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Home Health Agency Advisory Group
March 18, 2015
Meeting Summary

Attendance

HHA Advisory Group Members: Jackie Bailey; Keith Ballenger; Heidi Brown; Barbara Fagan; Rosellen Fleishman; Ann Horton; Laura Hughes representing Tim Kuhn; Dr. Alan Levitt; Patrick O'Malley; Rose Nowak representing Lauren Simpson; Jennifer Sexton representing Donna McCracken; Michelle Travis representing Dawnn Williams; Roslyn Tyson.

Audience: Mohamed Badawi; Fitaw Berhe; Lori Bryan; Misayo Kawabe; Kamilla Keldiyarova; Bruce Kozlowski; Theressa Lee; Daisuke Matsno; Wendy Quair; Barry Ray; Denise Ridgely; Lamin Tunkara; Catherine Victorine; Shannon Grace Wajer; Suellen Wideman; Chris Ziegler

Commission Staff: Carol Christmyer; Linda Cole; Paul Parker; Ben Steffen; Cathy Weiss

Follow-Up to Prior HHA Advisory Group Meeting

Two concerns expressed by some members at the Advisory Group's first meeting held on February 5, 2015 were addressed. Barbara Fagan, Program Manager, Ambulatory Care Unit at the Office of Health Care Quality (OHCQ) addressed the issue raised regarding certain agencies claiming to have some difficulty with getting the agency's name on the hospital's referral list. Ms. Fagan reported that based on her conversation with Renee Webster, Director of the Hospital Unit at OHCQ, a hospital patient should be informed of all of his or her choices among home health agencies (HHAs) at time of discharge. If an HHA can make a case, with evidence, that the patient was not informed of these choices, that HHA should submit a complaint to Ms. Webster and her OHCQ staff will investigate.

Carol Christmyer addressed the second concern expressed by certain Advisory Group members regarding the use of performance measures. The concern is that non-hospital affiliated HHAs may have a more difficult time achieving high levels of performance because hospitals influence their referral pattern such that their patient population is inordinately skewed toward more complex and difficult clients. Ms. Christmyer reported that based on a comparison of performance scores for 10 selected measures used for the Five Star Ratings, there were no significant differences between Maryland's non-hospital affiliated and hospital-affiliated agencies.

Qualifying Factors for a Jurisdiction

Cathy Weiss, Chairperson, noted that the focus of today's meeting was on identifying qualifying factors for both jurisdictions and applicants. Ms. Weiss encouraged the Advisory Group to participate during

discussion and welcomed an exchange of ideas and thoughts. Ms. Weiss referred to the Background Paper on "Consumer Choice and Market Concentration" and the Table illustrating the number of parent HHAs authorized and serving in a jurisdiction, as well as the jurisdiction's market concentration based on the Herfindahl-Hirschman Index (HHI). She noted that the concept of extending consumer choice is not new; it is addressed in the current HHA Chapter of the State Health Plan.

The three qualifying factors suggested to be considered for identifying a jurisdiction as having a need for additional home health agency services include: insufficient consumer choice; a highly concentrated market; and an insufficient choice of high performing HHAs.

Insufficient consumer choice could be defined as a jurisdiction with two or fewer HHAs which served 10 or more clients in the most recent three-year period for which data is available. This is generally based on the current docketing rule in the HHA Chapter which allows an existing agency to expand its authority to serve an adjacent jurisdiction, should that jurisdiction have fewer than three agencies. It is now being suggested that this rule be extended to not only apply to existing agencies seeking to expand their service areas, but also to new entrants seeking to establish an HHA..

Another qualifying factor would be a highly concentrated market in a jurisdiction. As described in the Background Paper, the HHI is used to measure whether the HHA market in a jurisdiction is highly concentrated – that is, whether a disproportionate market share of clients are served by some agencies. The Department of Justice (DOJ) and Federal Trade Commission (FTC) use the HHI as an accepted measure of market concentration for purposes of evaluating mergers in the context of antitrust enforcement. A market with an HHI measure of 0.25 or greater would be considered by the DOJ/FTC as "highly concentrated." It is suggested that the same threshold used by the DOJ/FTC would be applied to the HHA industry for targeting highly concentrated (and, thus, by definition, less competitive) markets for consideration of additional competing HHAs. If an HHI of 0.25 or greater were established as the threshold, 15 jurisdictions would be viewed as having a high level of market concentration and, on that basis, would be eligible for the initiation of CON reviews in those jurisdictions.

