steadily increases.

As can be seen in Figure 1, there are currently more than 80,000 residents over the age of 65 in the nine counties of the Eastern Shore who make up about 18 percent of the total population.

This demographic trend is occurring throughout Maryland; however, the Eastern Shore is aging even faster than the rest of the state (Figure 2). Why?

First, we tend to lose our younger generation to urban areas with more employment opportunities. Second, our resident population is "aging in place." Third, the Eastern Shore has become a baby boomer "retirement magnet" because of its many quality-of-life offerings (e.g., moderate climate, good health care, lower taxes, environmental beauty, and proximity to major metropolitan areas).

These demographic changes will have significant societal and economic consequences over the next two decades. To prepare, the GraySHORE Coalition, an initiative of the Business, Economic, and Community Outreach Network (BEACON) of the Perdue School of Business at Salisbury University, organized a public policy summit earlier this year.

The summit, hosted by MAC, the Lower Shore Area Agency on Aging and the 50+ Network for Creative Engagement brought over 100 stakeholders together to discuss following issues of interest related to our aging population:

- Elder care (health and wellness including lifelong learning)
- Elder shelter (housing)
- Aging and the workforce (seniors as employers and employees)
- Elder transportation (public and private)
- Economic challenges and opportunities (senior-owned and senior-serving firms)
- Lifelong learning

At the conclusion of the summit, a number of public policy recommendations were made. Some key recommendations included:

- Implement tighter (nationwide) control of costs of pharmaceuticals;
- Provide incentives for elder care, specifically, in-state senior-friendly medical care centers, to combat rising care costs;
- Increase physician residency programs in rural areas;
- Set up more rural health centers;
- Protect and increase funding for day programs for elderly and for family caregivers;
- Develop smaller housing units (for which incentives and tax credits could be given to builders and developers respectively);
- Develop "planned communities" for seniors that include medical, mental, recreation and transportation services along with commercial opportunities;
- Increase state and federal programs to support the construction of safe and affordable houses;
- Promote building codes requiring more universal design for residential construction;
- Find developers that are willing to produce smaller and safer housing units;
- Offer tax credits for home modifications for persons with disabilities or the aging;
- Support "senior-friendly" businesses and entrepreneurship for the 50+;
- Create a business model to bring in products and services for the 50+;
- Train the workforce to better serve the 50+;
- Reduce the hurdles and obstacles to entrepreneurship by the 50+;
- Support seniors as mentors;
- Offer employer tax credits for employing older persons.

We know that an aging population has more disabilities and health problems than a younger population. With today's seniors living longer with chronic diseases, they increasingly require housing that combines shelter with personal and medical care.

We also know that an aging population presents economic opportunities and challenges. Seniors can be a tremendous boom to an economy. Nationally, Americans age 50 and above control 70 percent of all U.S. wealth and account for 50 percent of all discretionary spending.

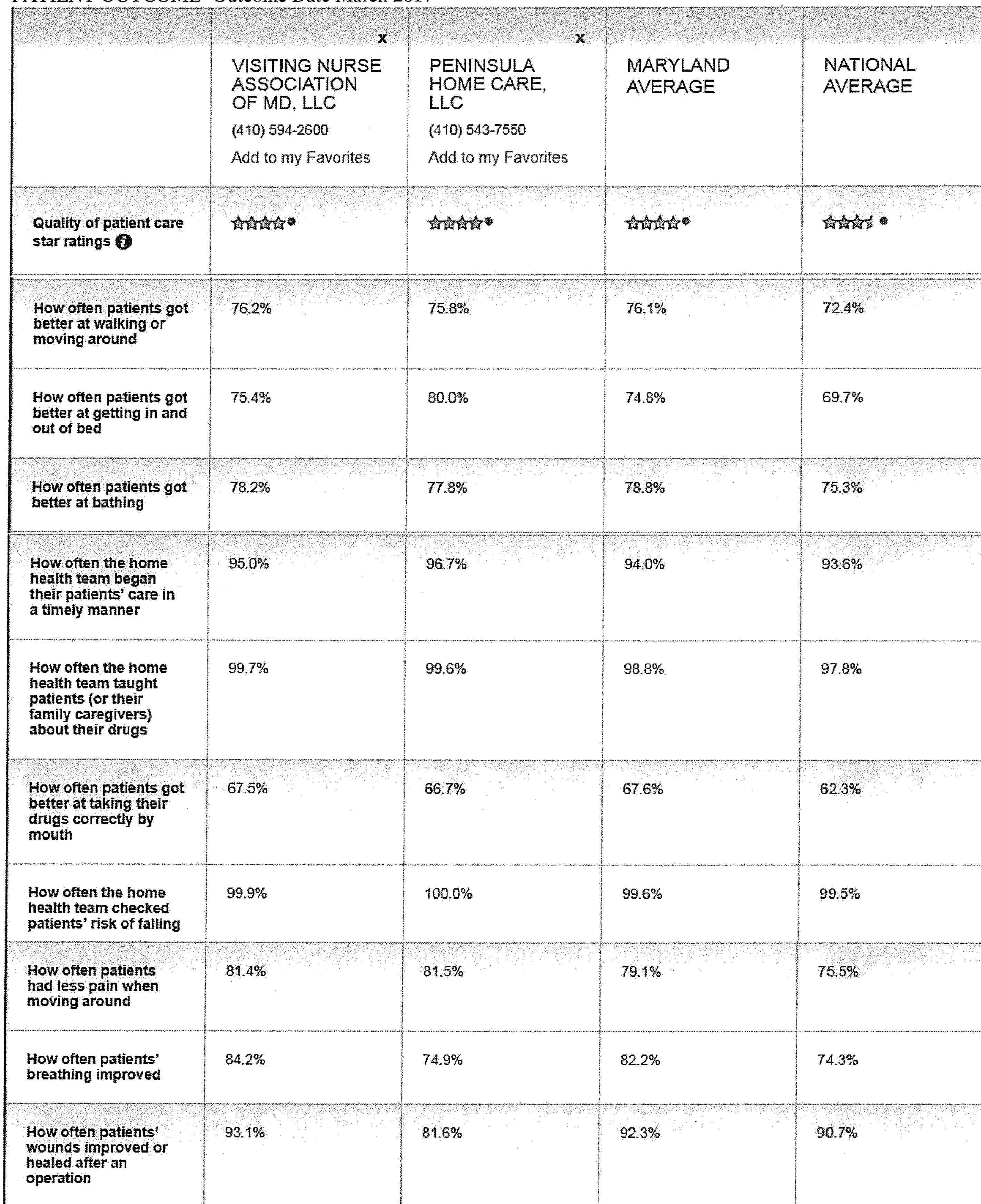
However, as seniors live longer than previous generations, they now get poorer in their later years due to depletion of resources. As these seniors exhaust their personal resources, they increasingly rely on public programs to meet their needs for shelter and care.

