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Maryland Health Care Commission
41360 Patterson Avenue
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RE:GENERAL HOSPICE SERVICES MHCC CON
STUDY, 2017-18

Please consider your answers in the context of Maryland's commitment to achieve the goals of the Triple Aim[1] and its aspiration to bring health care spending under a total cost of care model beginning in 2019. Please provide a brief explanation of the basis for your position(s) in each area of inquiry beginning with the overarching question regarding continuation of general hospice CON regulation. All responses will be part of the Maryland Health Care Commission's public record for the CON Workgroup.

Need for CON Regulation

Which of these options best fits your view of general hospice CON regulation?

0 CON regulation of general hospices should be eliminated. [If you chose this option, many of the questions listed below will be moot, given that their context is one in which CON regulation would continue to exist. However, please respond to Questions 12 and 13.]

0 CON regulation of general hospice services should be reformed.

X 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. Current CON regulations do not eliminate competition. They provide limits to entry into or expansion in the jurisdiction, but ultimately innovation, quality of patient care and regulatory compliance determines a hospice programs success. Competition among existing hospice providers is adequate as there are more than five CON's in Montgomery County (JSSA Hospice, Montgomery Hospice Society, Hospice of Frederick County, Washington Home and Hospice, Seasons Hospice, Holy Cross Home Care and Hospice, as well as others that are less active) and as a result, patients have a sufficient number from which to choose. Removal of CON process will likely have a negative impact on the existing providers, as this will result in an influx of new hospice providers across the state and obviously include Montgomery County as well. Increased competition will result in competition for limited clinical resources (hospice nurses, social workers, chaplains, and trained hospice aides) thereby diminishing return on realized economies of scale. Required components of the Medicare hospice benefit, like volunteer hours (for which there is a Medicare requirement that 5% of total patient care hours by all disciplines be provided by volunteers, and bereavement support for 13 months following the death of a patient, that is unreimbursed-would be compromised with new non-community based providers competing for volunteer and trained bereavement support . Hospices would be forced to spend a larger percentage of their budgets on recruiting scarce staff as well as dollars spent on sales and marketing with the additional competition of more providers in a jurisdiction. These budget impacts would translate to being forced to provide fewer dollars on serving the uninsured and historically underserved populations. Additionally, more hospice providers would drive up (redundant) fixed costs, which is one of the core benefits of a service-based model. It would also drive up the cost and strain on our overtaxed health care delivery system by requiring the department of health care quality to hire additional surveyors and administrative staff to ensure compliance, quality and licensing. Montgomery County's densely populated jurisdiction has significant competition 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. Without the CON process, areas that are more populous

attract providers, and less populated areas ignored.

Hospice & Palliative Care Network of Maryland and JSSA Hospice 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 affect 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, of the 27 current active hospices, seven are for-profit and six of the seven are branches of multistate or national corporate entities. Significant new growth in this class of agency is to be expected if CON is eliminated.

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 serves the purpose for which it was intended; it provides necessary barriers to market entry and jurisdiction expansion. The densely populated jurisdictions have appropriate competition. Jurisdictions that are more rural i.e. - less densely populated areas who have a single providers, would likely could not be able to sustain a viable business model and would be unlikely to attract new market entrants, due to their low volume of need because of this low population density.

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. JSSA Hospice currently provides a free program called "Transitions". This program provides regular visits by a nurse and the support of a hospice trained volunteer. Generally, this program admits patients who have a year to live, vs. the 6-month prognosis required by the Medicare Hospice. The aim of the program is to identify potentially terminally ill individuals in need of support and low level oversight an avenue to the more comprehensive care that

hospice provides. All patients in this program are offered a choice of hospice provider when it is clear that hospice is indicated. Currently this program is providing service to 90 individuals and transfers 40-50 patients a year to hospice providers. Some patients elect to stay with JSSA Hospice, while others will choose other providers. For patients who elect JSSA Hospice as their provider, they continue to receive support and attention from their volunteer.

