Hospice & Palliative Care Network
OF MARYLAND

January 12, 2018

***Sent via email and USPS***

Mr. Paul Parker
Director of the Commission's Center for Health Care Facilities
Planning and Development
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, Maryland21236

RE: COMMENT GUIDANCE - GENERAL HOSPICE SERVICES MHCC CON STUDY, 2017-18

Dear Mr. Parker:

The Hospice & Palliative Care Network of Maryland (HPCNM) has completed the Comment Guidance – General Hospice Services MHCC CON Study. Please see our response to the questions below which were formulated based on a consensus with our membership.

**Need for CON Regulation**

HPCNM strongly supports the idea that CON regulation of general hospice services should, in general, be maintained in its current form.

**ISSUES/PROBLEMS**

**The Impact of CON Regulation on General Hospice Service Competition and Innovation**

1. **In your view, would the public and the health care delivery system benefit from more competition among general hospice programs?**

No, HPCNM does not believe that the public and the health care delivery system benefit from more competition among general hospice programs. The current CON regulation doesn't eliminate competition. It provides limits to entry into or expansion in the market, but the free market determines the provider's survival. Competition among existing hospice providers is

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adequate and sufficient to offer patients choice. Removing the barriers to entry of new providers will not necessarily improve services. In fact, it may have a detrimental impact. Removal of the CON process will likely result in an influx of new hospice providers across the State. Primarily, more hospice providers would cause increased competition for limited clinical resources and diminishing return on realized economies of scale. Required components of the Medicare hospice benefit, like volunteer hours, would be compromised with more providers competing for limited resources. Hospice providers, utilizing a greater percentage of budget resources for staff recruiting and sales and marketing with additional competition, would have fewer resources available to support those in the community needing financial assistance or charity care. Additional general hospice providers would drive up (redundant) fixed costs, which is one of the core benefits of a service based model. In addition, it would also drive up the cost of the health care delivery system by adding additional providers to oversee compliance and quality. The densely populated jurisdictions have significant competition presently, and utilization (delivery) trends are growing well alongside the new hospital reimbursement models. In addition, the careful selection of hospice providers into the market based upon need helps ensure that patients most in need receive quality services in their same geographic area. Without the CON process, more populous areas attract providers, less populated areas are ignored.

Hospice & Palliative Care Network of Maryland research indicates that Maryland might experience the following should CON be relaxed or removed:

- Growth in Number of Hospices
  If CON were removed in Maryland, some amount of growth in the number of providers is a certainty, based on the pace of growth in states without CON in recent years. For instance, between 2009 and 2014, the number of hospice agencies in California expanded from 231 to 501, a startling 117% increase. Non-CON states more comparable to Maryland in population and percentage of population over 65 have also experienced growth across a wide range. Over all 50 states, the total number of new agencies in CON states was 15; whereas non-CON states added 736. In general, more growth has occurred in southwestern and western states (average 36%) and in the for-profit sector (739 new for-profit agencies vs. 12 new non-profit). On average, the number of hospices in CON states has increased by one new agency over the five-year span. In non-CON states, the number of hospices has increased by an average of 21 new agencies.

- Growth in For-Profit and Multistate or National Service Providers
  Growth in the number of agencies is one issue; another is the kind of agency that would likely be added and how that might impact overall quality of care. In large part due to

controlled growth in the number of agencies, CON states have maintained a higher percentage of community-based, freestanding and nonprofit agencies vs. corporate, multi-location for-profit agencies: On average nationally, nonprofit hospices are 32% of the total; in non-CON states, over 50. In Maryland, currently, of the 27 active hospices, 7 are for-profit and 6 of the 7 are branches of multistate or national corporate entities. Significant new growth in this class of agency is to be expected if CON is discontinued.

- Growth from Outside Hospice
  If Hospice CON were eliminated in Maryland, there may be extensive growth in the number of hospices from outside the hospice community by other provider types. Growth from this sector would likely contribute to a number of new agencies at the high end of the projected range and from providers not as thoroughly steeped in hospice philosophy or trained in specialized palliative skills. Growth in this sector is likely also to be for-profit and multistate or national.

Adding more hospices will not assure more hospice access. As the Medicare Payment Advisory Commission (MedPAC) wrote on page 148 in its 2010 Report to Congress, "Recognizing that the raw number of hospices may not be the best measure of provider capacity, we examined the relationship between the supply of hospices and the rate of hospice use among Medicare decedents across states." On page 149, in Figure 2E-1, MedPAC concluded, "Hospice enrollment rates are unrelated to the number of hospices in a state."