Another factor for qualifying need in a jurisdiction would be an insufficient choice of high performing HHAs. It is proposed that this condition would be viewed as existing for a jurisdiction if the HHAs serving 60% or more of the clients in that jurisdiction in the most recent year for which data is available, achieved a CMS Star Ratings of less than 3.5 Stars. (Further discussion on defining a "high performing" HHA was addressed later in the meeting, with Carol Christmyer's presentation.)

Furthermore, it is suggested that a jurisdiction not be targeted for consideration of additional competing HHAs when an existing HHA serving the jurisdiction has operated for less than three years.

Discussion: Qualifying Factors for a Jurisdiction

HHA Advisory Group members discussed several issues related to identifying when a jurisdiction would qualify as having need for additional HHA services. Key points raised during the discussion included the following:

- HHAs authorized and not serving are not included in the calculation of the jurisdiction's HHI, as the HHI is based on market share of agencies serving in the jurisdiction.

- Jackie Bailey asked whether, if HHAs are authorized and not serving, could this imply that there is no need? If an HHA is not performing based on certain quality measures, would the State allow this to

continue? There are high costs for an agency to be serving a few clients and the issue of costs for providing quality services has not been addressed.

- The MHCC does not have the authority to retroactively take back a Certificate of Need (CON) for an HHA not serving all its authorized jurisdictions nor for an HHA not providing quality care.

- A question arose as to what OHCQ's authority is to remove a license for non-performance. Ms. Fagan noted that OHCQ conducts site surveys to recertify HHAs every three years. However, as noted by Ms. Fagan, OHCQ gets a snapshot of the HHA at the time of the survey. Overall, OHCQ has not found a lot of serious quality issues; no Maryland HHA has had a condition level deficiency for not meeting Medicare's Conditions of Participation (CoP). Fourteen of the 56 Maryland HHAs have deemed status, meaning that those agencies are surveyed by one of three accreditation organizations (AO). Paul Parker reminded the Advisory Group that staff is suggesting using CMS' Home Health Compare as a report card for grading an agency's quality performance, not about the infrastructure of the agency as measured by meeting Medicare's CoP.

- A competition index of .25 or greater does not imply that there is insufficient consumer choice. Rather, it means that a few HHAs serve a very large proportion of the total clients in the jurisdiction. Thus, by definition, the jurisdiction is not a competitive HHA market. Some Advisory Group members suggested that perhaps .25 is not the correct measure for HHAs.

- Referring to the information on Table 1, and using Frederick County as an example, Advisory Group members suggested that even though Frederick County is considered to be a highly concentrated market based on its HHI of 0.42, does it make sense to allow more agencies to serve Frederick County when there are 12 agencies authorized and 11 are actually serving, and the vast majority are performing at or above quality performance standards? Is there evidence that adding a twelfth HHA would enhance quality or consumer choice? Hypothetically, this approach would allow a high quality HHA to enter a marketplace dominated by lower performing HHAs. Ms. Christmyer noted that there is some empirical evidence from the nursing home sector that quality performance increased in competitive markets. (The article is appended to this meeting summary.)

- With respect to whether there should be limits on the pace of expansion and new market entry, Ann Horton suggested that in-state providers be granted preference during a CON review. Ms. Weiss responded that based on the advice of legal counsel, the Commission does not support a blanket approach to giving preference to existing in-state providers over out-of-state providers.

- In order for consumers to be able to make informed choices, it is important that HHA clients become aware of Home Health Compare to obtain information about the quality of HHA services offered. Rosellen Fleishman recommended putting the appropriate website linkages on the hospital discharge planner's notes and papers given to the hospital patient at time of discharge.

- There was general consensus that some areas of the State are underserved and single provider jurisdictions are not desired. However, rural territories are difficult to cover and serve. HHAs cannot afford to serve a few clients and drive long distances. Finding skilled nurses and physical and occupational therapists to serve in rural areas of the State is challenging. In some cases, patients cannot get home care services in their private residence and end up in the hospital. Some access is limited due to payer mix and the way services are reimbursed; for example, telemedicine consults are not reimbursable by Medicare. Since HHA services are intermittent, agencies need to train family members to assist in the care of the HHA client.

