January 11, 2018

Robert E. Moffitt, Ph.D., Chair
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Reforms to the Health Planning and Certificate of Need Process

Dear Dr. Moffitt:

On behalf of the Health Facilities Association of Maryland ("HFAM"), we appreciate the opportunity to provide input as solicited by your November 21, 2017 letter concerning the health planning and certificate of need ("CON") process under the authority of the Maryland Health Care Commission (the "Commission"). We endorse this decision by the Commission to review the CON process.[1]

HFAM has been a leader and advocate for Maryland's long-term care provider community for nearly 70 years. HFAM has over 150 skilled nursing and rehabilitation center members who collectively employ 19,000 Marylanders who provide over 9 million days of care annually across all payer sources (Medicare, Medicaid, private pay). HFAM members provide quality care for 72 percent of all Maryland Medicaid long-term care beneficiaries.

HFAM represents every type of long-term care provider, including assisted living, sub-acute, rehabilitation and comprehensive care facilities ("CCFs"). HFAM's membership ranges from small, local, family-owned independent nursing facilities, to larger regional and national organizations to faith-based nonprofit organizations (including the largest nonprofit long-term care facilities in Maryland). HFAM facilities are found in every community, county and city across Maryland.

1. Need for reform of the CON process governing capital projects. Suggestions for deregulation.

[1] Since there is overlap between the questions posed, we have organized our response in this manner. If you need a cross-walk to link our suggestions to the questions we answer with them, please let me know.

601 Global Way, Suite 100-103 ▪ Linthicum, MD 21090 ▪ www.HFAM.org
410.290.5132 ▪ 301.490.8413 ▪ Toll Free: 1.877.LTC.HFAM

HFAM believes the CON process governing capital projects should be maintained but reformed. There should be an exemption from CON review where a capital cost is being incurred that does not result in an increase in health care delivery system rates. At the time the CON process was established, both Medicare and Medicaid reimbursement was cost-based. Those forms of state and federal reimbursement are now prospective, and rates are not increased by such costs. Commercial insurance rates are set by a third party payer and private pay rates are constrained by market forces. Investment of providers in the repair, renovation and replacement of a CCF should not require prior CON approval.

Moreover, given that the acuity of CCF patients now mirrors patients who were formerly receiving care in hospitals when the CON thresholds for capital expenditure (the "Capital Threshold") were established, it is illogical for CCFs to be subject to the lower Capital Threshold applicable to providers such as home health agencies, and not the Capital Threshold applicable to hospitals. Given the role of CCFs in the health care delivery system and the benefits of facilitating the ability of CCFs to prevent hospitalizations and rehospitalizations, CCFs (a) should be subject to same Capital Threshold as hospitals and (b) should be entitled to the same exemption as is available to hospitals for capital expenditures that exceed the Capital Threshold but do not result in rate increases above a designated amount, under Health-General, Section 19-120(k)(1) and (6)(vii), and COMAR 10.24.01.01B(40) and .04A(5).

2. Would the public and health care delivery system benefit from more competition among CCFs?

There is already competition among CCFs. Costs of capital improvements and operations in delivering care that meets quality standards, health care innovation, consumer expectations and strictly enforced government oversight are very high. Medicare and Medicaid reimbursement is both underfunded and prospectively established. There is unchecked competition from assisted living facilities since they are not subject to the CON process. There are Medicaid waiver programs designed to provide alternatives to CCFs and discharge to the community. Occupancies are not increasing. There are state and federal ranking systems that engender competition for quality scores. There is already competition among CCFs. A change to the CON bed need process is not needed.