2. **Does CON regulation impose substantial barriers to market entry for new general hospices or expansion of general hospice service areas? If so, what changes in CON regulation should be implemented to enhance competition that would benefit the public?**

The CON provides necessary barriers to market entry and jurisdiction expansion. The densely populated jurisdictions have appropriate competition. More rural jurisdictions, which have a single provider, likely could not sustain a business model and likely would not attract new market entrants, due to their low volume of need.

3. **How does CON regulation stifle innovation in the delivery of general hospice services under the current Maryland regulatory scheme?**

There has been NO negative impact on innovation and no experience or data to suggest that Maryland is less innovative regarding end of life care than non CON states. In fact, there is MORE attention to quality and innovation afforded from scale and avoided distraction due to questionable practices that arise with oversaturation, as well as, instability of staff caused by

inflated supply of providers. As an example, hospice providers across Maryland invest in innovation with special programs that are not required by hospice regulation. Programs like Palliative Care Services, Pet Therapy, Massage Therapy, Music Therapy and utilization of telehealth technology are just a few examples of areas of innovation in Maryland. Additionally, HPCNM provides a collaborative venue for hospices to share innovative solutions and this is accomplished through multiple venues such as General Membership Meetings, Annual Education Conferences, an Annual Quality/Regulatory Conference and other numerous collaborative opportunities.

[1]The Institute for Healthcare Improvement's "Triple Aim" is a framework that describes an approach to optimizing health system performance. It is the Institute for Health's belief that new designs must be developed to simultaneously pursue three dimensions: 1) Improving the patient experience of care (including quality and satisfaction); 2) Improving the health of populations, and; 3) Reducing the per capita cost of health care.

**4. Outline the benefits of CON given that hospice services do not require major capital investment, do not induce unneeded demand, are not high costs and usually do not involve advanced or emerging medical technologies.**

The key benefit of the CON process with regard to hospice care, and particularly care for the needy, is that it supports avoidance of unnecessary services and encourages more services where they are needed. The CON actually promotes innovation and the ability to scale to meet the demands of the market. Having a controlled number of licensed providers enables hospice to focus on key partnerships with hospital systems, skilled nursing homes and assisted living providers to keep readmission and mortality statistics minimized. Thus, supporting the significant savings achieved in the total cost of care model in Maryland. Post-acute ambulatory end of life care requires massive labor and infrastructure costs. Additional providers would add unnecessary competition for already competitive resources like Physicians (Board Certified), Nurses, Social Workers, Hospice Aide's, Chaplains, Volunteers, and clinical operations leadership. All of which are difficult to hire and could factor against existing hospice providers ability to scale and meet the needs of the market. The cumulative impact would be a reduction in the hospice providers ability to support the total cost of care initiative entering its second phase.

**Scope of CON Regulation**

**5. Should the scope of CON regulation be changed?**

**A. Are there general hospice projects that require approval by the Maryland Health Care Commission that should be deregulated?**

The scope of the CON regulation appears sufficient at this time. HPCNM is not aware of any general hospice projects that should be deregulated.

**B. Are there general hospice projects that do not require approval by the Maryland Health Care Commission that should be added to the scope of CON regulation?**

HPCNM is not aware of any general hospice projects that do not require approval by the MHCC that should be added to the scope of the CON regulation.

**The Project Review Process**

**6. What aspects of the project review process are most in need of reform? What are the primary choke-points in the process?**

The timeliness of the CON process is in the most need of reform. While there are existing regulations which set forth the timeline for review, they typically are neither followed nor upheld. In addition, for hospice providers, the need methodology and timeliness of data upon which the need methodology is determined should be re-examined. The addition of need methodology for inpatient beds also needs to be developed.

**7. Should the ability of competing general hospice programs or other types of providers to formally oppose and appeal decisions on projects be more limited?**

**Are there existing categories of exemption review (see COMAR 10.24.01.04) that should be eliminated? Should further consolidation of health care facilities2 be encouraged by maintaining exemption review for merged asset systems?**

A formal process to oppose and appeal is needed and should not be limited. Interested parties should have a venue and a platform to challenge and discuss competing hospice CON filings.

