***Draft* Meeting Summary**
Certificate of Need (CON) Modernization Task Force
Maryland Health Care Commission
Meeting of Friday, May 11, 2018
MHCC Offices, 4160 Patterson Avenue, Baltimore, MD

Committee Members in Attendance:
Frances Phillips, Co-Chair
Randolph Sergent, Co-Chair
Regina Bodnar
Ellen Cooper
Lou Grimmel
Elizabeth Hafey
Ann Horton
Andrea Hyatt (Phone)
Adam Kane (Phone)
Ben Lowentritt
Brett McCone
Michael O'Grady (Phone)
Barry Rosen
Andrew Solberg

MHCC Staff in Attendance:
Paul Parker
Ben Steffen
Suellen Wideman

Others in Attendance:
Brian Ackerman
Pat Cameron
Daniel Carter
Linda Cole
Peggy Funk
Marta Harting
Anne Langley
Patricia O'Connor
Dawn Seck
Shelley Steiner
Noson Weisbord

Co-Chair Frances Phillips called the fifth meeting of the Task Force to order.

Adam Kane, Andrea Hyatt, and Mike O'Grady joined the meeting via phone.

Ms. Phillips asked for comments on the draft summary of the April 20, 2018 meeting. She asked for introductory remarks from Ben Steffen.

Mr. Steffen noted that this meeting would conclude Phase I of the study on modernizing CON regulation with the primary focus of the meeting being consideration of an interim study report. He asked that members of the Task Force provide any additional comments not presented at this meeting on the draft interim report by Monday, May 14. He stated that the draft report, with any revisions or other changes emerging from today's Task Force meeting would be considered by the Commission on Thursday, May 17, 2018 and would be submitted to the General Assembly Committee chairs by June 1. Phase II meeting dates will be distributed to the Task Force members in the near future. The Commission will be considering how to reconstitute the Task Force, which will probably involve some expansion, for the next phase.

Co-Chair Randolph Sergent noted that the Task Force was not required to endorse everything included in the document, but the goal is to ensure consensus that the items included in the report represent what had been discussed up to this point in the process.

Paul Parker took the lead in review of the draft by the Task Force by asking for questions, comments, and discussion section by section.

Report Section - Introduction

A few individuals provided edits to the Task Force roster. Adam Kane noted that he only represented HSCRC and did not officially represent continuing care retirement communities. Ann Horton corrected the spelling of her name and the name of her employer. Ms. Horton also stated that she should be identified as representing the Maryland National Capital Home Care Association.

Report Section - Overview of Common Themes: Need for CON/Benefits and Costs

Dr. Ben Lowentritt, Mr. Parker and Mr. Sergent discussed the references to two categories of facility commenters, on page six, which the report stated deviated from the general pattern of comments from other facility categories. Mr. Parker stated that the two categories were the ambulatory surgical facilities, where a number of commenters recommended elimination of CON regulation, and hospices, where the comments uniformly supported maintenance of CON regulation with few changes. This contrasted with the comments submitted by other types of regulated facilities, which tended to support maintenance of CON regulation in some form but with substantive changes in scope and process. Mr. Sergent suggested making changes to clarify this characterization.

Mr. McCone commented about page seven's reference to hospitals and total cost of care in the second paragraph. He noted that the content was fine but suggested changing the wording from "with respect to hospitals" to "with respect to health care services."

Mr. Sergent asked, how would non-hospital CONs be affected by the all payer model? For example, if there was a CON for a nursing home, would it be expected to be reviewed relative to the all payer model?

Barry Rosen stated that a CON program that regulated hospital bed supply could be assisting in the control of costs because HSCRC may have lower capital costs that need to be accounted for in global budgets. In contrast, for example, if there was a proliferation of hospices, the cost of care might go down. On the one hand, CON helps to control some costs. On the other, CON might be limiting the ability to have a positive impact on costs.

Mr. Kane clarified that HSCRC did not regulate hospital charges on a line-item basis by facility type under the planned total cost of care model.

Regina Bodnar reminded the Task Force that more hospice providers did not increase hospice utilization, which is evident in Baltimore as the city has the highest number of providers and the lowest hospice use rate in the state. The theory that more providers may increase utilization and decrease cost has not been proven.

Mr. Steffen stated that the idea of broadening CON was good. CON should be viewed as a tool, but how it was being deployed relative to total cost of care is going to be different by sector. The idea that CON was going to constrain was probably too narrow a framework. In some instances, it may enable while in others it may constrain.

Mr. Sergent commented that with hospitals, there is a technical "need" for review. Mr. Steffen commented that the issue was the word "need." He wondered if driving things to the most cost-effective venue was considered a need. Maybe there should be new ways of looking at CON as more than just population need or need for capacity. Maybe need should be redefined based on cost effectiveness.