3. How does CON regulation stifle innovation among CCFs?

a. Our comments above concerning the Capital Threshold apply to this response. Innovations among CCFs should be fostered by either eliminating the Capital Threshold for innovative projects or those involving innovation, renovation, replacement and improvement of CCFs.

b. The Medicaid Memorandum of Understanding ("MOU") requirement under the Nursing Home Services Chapter of the State Health Plan under COMAR 10.24.08 should be eliminated (or substantially reduced). Policy 3.3, Sections .05A(2)(a) and (d), and B(4). Among

the innovation efforts are those that would avoid or reduce the need for utilization of CCF services by Medicaid beneficiaries. The MOU requirement threatens to penalize CCFs unless they foster Medicaid patient days in their facilities. There is not current data to support the view that Medicaid beneficiaries have any barrier to receiving CCF services. The MOU stifles innovation.

c. Recent changes to the waiver bed process should be returned to prior interpretations. Waiver beds are an important "safety valve" in the effective use of existing inventory.

i. Until relatively recently, when waiver beds under COMAR 10.24.01.03E(2) were available, fractional numbers up to 10 beds were "rounded up." Now, in a change of policy, the fractional numbers are only "rounded down." The longstanding prior interpretation should be reinstated.

ii. Sometimes a beneficial capital project is stymied or reduced because, unlike under past policy, space for available waiver beds is not permitted to be constructed. So, for example, if a facility has triple or quad rooms, or wishes to increase private rooms, and it is entitled to 10 or fewer waiver beds under this regulation, the Commission does not permit new space to be constructed for the waiver beds. Only if there is existing, pre-construction space available for the waiver beds are they available. This is can be a problem when the revenue from the incremental waiver beds can facilitate a capital project for all facility residents. Onsite use of waiver beds in new space should be permitted if the overall project does not require a CON.

4. Suggestions concerning the project review process

a. The completeness review aspect of the CON review regulations under COMAR 10.24.01.08C should be reformed. Under the current process, there is a 10 business day deadline for the Commission staff to issue completeness questions and the Staff sets a deadline for reply. However, once that information is provided to the Staff, there is no timeline or deadline for the Staff to reply to that additional information or find the application "complete" for docketing purposes. The entire CON review can be delayed as a result. There should be a deadline by which an application should be considered complete unless there is a problem with what was submitted.

b. There can be an unlimited number of Interested Parties and/or Participating entities, each of which can file up to 25 pages of comments on an application, up to 35 pages in a comparative review. Moreover, the Interested Parties and Participating entities will have access to the CON application through the months as soon as it is filed and through the completeness process, including at least 30 days from docketing. However, irrespective of the number, volume or content of any unlimited comments developed over weeks if not months, under COMAR 10.24.01.08F the applicant has only 15 days to develop a reply and only one 25

page reply to all of the comments collectively (35 pages in a comparative review), putting the applicant at a substantial disadvantage.

5. Changes to performance requirements.

There are a variety of ways the CON process should be reformed with respect to project review and performance requirements. Some of these are based on the language of the CON regulations and others are based on interpretations of the CON regulations as expressions of policy.

a. Currently, there are strict performance requirements with only one extension for up to 6 months each being permitted for whatever reason may arise. Failure to meet these deadlines requires a project under ongoing development to go back to the starting point of the CON process. This should be changed under COMAR 10.24.01.12E and F.

b. Each of the performance requirements should be reviewed. For example, under COMAR 10.24.01.12C(3)(a) and (b) a new health care facility is required to be constructed within 18 months after financing while renovations of existing facilities can have up to 24 months to be completed. This is illogical and inconsistent with the time it takes for a new facility to be developed.

c. Some of the performance requirements have implementation periods that are tied to capital amounts that have not changed over time and no longer make sense, such as under COMAR 10.24.01.12C(3)(b), (c) and (d). These should be eliminated, updated or tied to inflation.

d. There are restrictions on when a health care facility can propose to construct a project in phases to projects with a cost above $40 million under COMAR 10.24.01.01B(28) and .12C(3)(g). The ability to develop a project in phases should not be so constrained.

e. The Commission staff interprets the CON regulations so as to prohibit any change in the identity of owners within the legal entity that is the applicant, during the CON review, even if the change is less than the 25% threshold that would trigger notice to the Commission after the facility is constructed. There can be legitimate reasons why there should be additional or different minority owners in an applicant entity during a CON review, so long as this is disclosed.

f. Sometimes there is a judicial appeal of a CON decision or a related appeal such as through the zoning process. The regulations should state clearly that an applicant may, but is not required to, delay a project while the appeal is pending.