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**8. Are project completion timelines, i.e., performance requirements for implementing and completing projects, realistic and appropriate? (See COMAR 10.24.01.12.)**

In general yes, the project completion timelines, i.e. performance requirement for implementing and completing projects is realistic and appropriate. The MHCC has demonstrated flexibility when needed to changing situations and unforeseen circumstances.

**The State Health Plan for Facilities and Services**

**9. In general, do State Health Plan regulations for general hospice services provide adequate and appropriate guidance for the Commission's decision-making? What are the chief strengths of these regulations and what do you perceive to be the chief weaknesses?**

Overall the framework for the CON in the State Health Plan (SHP) is adequate and appropriate. The chief weakness of the SHP for hospice is the need to simplify and improve the current need methodology or projections. An area of opportunity to improve the current formula in which need is determined is a demographic weighting related to the underserved communities. As an example, African American hospice utilization is low nationally as reported by the National Hospice and Palliative Care Organization (NHPCO). On a national level African American population as a percentage of total population is about 14% and in Maryland 29.4% of the total population is African American. Overall hospice utilization in the state of Maryland is slightly lower than the national average, but this does not mean there is unmet need. The existing need calculation does not factor the impact of cultural diversity and the utilization of hospice. HPCNM's recommendation would be to compare "demographically" weighted utilization against those same demographically weighted national utilization rates.
The network would also recommend the SHP establish clarity and guidelines regarding the decision-making criteria as to the number of additional CON's to be awarded in a jurisdiction that has unmet need.

The answer to the second part of this questions is that, under Maryland CON law, home health agencies are classified as "health care facilities"

**10. Do State Health Plan regulations focus attention on the most important aspects of general hospice projects? Please provide specific recommendations if you believe that the regulations miss the mark.**

The State Health Plan would benefit by adding quality markers related to impacting the total payor model. The Network supports collaboration with the HSCRC and the State of Maryland in

achieving meaningful and impactful outcomes that keep patients in place, avoid readmissions and drive down overall costs while improving quality. Establishment of key performance indicators (KPI's) related to Hospice and the State Health Plan should be considered. Hospice is most effective when the interdisciplinary team (IDG) has time to work with the patient and family. This takes time to build the trust and have the crucial conversations that provide the outcome of a high-quality hospice experience. Nationally and similarly in Maryland our average length of stay (ALOS) is approximately 69 days while our median length of stay (MLOS) is 23 days and almost 30% of our admissions die within 7 days. Considering the baseline for hospice eligibility is a prognosis of 6 months or less, there is significant variance in the hospice benefit design and actual outcome. Earlier referrals would lead to greater hospice impact on the total cost of care model and provide enhanced end of life experiences in Maryland.
One productive change in the regulations occurred in 2013 when the need formula began using total deaths instead of cancer deaths. The accuracy regarding utilization was improved because, as recently reported in the annual report by the American Cancer Society, the cancer death rate has declined 26 percent since 1991 in the United States. Another possible change in the need methodology would be to lower the minimum age at death from 35 to 25 years old. Looking at hospice utilization broken down by race and ethnicity also would be meaningful as it would improve the relevance of the hospice utilization data. As the MHCC stated on page 4 in its 2013 State Health Plan: Hospice Services, "The use of hospice services nationally and within Maryland varies by population groups. It has been shown that some individuals and groups are reluctant to access hospice services based on religious, ethnic, cultural and other factors." On page 5 the State Health Plan also notes that "several factors affect future hospice utilization. Differing views of health care, illness, and dying impact the use of end-of-life services by various ethnic and religious groups." It is well understood by hospice experts that minority communities tend to use hospice less than Caucasians.

**11. Are the typical ways in which MHCC obtains and uses industry and public input in State Health Plan development adequate and appropriate? If you believe that changes should be made in the development process for State Health Plan regulations, please provide specific recommendations.**

In general, summarized in previous questions. Regulation changes should be focused on need determination and Hospice Provider impact on the total cost of care model.

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**General Review Criteria for all Project Reviews**

**12. Are these general criteria adequate and appropriate? Should other criteria be used? Should any of these criteria be eliminated or modified in some way?**

HPCNM suggests that the following questions be considered as criteria for project review:

- Demonstrate and explain, as a new provider, your ability to establish timely and effective partnerships needed to achieve the State's goals for Global Budget Revenue and value based purchasing.
- The provision of charitable care, while already required data in a CON application submission, should be deemed an important element in the CON evaluation process.

