Maryland-National Capital Homecare Association
Position Paper on CON Modernization
August 2018

Modernization can be defined as *"The process of adapting something to modern needs or habits".* The modernization of Maryland's certificate of need process is a complex undertaking that involves stakeholders from across the state and throughout Maryland's healthcare system. Clearly, there exist numerous adaptations that could improve the CON process for Maryland health care providers, and home health is no exception.

The Maryland-National Capital Homecare Association (MNCHA), which represents home health, private duty and durable medical equipment providers across Maryland and the District of Columbia, has participated in the CON Modernization Task Force since its inception and has provided a previous presentation outlining the input of home care providers that were received during the initial public comment period.

This document outlines the rationale for and specific suggestions to modernize the CON for home health to adapt it to the future health care needs of Maryland.

Home health patients are among the most vulnerable in our health care system. Nearly 70% of home health patients are elderly and 60% are women. Home health patients are more likely to live alone and have poorer health status – an estimated 36% live alone. Home health care patients average 4.2 medical diagnoses, and 86% have three or more chronic conditions. Sadly, their isolation, fragile health, and extreme vulnerability *make them the target of fraud and abuse.*

Here in Maryland, we have 305 CONs held by 56 agencies (taking all counties agencies can serve into consideration). This home health infrastructure is a key component of the state's health care system, and it plays an important role in reducing hospital readmissions and reducing the overall cost of care. Maryland home health providers average 4 stars in the CMS Star Rating system – while the rest of the nation averages 3.5 stars. Our neighbors without CON requirements – Delaware, Virginia, and Pennsylvania – also remain at 3.5 stars. Hospital readmissions from Maryland home health providers are slightly lower as compared to the nation.

Moreover, Maryland home health providers are currently engaged in a CMS pilot program called "Home Health Value-Based Purchasing (HHVBP)" whereby agencies are financially incentivized or better quality and outcomes. Maryland is one of nine states in the pilot receiving payment adjustments tied to quality performance. We are currently in the second year of this 6-year pilot. Moving forward, home health will also become more of a factor in the success or failure of Maryland's Total Cost of Care pilot.

We strongly believe that any dramatic changes to the home health infrastructure during these two pilots (both in their infancy) – HHVBP and Total Cost of Care – would threaten the success of these projects and place at risk the established hospital/home health continuum of care.

In a previous presentation to this group, we emphasized that *6 of the 7 major home health fraud busts in 2017 were in non-CON states.* Historically, states with no home health CON requirement have the largest volume of fraudulent activity.

This should be a major concern for health planners, and should be taken into consideration as we consider modernizing the program.

Finally, on a national scale, the home health is in a "workforce crisis" – both in the short term and long term. Maryland providers are feeling this crunch every day, with starts of care impacted by the lack of qualified and available nurses, therapists and aides. We believe the home health CON helps manage the workforce supply and demand in such a way that is beneficial to Marylanders who want to recover in the lowest cost healthcare setting – home.

Looking forward, we agree that the home health CON process should be modernized, streamlined and made more accessible to established, high-quality home health providers so that we can continue to attract and reward high-quality home health providers that add value to the Maryland health care system.

We believe that improvements to streamline the application process, reduce the duration of the review process, and use of existing data submitted to MHCC from home health agencies as part of the review process would enable providers to continue to serve Marylanders with a robust, high-quality home health system.

Specific Recommendations:

- Continue to be a role model in high quality and service standards, wide geographical access, and cost containment, in support of the Triple Aim
- Continue to control the volume and quality of home health providers in Maryland by maintaining the CON requirement for home health
    - Add patient satisfaction criteria, using the CMS Star Rating system
- Maintain a need-based standard that considers population growth, the aging of the population
- Continue to allow for the opening of rural areas of the state with fewer providers for new home health agency applicants
- Do not require data from applicants that has previously been submitted via the state report
- Streamline the process for both providers and the Commission by allowing existing, licensed Maryland providers that meet the quality standards to expand to high need jurisdictions, with a modified application process that does not require resubmission data already in the public domain (state report, quality ratings)

Suggested Changes to the State Health Plan for Home Health

10.24.16.08G. Impact.
An applicant shall address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs' caseloads, staffing and payor mix.

Recommend REMOVAL – Impossible to determine the impact on existing agencies, and irrelevant as well – If/when the State determines there's a need in a particular area, they feel that way even after considering the existing HHAs. Hence, the opening of the CON in that county and the applying HHA's legitimate application.

10.24.16.08I. Linkages with Other Service Providers.
An applicant shall document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

(1) A new home health agency shall provide this documentation when it requests first use approval.

(2) A Maryland home health agency already licensed and operating shall provide documentation of these linkages in its existing service area and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve.

Recommend REMOVAL (either entirely, or at least of # 2) – If there is a need in a specific county/area, look at the applying HHA's track record and quality measures and determine if they have the possibility of success in the new area. It then falls to the applicant to work on building relationships with the existing healthcare facilities in the new area and market successfully (using their track record and quality measures). They would not need linkages before serving the new area.

10.24.16.08J. Discharge Planning.
An applicant shall document that it has a formal discharge planning process including the ability to provide appropriate referrals to maintain continuity of care. It will identify all the valid reasons upon which it may discharge clients or transfer clients to another health care facility or program.

Recommend REMOVAL – This language applies to hospitals and SNFs, not HHA. HHA should educate and teach disease management so patient can remain at home safely. HHA does not regularly discharge a patient to another healthcare facility.

10.24.01.08G(3)(b). The "Need" Review Criterion
The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Recommend EMENDATION: Recommend removal of first sentence entirely, and clearly marking this as applying only to applications where no need has been previously established. – Once the State determines need, the applying HHA should not have to further demonstrate that same need. This should ONLY apply in cases where there was no need previously determined by the State Health Plan.

10.24.01.08G(3)(c). The "Availability of More Cost-Effective Alternatives" Review Criterion
The Commission shall compare the cost-effectiveness of the proposed project with the cost-effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Recommend EMENDATION: Recommend removal of 'cost-effective' language and instead focus on 'higher quality' providers – HHA is proven to be more cost-effective than Hospital/SNF stays. Medicare sets HHA rates so rates will not vary by Provider. Any/all HHA will be the same cost; only quality performance and outcomes would differ.

10.24.01.08G(3)(f). The “Impact on Existing Providers” Review Criterion.
An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Recommend REMOVAL/UPDATING – As noted above (10.24.16.08G. Impact.), an applicant cannot determine the impact on existing providers, and it would be irrelevant once the State determines the need exists in that area. Further, this provision allows any existing provider currently operating in the area in question to file an ‘interested party’ concern, which serves to protect their own interests only. Once the State determines need, an interested party should only be allowed to file a concern based on quality standards or specific performance concerns. Currently an interested party can file a concern based solely on market share or referral worries.

SPECIFIC EXAMPLE: VNA of Maryland with lower Eastern Shore CON – another agency sought to keep all other agencies out, filed a concern, ended up contacting VNA of Maryland directly multiple times and requesting extensions, without actual evidence of any performance-based issues. This places an undue burden on the applicant HHA with regards to legal fees and rebuttals, and requires more time and manpower for the CON application process in that area.

SPECIFIC EXAMPLE: Adventist, one of the top quality providers in the state, submitted a CON application to expand into a contiguous county over 17 months ago and has not made it on the monthly, MHCC Meeting agenda yet for approval.