6. Changes to the requirements for when Commission review of project changes is required.

Under COMAR 10.24.01.17 there are regulations on when information about project changes is disclosed to and reviewed by Staff, when a change requires a vote of the Commission and those that are impermissible.

a. The Commission should not require a vote of the Commission for capital cost increases during the CON development process so long as notice to the staff is given and the applicant is going to absorb that cost and an increase in rates will not result.

b. The Commission has a policy that, after a CON is granted and during the implementation phase there can be no change whatsoever, however minor, to the composition of the ownership of the approved applicant, even below the 25% threshold that triggers review after the project is completed, even with Commission review or vote. This can stymie positive and routine changes that facilitate the development of an approved project.

7. In question 16, a response is requested to how the Commission can take into account an applicant's quality of care.

a. We would be concerned if the Commission were to consider a process akin to the process used in the Home Health chapter of the State Health Plan, to bar existing facilities from even filing a letter of intent unless preapproved by the Commission.

b. We have seen the Commission refer to the CMS Five Star process in CON reviews. This is a concern as anything other than an observation. There are both benefits and flaws to the Five Star system, which we can explain further. Moreover, rankings can be fixed for periods of time such as is being done as part of the new federal Requirements of Participation so they do not reflect current services. Moreover, periodically adjusts the Five Star scoring the effect of which is to cause a drop in star rankings until facilities adapt to the change. Over reliance on the Five Star rankings is a concern.

c. In this regard, in response to question 24, we do believe there is duplication between the MHCC and the MDH. We reviewed the Commission's enabling legislation under Health-General Article, Sections 19-103 and 115 related to the purpose of the Commission and its role in the health planning and development process. We do believe that, particularly as to the evaluation of whether an applicant renders quality care, there should be reliance on the Office of Health Care Quality's survey reports and plans of correction since that agency enforces the state and federal rules that apply in the delivery of day to day care. There should not be a different but overlapping set of standards that apply if CON review might be sought in the future.

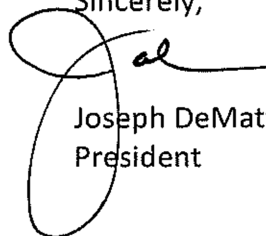
8. Acquisition Determination Process

The Commission has regulations under COMAR 10.24.01.03A, implementing the process for obtaining a determination that a CON is not required for the acquisition of a health care facility, which is defined as including a change in 25% among the existing owners or a change in control. Also, via a helpful policy the Commission has determined that a simple change in tenant with no change in the ownership of the "bed rights" is not the acquisition of a health care facility and that only notice of the change in tenant is required.

In obtaining such determination that no CON is required for an acquisition, the Commission requires disclosure of information on a specific form, some of which is not relevant to the applicable regulation and the scope of which has changed over time. For example, purchase price information is required even though the amount is irrelevant to the determination that no CON is required. Also, "market share" information is required to be provided, even though there is no provision of the regulation that ties to this information. Patient day and operating revenue information is required. The process should be more simple. Moreover, we propose that the acquisition notice be informational and that an affirmative determination of noncoverage not be required. Or, so long as a timely notice is given, upon the expiration of the applicable time period the determination of noncoverage should be presumed. It is not a good use of Staff resources to gather this information and require formal determinations of exemption.

Thank you for the opportunity to comment.

Sincerely,



Joseph DeMattos, Jr.
President

cc: Mr. Eric Shope, Chair, HFAM
Mr. Ben Steffen
Mr. Paul Parker
Mr. Kevin McDonald