Qualifying Factors for an Applicant

Ms. Weiss introduced the three types of potential CON applicants and how they could be qualified for submission and docketing to serve a jurisdiction that is qualified as having need for additional HHA services: 1) an existing Maryland HHA; 2) an existing Medicare-certified HHA in another State, but not in Maryland; and 3) a non-HHA applicant that has no experience in operating a HHA, but has experience as a hospital, nursing home or Maryland RSA providing skilled nursing services.

For all three types of applicants, there are common qualifying factors: 1) have not had Medicare or Medicaid payments suspended; 2) have not been cited with Medicare and Medicaid fraud or abuse; 3) have been operational for at least three consecutive years; 4) can document the availability of sufficient resources (staff and financial) to implement the proposed project; 5) have a history of serving, and agrees to serve, all payer types, and has provided an acceptable level of charity care; and, 6) affirms, under penalties of perjury, that its owners and senior management, or the owners and senior management of any related or affiliated entities, have not been convicted of a felony or other serious crime.

There are suggested additional qualifications by type of applicant. For existing Maryland and non-Maryland HHAs, applicants would: 1) be required to meet Maryland's requirements as a "high performing" HHA, and 2) have not been cited for a serious condition-level deficiency in the most recent two on-site surveys, in order for its application to be considered qualified for submission and docketing.

For existing Maryland HHAs, the applicant agrees to implement the project through its existing Maryland HHA license and Medicare certification number. For non-HHA applicants, they must provide documented experience of at least three consecutive years as a licensed and accredited provider of hospital, nursing home or Maryland RSA services, including skilled nursing services.

Discussion: Qualifying Factors for an Applicant

HHA Advisory Group members discussed several issues related to identifying when an applicant would be qualified for submission and docketing of a CON application to serve a qualifying jurisdiction. Key points raised during the discussion included the following:

- Laura Hughes, a RSA representative on the Advisory Group, noted that while Maryland RSAs do not have Home Health Compare, they may collect in-house data and other quality measures. Ms. Hughes noted that even if the same data collection survey (i.e., OASIS) were used, the outcomes would be different because HHAs and RSAs serve different types of populations. RSAs having Medicare-certified HHAs in other states could provide Home Health Compare data. Other HHA Advisory Group members recognized that there is a niche for non-Medicare providers such as RSAs; many Maryland HHAs also have RSA licenses.

  Ms. Hughes also questioned the factor of no history of fraud and abuse. If the incident occurred in the past and a plan of correction had been implemented, would that be acceptable?

- There was general agreement that all applicants be operational for at least three years and agree to serve all payer types. For non-HHA applicants, being licensed and accredited were considered by some as a way of measuring quality and an important qualification.

- Recognizing the difficulty for enforcing certain requirements, such as serving all payer types and evaluating a non-HHA applicant's track record of quality performance, the concept of awarding a CON with conditions was introduced. In general terms, a CON could be granted with conditions that

are agreed upon by the applicant. Should such conditions not be met, then the applicant would agree to voluntarily relinquish its HHA license. Advisory Group members suggested that the timeframe for which a non-HHA applicant should be assessed for meeting HHA performance measures and other CON conditions should be at least two years post initial HHA Medicare certification.

Establishing Thresholds Defining High Performance

Carol Christmyer presented a three-tiered definition of a "high performing" home health agency as follows: achievement of a minimum 3.5 stars on the CMS Home Health Star Rating System; achievement of a defined threshold level of performance based on selected home health process measures , outcome measures (Home Health Compare) and experience of care measures (HHCAHPS) for the most recent 12 month period; AND, demonstrated maintenance or improvement of high performance during the last three year period on selected process, outcome and HHCAHPS measures. (It was emphasized that the intention would be for all three parts of the definition to be met.)

General Comments:

- Ms. Christmyer stated that based on CMS' proposed Five Star Rating System, initial national data results show that 50% of agencies received 3.5 stars or higher and 75% of agencies received 3 stars or higher.

- Dr. Alan Levitt noted that CMS did not develop these measures for states to use for CON or value–based payment. However, these four process and six outcome measures are the same ones that have been collected and reported on Home Health Compare for some time.

