Discussion: Issues and Suggested Policy Direction for the HHA Chapter of the State Health Plan

A presentation to the HHA Advisory Group

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Paul Parker and Cathy Weiss
Center for Health Care Facilities Planning and Development

MHCC | MARYLAND HEALTH CARE COMMISSION

Overview of Issue Topics for Discussion

HHA Acquisitions

HHA Specialty Designation

Use of Regional Service Areas in CON Regulation of HHAs

Pace of Change in HHA Supply and Distribution: Limiting Potential Negative Impact

Acquisition of HHAs

Acquisitions are not addressed in HHA Chapter

- CON review is not required – 30 days notice with issuance of determination
- Purchaser can only acquire authorized jurisdictions served in FY 2001

Proposal: Address acquisitions in HHA Chapter for consumer protection, access for all patients, and improved accountability

- Purchaser can acquire right to serve all authorized jurisdictions
- Prohibit acquisition by persons with criminal record
- Require commitment to serve all payor types, the uninsured, & indigent
- Require HHA being acquired to be operational; purchaser must honor ongoing conditions of CON authorization; commit to service offerings historically provided; maintain Medicare and Medicaid certification

Discussion

- What has been the impact of recent HHA acquisitions?

- Should MHCC evaluate the quality performance of an entity seeking to acquire a Maryland HHA? If the buyer is a non-HHA provider, how should MHCC evaluate its performance?

- In cases where a corporation or its principals have had prior convictions for Medicare/Medicaid fraud or abuse or other crimes , should MHCC consider allowing it to acquire Maryland providers based on evidence concerning how the corporate entity and its owners and officers have changed post-conviction? If so, under what circumstances?

- Other?

Specialty HHA Designation

Maryland's CON program: recognizes two types of HHAs

- **General HHAs:**
  - Serve general population with general range of services
  - Only allowed to apply for a CON (new HHA or expansion of existing HHA) when need identified by MHCC
- **Specialty HHAs:**
  - Exclusively serve children, a subpopulation group with specified medical conditions or residents of a specific CCRC or provide a limited set of specialized services
  - Applicant required to demonstrate that there is need
  - No specific review schedule

Specialty HHA designation not recognized by OHCQ, Medicaid, or Medicare

Specialty HHA Designation (continued)

Maryland has 6 specialty HHAs

- 4 CCRC-based; 2 pediatric and maternal/newborn
- Most pediatric HHA service provided by general HHAs
- CCRC residents are not precluded from being served by other general HHAs authorized to serve CCRC jurisdiction

Proposal: discontinue specialty HHA designation

- General HHAs may tailor services to serve niche market
- All applicants must qualify under same policies
- Existing specialty HHAs continue to operate (grandfathered)

Discussion

- Are there specific types of populations requiring specialized training of HHA staff that a general HHA does not routinely provide?
- Are there specific types of medical conditions or services that your HHA is unable to address; if so, what is the frequency of denied admission?
- What is the potential impact, if any, on access if MHCC eliminates the ability to apply for a specialty HHA designation?
- Other?

Regional Service Areas – Jurisdictional Population

Montgomery: 1.036M
Prince Georges: 900K
Baltimore Co.: 832K
Baltimore City: 625K
Anne Arundel: 560K
Howard: 309K
Harford: 252K
Frederick: 246K
Carroll: 169K
Charles: 157K
Washington: 151K
St. Mary's: 114K
Cecil: 104K

Wicomico: 103K
Calvert: 92K
Allegany: 75K
Worcester: 53K
Queen Anne's: 50K
Talbot: 39K
Caroline: 34K
Dorchester: 33K
Garrett: 30K
Somerset: 27K
Kent: 21K

Estimated Population-2015, MDP

Regional Service Areas – Authorized HHA Population

Garrett Co. Hlth Dept:	30K
Chester River:	71K
Amedisys Elkton:	104K
Westrn Md Hlth System:	105K
Meritus:	151K*
Shore:	156K
HealthSouth Chesapke:	183K
Peninsula:	183K
Frederick Mem Hosp:	246K*
Amedisys Salisbury:	255K
Chesapeake-Potomac:	363K
Lutheran:	565K
HomeCall-Baltimore City:	625K
Baltimore Co Hlth Dept:	832K
Celtic:	832K
Maryland Home Health:	832K

13 HHAs:	1 – 2 M (million)
9 HHAs:	2 – 3M
3 HHAs:	3 – 4M
7 HHAs:	4M+

Estimated Population-2015, MDP

* Hospital-based HHA: can serve discharged patients beyond home county pop. shown at left

Regional Service Areas

Possible Multi-Jurisdictional Regions

Western Maryland
Allegany
Garrett
Washington
2015 Pop: 256K

Eastern Shore -*Upper*
Caroline
Cecil
Dorchester
Kent
Queen Anne's
Talbot
2015 Pop: 281K

Southern Maryland
Calvert
Charles
St. Mary's
2015 Pop: 363K

Eastern Shore -*Lower*
Somerset
Wicomico
Worcester
2015 Pop: 185K

Discussion

- Should the HHA Chapter provide for creation of multi-jurisdictional regions for purposes of CON review scheduling?
- Should multi-jurisdictional regions also be used in consideration of expansion proposals by existing HHAs, i.e., allowing these applicants to propose expanding into more than a single jurisdiction?
- Other ?

Limiting Change

- **Caseload Impact as a Governor of Change**

  MHCC could select a target maximum number of new entrants for any target jurisdiction or region based on limiting the potential impact on existing HHA caseloads

  See handout illustrating possible approach.

Discussion

- Should MHCC limit expansion by existing HHAs to a single contiguous jurisdiction every three years, to slow the pace of change? What is the best balance between allowing high performing HHAs to expand to new territory and also allowing for the system to adjust more gradually to changes?

- Should potential impact on caseload be used as a limiting factor in the number of new competitors allowed in any given review cycle? For example, if five qualifying applicants sought to expand into the same jurisdiction or multi-jurisdictional region, a policy stating that the potential impact on existing agency caseloads could not exceed a given level would establish a maximum number of applications that could be approved.

Discussion

- A caseload impact standard would require a strong set of preference rules be established in the SHP so that applicants could be reasonably and fairly ranked. If the caseload impact standard said only two applications should be approved, only the two top-ranked applicants would receive a CON. What preferences make sense for use in a process of this type?

- Track record in serving all types of patients, including the indigent
- Existing HHA expansion preferred over new agency
- More discrimination with respect to performance on quality measures
- Growth of smaller agencies preferred over expansion of large agencies