Andrew Solberg commented on the benefits section. He suggested that the report needed to state that CON regulation is the primary mechanism through which the Commission can implement policies it has adopted for influencing change in the institutional sector of the health care delivery system.

Mr. Sergent stated that it didn't matter if CON was a tool if it was not a good tool. Ms. Phillips reflected on Mr. Solberg's remarks, saying that CON was a mechanism, not classified as good or bad, but only wanted to note it was a tool.

Mr. Rosen gave an example that argued for "opening up" CON. If care could be more efficient in an ambulatory setting rather than a hospital, then allowing for deregulation of ASCs that have two operating rooms or even larger would help the all payer model.

Mr. Kane asked Mr. Parker and Mr. Steffen if HSCRC commented on CON applications involving non-hospital projects? Mr. Parker responded that it did not. Mr. McCone stated that the implication was that for HSCRC to be of increased value then it would be necessary to expand its

review reach. It was then noted that over the last five years, HSCRC had reviewed hospice projects in certain instances and that does seem to be the direction things are heading.

Mr. Parker noted that MHCC has assumed that an all payer model addressing the total cost of care would change the collaborative relationship that has been the norm between MHCC and HSCRC. In the past year there had been a nursing home applicant considering an alternative payment model involving partnering with hospitals. In that instance the commission asked HSCRC to review the materials that applicant had provided. The Commission has considered collaborative relationships between hospitals and nursing homes aimed at reducing the total cost of care as something that the State Health Plan (SHP) might incorporate as an innovation justifying more flexibility with respect to bed need limitations that would otherwise apply in a particular jurisdiction.

Mr. McCone commented that, with controlling the total cost of care as a framework for the All Payer Model, an administrative process for non-hospital applications that involve a relationship with hospitals would be needed.

As discussion of this section was concluding, Mr. Parker stated that he would remove the wording relating to "pure market forces" given the existence of hospital rate regulation as an obvious limitation on this concept.

Ms. Phillips then recapped the main points discussed so far:

1. Change the first statement regarding "all payer system" to "health care services"
2. Capture the technical understanding of the redundancy between MHCC and HSCRC
3. Characterize CON as a policy lever
4. Remove reference to pure market forces

Ms. Phillips transitioned conversation to the Scope and Role Section.

Report Section - Overview of Common Themes: Scope and Role of CON Regulation

Mr. Parker noted that many comments were received regarding the need to alter the scope of CON regulation in various ways, with a particular emphasis on eliminating or modifying the use of a capital expenditure threshold. For hospitals, he stated that it was important to think about how changing the threshold would be accomplished because it has played a different role in hospital CON regulation than in the non-hospital sector. Changes for non-hospital facilities would be simpler.

Mr. McCone commented that the second portion of the second paragraph in the scope and role section on page eight should be removed given that it started to provide a solution rather than just identifying problem statements. The third sentence of the second paragraph of this section that begins with "one alternative concept" should be removed.

Mr. Rosen stated that that sentence may just need to be rephrased as a problem. Mr. McCone reminded the group that two paragraphs later, the point was addressed regarding duplication.

Report Section – Overview of Common Themes: State Health Plan

Mr. Solberg pointed out that on the bottom paragraph of page nine of the draft report, the problem was that the SHP standards didn't address documented problems. Rather, they represented things that the staff believed were good ideas. Going forward, the Commission should identify the problems and then consider which SHP standard(s) is needed to address the problem.

Mr. McCone made a point that on the second paragraph of the SHP section, it was not just a hospital payment model. Also, regarding the third paragraph about consolidation, he was unsure if the group had sufficient discussion on this topic.

To Mr. McCone's question, Mr. Steffen answered that the group had two different conversations related to the impact on consolidation, as well as innovation, but those items were not discussed in depth.

Commissioner O'Grady also stated that the topic of consolidation was brought up a few meetings ago and the discussion related to incentives being in place for consolidation, but that consolidation was also criticized.

Dr. Lowentritt commented that he was struck by the statement that consolidation stifles innovation. In his view, the two phenomena are not mutually exclusive, so he recommended that innovation and consolidation should be addressed as two separate concerns. Ms. Philips stated that the consensus within the group was that these topics were discussed, but there was not consensus on their interrelationship, as described in the draft.

Mr. Sergent and Dr. Lowentritt commented that consolidation should not be characterized as a blanket negative. Unintended consequences can sometimes be positive and sometimes negative.

Report Section – Overview of Common Themes: Project Review and Post Project Review

Mr. Solberg suggested adding another issue to the post project review process. Why did projects have to undergo a full review by MHCC if they are not in a competitive review? There ought to be classes of projects that don't have to go to through a full Commission review Mr. Sergent suggested adding a bullet point to address this issue.