- The question was raised as to whether it was premature to propose use of the Five Star Rating System and whether the 3.5 stars should not be used as a threshold at this time, given that there have been problems with other star rating systems for other services. Dr. Levitt responded that CMS was on time to implement the Five Star Rating for HHAs by July 1st.

- Ann Horton asked if percentiles should be used in place of the 5-star ratings; then HHAs could be compared to each other rather than to a standard measure. Ms. Christmyer responded that the national median, the statewide median, or a percentile measure could be used.

- Rosellen Fleishman stated that the threshold chosen does not matter to consumers, but that it is important to make it easy to understand. She also noted the information needs to be disseminated to the consumer that quality measures exist. One method suggested was to include a link to the Consumer Guide in the list supplied by hospital discharge planners.

Weighting Certain Measures:

- Several Advisory Group members agreed that acute care hospitalization is an important measure and suitable for weighting.

- The medication education measure was mentioned as important by more than one person because poor medication adherence is a huge risk for re-hospitalization.

- There was considerable discussion about the vaccination measures. Several members noted the HHA does not vaccinate, but does identify if vaccinations were received. Dr. Levitt responded that CMS received considerable feedback about vaccination measures. These are the measures endorsed by

NQF, although there are other vaccination measures available. He also noted that flu vaccination for this population is very important to CMS, as well as pneumonia vaccination. He said removing one variable did not affect the overall rating to a great degree.

- At least one Advisory Group member was in favor of assigning outcome measures a greater weight.

- The experience of care measures were considered important, but it was noted that response rates must be considered.

Other Measures:

- Ms. Christmyer explained that the measures selected had to show some differences in performance, but not be topped out (e.g, everyone performing above 90%).

- How often patients got better at taking their drugs correctly by mouth; medication compliance was viewed as very important.

- Regarding "How often patients needed urgent, unplanned care in the Emergency Room (ER) without being admitted," it was noted that all aspects of ER visits are not under the control of HHAs. For example, HHAs cannot prevent patients from going to ER – at times this occurs due to family/caregiver anxiety. HHAs have on-call staff, but families often do not use this service and call 911 instead. A physician may also recommend ER. Dr. Levitt noted that the expectation for this measure is not 0% and CMS recognizes that in some cases HHA patients will use the ER; however, HHAs do have a part in stabilization of unnecessary ER utilization. He also noted the performance on this measure is consistent nationally.

- Keith Ballenger mentioned that there needs to be a culture change and education of physicians not to readmit patients when they call.

- Ms. Fleishman stated that drug education needs to be done early, particularly when family members have dementia. Mr. Ballenger stated that some vendors make a recording and send reminders by phone.

- Jackie Bailey reminded the group that although these quality issues are important, providing quality care costs money.

Comments from the Audience

Barry Ray, CEO, Visiting Nurse Association of Maryland, addressed the Advisory Group and summarized his concerns with the suggested qualifying factors for a jurisdiction and an applicant. Implementing a threshold for allowing additional agencies to serve a jurisdiction based on a competition index of .25 or greater may make some sense if only one or two HHAs were serving in a jurisdiction. But to artificially decide to open up a jurisdiction if there are 10 high quality agencies, unless you can control referral sources, would not make a difference. The greatest challenge is finding qualified professional staff (therapists), especially to serve in the more remote geographic areas; there is a need to consider expenses. Medicare and Medicaid fraud and abuse is a serious charge at any time; compliance plan is not enough and an applicant with a history of such fraud and abuse should not be considered as qualified. Mr. Ray referred to the statement made by Dr. Allan Levitt, the CMS representative, that it may be too early to make a determination on how to use the Five Star Rating System at this time with ongoing Open Door Forum discussions. Therefore, Mr. Ray suggests that 3.5 stars may not be the right number and should not

be used as a standard, at this time. As a cautionary note, nursing homes have issues with using CMS Star Rating System.

Next Meeting and Next Steps

The HHA Advisory Group is scheduled to meet on April 14, 2015 at 1:30 p.m. The focus of that meeting will be discussion regarding HHA acquisitions and specialty HHAs. The update of the HHA Chapter to the State Health Plan is an open and public process, with informal and formal public comment periods.