The Hospice & Palliative Network provides a collaborative venue for hospices to share innovative solutions and this is accomplished through multiple venues such as General Membership Meetings, Annual Education Conference, Annual Regulatory Conference and other numerous collaborative opportunities. Existing providers enjoy a sense of collaboration and sharing of best practices that would surely be lost if many other providers entered the market.

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[1]The Institute for Healthcare Improvement's "Triple Aim" is a framework that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimension: (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 those who are financially compromised, is that it supports avoidance of unnecessary services such as Emergency Room visits and hospital admissions, and encourages care in the home where services are most needed. The CON facilitates and encourages innovation and the ability to scale up to meet the demands of the market. JSSA Hospice has grown every year by an average of 10-15%. We have done this by being innovative in hiring practices, in the processes of our work, in becoming efficient in orienting and mentoring new staff. In addition, 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 hospital readmission rates and mortality statistics minimized. In 2016, less than 2% of JSSA Hospice's patients were readmitted to area hospitals. Thus, contributing to and 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 anticipated second phase.

Scope of CON Regulation

Generally, Maryland Health Care Commission approval is required to establish a general hospice, increase the bed capacity (general inpatient hospice care) of a general hospice, or expand the service area of an existing general hospice into new jurisdictions. For a more detailed understanding of the scope of CON and exemption from CON review requirements, you may wish to review COMAR 10.2f 01.02 - .04, which can be accessed at:

http:// www.dsd.state.md.us/comar/Subtitle5earch.aspx?search=10.24.01. *

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. We are 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?**

We are not aware of any general hospice projects that do not require approval by the MCHH 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 need of significant reform. While there are existing

regulations that set forth the timeline for review, they typically are neither followed nor upheld by the MHCC. 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 for existing providers 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 facilities[2] be encouraged by maintaining exemption review for merged asset systems?

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

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 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 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. Our recommendation would be to compare "demographically" weighted utilization against those same demographically weighted national utilization rates.

We 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.

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2 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 affecting the total payor model. We support 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. It takes time to build this trust that enable the crucial (and often difficult) conversations to take place. This contributes to the outcome of a high quality hospice experience. Nationally and similarly in Maryland our average length of stay (ALOS) is approximately 84 days while our median length of stay (MLOS) is 39 days and 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 utilization. Earlier referrals would lead to greater hospice impact on the total cost of care model, and provide enhanced end of life experiences in Maryland. Without hospice access and acceptance, one must consider, however, the impact of the total cost of care model for patients who would then utilize expensive inpatient services of emergency rooms and ICU beds

One productive change in the regulations occurred in 2013 when the need formula began

using total deaths instead of just cancer deaths, given that only 20% of hospice admissions are comprised of patients with cancer diagnoses. 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.

<u>General Review Criteria for all Project Reviews</u>

COMAR 10.24.01.08G(3)(b)-(f)) contains five general criteria for review ofall CON projects, in addition to the specific standards established in the State Health Plan: (1) Need; (2) Availability of More Cost-Effective Alternatives; (3) Viability; (4) Impact; and (5) the Applicant's Compliance with Terms and Conditions of Previously Awarded Certificates of Need.

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?**

JSSA Hospice and The Hospice and Palliative Care Network of Maryland suggest 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.
- Commitment to providing care to underserved populations.

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?**

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 Department of Health and Human Services (DHHS) should not be involved in the CON process. The DHHS 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.

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, as they have- and 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

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. JSSA Hospice firmly believes that applicants or corporate affiliated entities with active DOJ investigations related to potential fraudulent practice be disqualified from applying.* 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

17. **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 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.**

This would appear to take away the ability of the public to oppose or comment on new projects and limit transparency and we do not support this.

18. **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 or expansion of GIP beds to meet patient demand should be considered 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

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

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

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

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

21. **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.

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

Yes-JSSA Hospice is in agreement with this suggestion. Measures to expedite and clarify the process are needed improvements.

Duplication of Responsibilities by MHCC and MOH

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

Not at this time, the departments serve different functions

We thank you for the opportunity to respond and share our ideas for improvement.

Sincerely,

Joyce Sexton, RN
Hospice Director,
Jewish Social Services Agency Hospice