The time is now to make sure we have the right programs in place that will increase the positive economic impacts of an aging population and reduce the burdens on public finances over time. Not being ready is no longer an option.

For a full e-print of the report "The Graying of the Eastern Shore: An Analysis and Recommendations for 2017," contact BEACON at beacon@salisbury.edu.

Exhibit B

PATIENT OUTCOME -Outcome Date March 2017



	x VISITING NURSE ASSOCIATION OF MD, LLC (410) 594-2600 Add to my Favorites	x PENINSULA HOME CARE, LLC (410) 543-7550 Add to my Favorites	MARYLAND AVERAGE	NATIONAL AVERAGE
Quality of patient care star ratings	☆☆☆☆	☆☆☆☆	☆☆☆☆	☆☆☆☆
How often patients got better at walking or moving around	76.2%	75.8%	76.1%	72.4%
How often patients got better at getting in and out of bed	75.4%	80.0%	74.8%	69.7%
How often patients got better at bathing	78.2%	77.8%	78.8%	75.3%
How often the home health team began their patients' care in a timely manner	95.0%	96.7%	94.0%	93.6%
How often the home health team taught patients (or their family caregivers) about their drugs	99.7%	99.6%	98.8%	97.8%
How often patients got better at taking their drugs correctly by mouth	67.5%	66.7%	67.6%	62.3%
How often the home health team checked patients' risk of falling	99.9%	100.0%	99.6%	99.5%
How often patients had less pain when moving around	81.4%	81.5%	79.1%	75.5%
How often patients' breathing improved	84.2%	74.9%	82.2%	74.3%
How often patients' wounds improved or healed after an operation	93.1%	81.6%	92.3%	90.7%

	VISITING NURSE ASSOCIATION OF MD, LLC (410) 594-2600 Add to my Favorites	PENINSULA HOME CARE, LLC (410) 543-7550 Add to my Favorites	MARYLAND AVERAGE	NATIONAL AVERAGE
How often the home health team checked patients for depression	99.4%	100.0%	97.3%	97.9%
How often the home health team made sure that their patients have received a flu shot for the current flu season	80.5%	76.5%	82.8%	77.2%
How often the home health team made sure that their patients have received a pneumococcal vaccine (pneumonia shot)	79.6%	80.1%	82.7%	80.3%
For patients with diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care	99.9%	99.9%	98.1%	97.2%
How often home health patients had to be admitted to the hospital	15.0%	16.7%	15.8%	16.2%
How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital	12.6%	17.9%	12.6%	12.8%

Exhibit C

Patient satisfaction- Data period June 2017

	x VISITING NURSE ASSOCIATION OF MD, LLC (410) 594-2600 Add to my Favorites	x PENINSULA HOME CARE, LLC (410) 543-7550 Add to my Favorites	MARYLAND AVERAGE	NATIONAL AVERAGE
Patient survey summary star rating. More stars are better. Learn more	☆☆☆☆☆	☆☆☆☆•		
How often the home health team gave care in a professional way	93%	89%	87%	88%
How well did the home health team communicate with patients	90%	86%	85%	85%
Did the home health team discuss medicines, pain, and home safety with patients	88%	82%	81%	83%
How do patients rate the overall care from the home health agency	88%	82%	81%	84%
Would patients recommend the home health agency to friends and family	86%	77%	76%	78%