Montgomery HOSPICE

Hospice at Home
1355 Piccard Drive, Suite 100
Rockville MD 20850
phone 301 921 4400
fax 301 921 4433

Casey House
6001 Muncaster Mill Road
Rockville MD 20855
240 631 6800 phone
240 631 6809 fax

www.montgomeryhospice.org

January 11, 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, MD 21236

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

Dear Mr. Parker:

Montgomery Hospice has completed the Comment Guidance – General Hospice Services MHCC CON Study. Please see our response to the questions below.

Need for CON Regulation

Montgomery Hospice 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?**

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."
Hospice is an interdisciplinary medical model that cares for extremely fragile and sick patients in their homes with resources available on a 24 hour basis. Small hospices cannot provide this comprehensive care because the insurance payment level is inadequate to support a high level of fixed costs (labor and overhead) unless the average daily census is well above 100 patients. Therefore, adding more small hospices does not increase utilization since the small hospices are incapable of providing the level of care that is needed.
One area where the public and health care delivery system benefit is when fewer terminally ill patients die in hospitals.

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?**

CON regulation should be concerned with good consumer access to quality hospice care. Competition and market entry are not the primary concern for terminally ill Marylanders. Ensuring an adequate number of larger hospices delivering quality patient care is.

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

CON regulation does not stifle innovation. Inadequate reimbursement stifles innovation.

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.**

CON ensures that Maryland does not have dozens of small, ineffectual hospices that are incapable of keeping dying patients out of hospitals. When a small hospice does not have a nurse available to visit a home in the middle of the night, the patient with uncontrolled symptoms will be sent by ambulance to the hospital. This is a common occurrence with small hospices.

Hospice care is delivered in patient homes which improves the patient and family experience of care; improves the health and well-being of the family members; and reduces the per capita cost of caring for dying patients who would be admitted to an ICU if they were not cared for at home. Hospice patients, by definition, are the sickest patients in the healthcare system. Many futile medical interventions could be used in a hospital (intubation, respirators, etc.)

Inpatient hospice is the one service where hospices resemble hospitals. Inpatient hospices, like Casey House, require major capital investment. The financial viability of the free-standing inpatient hospices can be compromised when hospitals or nursing homes convert unused beds

to inpatient hospice beds. The MHCC, through the CON process, should develop a targeted need methodology and a separate projection for hospice inpatient beds in order to analyze whether new inpatient hospice beds are necessary in a jurisdiction that has a free-standing inpatient hospice.

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?

No

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?

No

<u>The Project Review Process</u>

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

A chokepoint occurs when an applicant is given extra time even though it did not meet the timeliness or CON content requirements. This creates an unnecessary delay in the CON process for the applicants who know how to follow rules and regulations.
By allowing noncompliant applicants extra time, the MHCC appears to want to issue more CON's. The MHCC should be concerned mainly with the ability of applicants to provide quality hospice care. There should be no regard for the quantity of applicants. Hospices can grow to be as large as needed in order to meet the hospice demand. Maryland should want larger hospices since they are more financially viable and sustainable.

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?

It depends on whether the state wants to hear from the existing hospices. Existing hospices will object to the applicants because, given the low reimbursement rate for patients who truly have a short-term prognosis, losing any referrals to a new hospice results in financial hardship for the existing hospices.

When hospices merge, it tends to produce a stronger, more robust hospice; therefore, it is advisable that hospices should be able to merge without CON review. However, if each hospice has a CON, the merged asset system should only retain one. The other CON(s) should be null and void.

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

The CON process can be lengthy; therefore, economic conditions may have changed once CON approval is given. Since project completion depends on the current economic and medical environment, adequate time should be given in order for the applicant to maximize its business model before finalizing the project.

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?

A chief weakness is that the State Health Plan does not have a specific need methodology or projections for inpatient hospice beds. Freestanding inpatient hospices are important medical providers in several Maryland jurisdictions. Adding inpatient hospice beds without regard to need or demand puts the existing inpatient hospices in financial jeopardy.

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.

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, this has been summarized in previous questions. Regulation changes should be focused on need determination and hospice's helpful impact on the total cost of care model.

General Review Criteria for all Project Reviews

COMAR 10.24.01.08G(3)(b)-(f)) contains five general criteria for review of all 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?

"Availability of more cost-effective alternatives that deliver quality hospice service" should be eliminated, and the following expanded criteria could be implemented:

- 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?

I do not believe that CON regulation of 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 federal government has demonstrated that the public sector does not adequately police low quality providers. Medicare certification requirements are more rigorous that Maryland licensure, yet few hospices have been sanctioned. When the federal government finds a very serious problem, it usually only asks for a plan of correction. Recently, VITAS was fined $75 million after having provided plans for stopping its fraudulent behavior.

Using the Maryland Department of Health is not a viable alternative.

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 restrict innovative hospice behavior.

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?

I do not understand this question. Home health agencies do not provide complex, interdisciplinary palliative care for patients AND families. Home health agencies and hospices are not similar.

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 consider the applicant's history of quality care performance in the very beginning of the process. An applicant should be eliminated if it cannot demonstrate its commitment to quality.

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 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.

Hospices are currently able to initiate major projects and services without CON review. For example, Montgomery Hospice started a pediatric service, as well as a specialty team for patients who have only a week to live at the time of referral. Montgomery Hospice strongly believes that adding inpatient hospice beds to a jurisdiction, where free-standing inpatient hospices have been built, should be subject to a full CON process, with carefully constructed need methodology. The CON regulation should be maintained.

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

There is no need for a whole new regulatory process.

The Project Review Process

20. Are there specific steps that can be eliminated?

No specific steps should 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 Commission has shown 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.

This was addressed in the response to question 18.

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

Yes

Duplication of Responsibilities by MHCC and MOH

24. 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

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

Sincerely,

Ann Mitchell

Ann Mitchell, MPH
President & CEO