**CHANGES/SOLUTIONS**

**Alternatives to CON Regulation**

**13. If you believe that CON regulation of general hospices should be eliminated, what, if any, regulatory framework should govern establishment and service area expansion of home health agencies?**

HPCNM does not believe that CON regulation of general hospice should be eliminated.

**14. Are there important benefits served by CON regulation that could be fully or adequately met with alternative regulatory mechanisms? For example, could expansion of the scope and specificity of general hospice licensure requirements administered by the Maryland Department of Health serve as an alternative approach to assuring that these services are well-utilized and provide an acceptable level of care quality, with appropriate sanctions to address under-utilization or poor quality of care?**

The Maryland Department of Health (MDH) should not be involved in the CON process. The MDH serves a different purpose. It ensures existing providers meet the minimum regulatory requirements for the provision of services. As noted above, the CON process is and should remain a benchmark for entry into the market, not for continuation in the market.

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**The Impact of CON Regulation on General Hospice Program Competition and Innovation**

15. **Do you recommend changes in CON regulation to increase innovation in service delivery by existing general hospice programs and new market entrants? If so, please provide detailed recommendations.**

CON regulation does not stifle innovation. Hospice providers will continue to innovate within the existing Medicare Benefit.

16. **Should Maryland shift its regulatory focus to regulation of the consolidation of general hospice programs to preserve and strengthen competition for home health agency services?**

We do not believe Maryland should shift its regulatory focus to regulation of the consolidation of general hospice programs to preserve competition for home health services. The two services respond to different factors, treat different patients, and are paid under a different regulatory scheme.

**The Impact of CON Regulation on General Hospice Access to Care and Quality**

17. **At what stage (prior to docketing or during project review) should MHCC take into consideration an applicant's quality of care performance? How should applicants be evaluated if they are new applicants to Maryland or to the industry?**
***Note: docketing is the determination by the MHCC when an application is judged complete and ready for review.***

MHCC should use actual complaint and survey data of the existing providers. New applicants should be evaluated on like data from state or states in which they operate. Applicants or corporate affiliated entities with active DOJ investigations related to potential fraudulent practice should be disqualified. Applicants should be evaluated with industry benchmarking standards such as Hospice Compare and the PEPPER report, which are indicators of quality, satisfaction, and regulatory adherence.

**Scope of CON Regulation**

18. **Should MHCC be given more flexibility in choosing which general hospice projects require approval and those that can go forward without approval, based on adopted regulations for making these decisions? For example, all projects of a certain type could require**

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**notice to the Commission that includes information related to each project's impact on spending, on the pattern of service delivery, and that is based on the proposals received in a given time period. The Commission could consider staff's recommendation not to require CON approval or, based on significant project impact, to require the general hospice project to undergo CON review.**

HPCNM believes that this action would appear to take away the ability of the public to oppose or comment on new projects and limit transparency.

**19. Should a whole new process of expedited review for certain projects be created? If so, what should be the attributes of the process?**

Existing hospice provider expansion within their licensed jurisdictions could be considered for expedited review. As an example, inpatient beds is an area for expedited review. In the interest of meeting patient needs in a timely manner, if an existing hospice provider has the capital, location and agreements to build and construct an inpatient center there should be an expedited process to move the project forward.

**The Project Review Process**

**20. Are there specific steps that can be eliminated?**

No specific steps to be eliminated other than previously noted in this document.

**21. Should post-CON approval processes be changed to accommodate easier project modifications?**

Post Con process is reasonable and adequate and the MHCC has demonstrated flexibility in working with providers on reasonable project modifications.

**22. Should the regulatory process be overhauled to permit more types of projects to undergo a more abbreviated form of review? If so, please identify the exemptions and describe alternative approaches that could be considered.**

As noted in the document.

**23. Would greater use of technology, including the submission of automated and form-based applications, improve the application submission process?**

Yes, greater use of technology, including the submission of automated and for-based applications would improve the CON application submission process.

**Duplication of Responsibilities by MHCC and MDH**

**24. Are there areas of regulatory duplication in general hospice regulation that can be streamlined between MHCC and MDH?**

Not at this time. These departments serve different functions

Thank you for the opportunity for HPCNM to provide our comments on this very important issue. We look forward to hearing the results of this survey in the near future.

Sincerely,

Peggy Funk
Executive Director
Hospice & Palliative Care Network of Maryland

cc: Ben Steffen, Executive Director, MHCC
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