Report Section – Problem Statements Section

Mr. McCone expressed some concern about the problem statement related to community input, stating that anybody could write a letter or try to obtain interested party status in any CON application review. He believed that there were opportunities for substantive input, but questioned how far that element of the review process needs to go - where does it end? Ms. Phillips suggested using "underdeveloped" instead of "inadequate." Mr. Solberg also suggested softer language, using "might be", as there was no evidence that the current process isn't sufficient for many if not most project reviews. Mr. Steffen argued that the statement should be framed to reflect that the Task Force is anticipating potential problems, not only looking at problems historically.

Mr. Grimmel commented that the line was being blurred between the All Payer system and total cost of care. HSCRC only controlled 60 percent of costs, what about the other 40 percent? CON might be able to help address the 40 percent. Mr. Grimmel proposed that when a hospital discharges a patient to a nursing home, the nursing home is held accountable for readmission. The same should be true for hospice and home health agencies. Dr. Lowentritt stated that problem statement eight under nursing homes identified the problem, but Mr. Grimmel was providing a solution to the problem. Mr. Grimmel argued that this is, in fact, a problem and that nursing homes not being held accountable for readmission rates is a problem that we need to articulate.

Ms. Phillips asked, in response, how that was a CON problem? Could that point be put under problem statement five under section B or reframed and put under the scope section?

Mr. Grimmel agreed to changes in the wording in the last problem statement under section B that the CON program and the SHP did not support the development of innovative models. He noted that hospitals had an exemption for post-acute care units and CCRCs had an exemption for CCF beds, so precedents had been set in these instances.

Mr. Rosen stated that this was a broader issue as there are now "siloes" between assisted living, nursing home, home health, and hospice, which is an unintended consequence of how CON regulation is structured.

Ms. Phillips summarized the conversation on this section:

1. Augment the last bullet related to nursing homes
2. Add to the discussion of the scope of CON regulation the problem of separated health care facility "siloes" hindering the development of more integrated referral handoffs between acute and sub-acute providers and different types of sub-acute providers.

Ms. Phillips transitioned discussion to next steps and Phase Two of the study.

Phase II/Next Steps

Mr. Steffen stated that the draft report would be revised over the next few days and would then be presented to the Commission. After approval by the Commission, the report would be made available to the Chairs and available for public comment. Comments would be collected over the next three to four weeks, which would become the starting point for Phase II. Phase II would begin in June and continue through October, with a report to the Commissioners in November. It will be a tight timeline, but it is achievable. Additionally, the Task Force would probably add a couple of representatives from other organizations, with a twenty-member maximum.

Mr. McCone noted that public comments or a public hearing would be important in the process.

Mr. Steffen stated that now was also the time to think about the guiding principles. Those that were used in 2005 would be shared and other thoughts were welcomed as well. The guiding principles would be a topic at the next Task Force meeting. Mr. Grimmel commented that the 2005 principles were fine as a baseline but would need to be modified for the realities of 2018.

Mr. Steffen thought that the 2005 principles were fairly broad and would still apply but needed to be more specific as this group would want more guidance in evaluating modernization ideas and making "concrete" recommendations.

Mr. McCone asked how recommendations that are provided during Phase II would be reviewed? Mr. Steffen responded that the Task Force could be the first step in vetting the suggestions and that the Commission would also make some decisions regarding if direct responses are necessary. It was also noted that if certain items sounded promising but required additional detailed staff analysis, then the Task Force might be unable to make a final decision on those items in December.

Appendix G

Task Force members also reviewed and discussed information provided by staff on the time required to complete CON application reviews. Mr. Parker outlined the elapsed time for the last 49 final actions or docketed application withdrawals at MHCC, noting the differences seen in average and median review times for contested cases and uncontested cases. He opined that part of the problem in the excessive average and median times taken in contested reviews was the failure to effectively manage the two tracks created by the "triage" approach used by staff. While ensuring that most simple and uncontested project reviews get completed more quickly, the longer time frames for review of larger, more complicated, and contested reviews continue to have too much "dead time" occurring, as short-term work to process the simpler projects fills up staff time. The process itself creates time line expectations that require more rigorous adjustment of priorities as the work load changes.

Closing

Mr. Parker thanked Ascendient and Mr. Sergent for the roles they played in drafting the report. Mr. Sergent thanked the staff and Task Force for their diligent work and input. Ms. Phillips echoed thanks and opened up the floor for the audience to ask any questions.

Anne Langley made note of the fact that there was a section in the viability criterion about the community[1] that wasn't typically used, and she wondered if that was a way to get more community input where it was relevant.

Ms. Langley was thanked for her suggestion and the meeting was then concluded.

[1] Ms. Langley is referring to COMAR 10.24.01.08G(3)(d) "Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project."