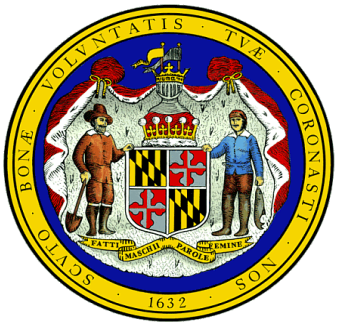
White Paper:

A New Approach for Planning and Regulatory Oversight of Home Health Agency (HHA) Services in Maryland



Developed by the

Center for Health Care Facilities Planning and Development

Maryland Health Care Commission

January 2015

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Appendix (Con't)

Introduction

The Maryland Health Care Commission has regulatory oversight for the development of certain health care facilities and services, including home health agencies, through its Certificate of Need (CON) program. The Commission has the responsibility to develop a State Health Plan, which contains policies, a model for forecasting need, and CON review standards and criteria, to guide decision-making in the CON process. The purpose of this White Paper is to provide a conceptual framework for updating the Home Health Agency (HHA) chapter of the State Health Plan (SHP) to reflect recent and anticipated changes in the delivery and financing of HHA services. Current regulations addressing HHA services begin at COMAR 10.24.08.08 (the HHA Chapter), within COMAR 10.24.08, which was promulgated in 2007 as the *State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services*. A new Hospice Services Chapter was promulgated in 2013 at COMAR 10.24.13. A separate and new State Health Plan chapter focused on HHA services will be developed and promulgated at COMAR 10.24.16.

This White Paper provides an overview of HHA services in Maryland including: the supply and distribution of HHAs; utilization and financing of HHA services; and quality assurance mechanisms. Issues regarding certain aspects of the Commission's current regulatory approach for development of HHA services in Maryland are also discussed. A possible new conceptual approach for forecasting HHA need that promotes consumer choice of quality providers is recommended. Other suggested changes include: the incorporation of quality and performance measures in the State Health Plan and CON review; the elimination of the specialty HHA designation; and implementation of new SHP regulations regarding acquisitions.

A 2015 Home Health Agency Advisory Group has been created to review the issues and a possible new regulatory approach outlined in this White Paper, as well as to discuss other relevant concerns. The role of the HHA Advisory Group is to assist Commission staff in analyzing utilization trends, identifying contributing factors to the changes in the utilization of HHA services, and discussing the underlying policies inherent in staff's suggested new conceptual approach for regulating HHA services in Maryland. Participants on the Advisory Group consist of representatives from Maryland HHAs of varying size, geographic location, and type, most of who were nominated by the Maryland National Capital Homecare Association (MNCHA), and a representative of a local health department that provides HHA services. Other representatives include consumers, payers, and State and federal regulatory agencies.

Current Landscape: Home Health Agency (HHA) Services in Maryland

In Maryland, a variety of licensed entities provide home care services to sick or disabled persons in their places of residence. The types of home care providers include, but are not limited to: HHAs; residential service agencies (RSAs); and nursing referral service agencies (NRSAs).[1] The Maryland Health Care Commission regulates only one of these entities, home health agencies, through its Certificate of Need program. Therefore, the focus of this paper will be on licensed home health agencies.

Maryland law[2] defines a home health agency as

> a health-related institution, organization, or part of an institution that:
>
> (1) Is owned or operated by one or more persons, whether or not for profit and whether as a public or private enterprise; and
>
> (2) Directly or through a contractual arrangement, provides to a sick or disabled individual in the residence of that individual, skilled nursing services, home health aide services, and at least one other home health care service that are centrally administered.

Only a home health agency that meets Maryland licensure requirements, found at COMAR 10.07.10.02, may be certified to receive Medicare reimbursement. Types of home health services covered by Medicare include the following six major disciplines: part-time or intermittent skilled nursing;[3] home health aide; physical therapy; occupational therapy; speech therapy; and medical social services. A patient is eligible for the Medicare home health benefit if the patient: is homebound;[4] is under the care of a physician; will receive services provided under a plan of care established by a physician; and, requires skilled nursing care on an intermittent basis or physical therapy or speech therapy services, or has a continued need for occupational therapy.[5]

[1] Home health agencies (HHAs) are licensed under COMAR 10.07.10; Residential Service Agencies (RSAs) under COMAR 10.07.05 and Nursing Referral Service Agency (NRSA) under COMAR 10.07.07.
[2] Health–General Article § 19-401(b), Annotated Code of Maryland.
[3] Medicare defines "part-time" as fewer than eight hours per day; "intermittent" means from as much as every day for recurring periods of 21 days – if there is a predictable end to the need for daily care – to as little as once every 60 days.
[4] To be homebound and considered "confined to the home" means you have trouble leaving your home due to your illness or injury; leaving your home is not recommended because of your medical condition; and, you are unable to leave your home because it is a major effort and assistance is required. A doctor must certify that the patient is homebound. Department of Health & Human Services, CMS; CMS Manual System Pub 100-2 Medicare Benefit Policy, Transmittal 192, August 1, 2014
[5] Department of Health & Human Services (DHHS), Centers for Medicare & Medicaid (CMS), Medicare Benefit Policy Manual, CMS Pub. 110-2.

Supply and Distribution of HHAs in Maryland

As of January 2015, there were 56 licensed HHAs in Maryland. Of these, 50 are classified by the Commission as general home health agencies serving the general population in authorized jurisdictions, while the remaining six are authorized as specialty home health agencies that serve only a specified population.[6] Of the 56 HHAs, 43 are freestanding, six are hospital-based,[7] four are specialty agencies operated by continuing care retirement communities (CCRCs) for their resident populations, two are local health departments (Baltimore and Garrett Counties) and one is nursing home-based. Thirty-five agencies, or 62.5% of all home health agencies statewide, are organized as for-profit entities.

Based on FY 2013 data reported by agencies in response to the Commission's annual Home Health Agency Survey, the majority or 80% of the 50 general HHAs are authorized to serve more than one jurisdiction under one HHA license. However, not all agencies served all of their authorized jurisdictions. This is illustrated by comparing the distribution of authorized jurisdictions (refer to Table 1 in Appendix) with that of jurisdictions actually served (refer to Table 2 in Appendix). For example, while nine agencies (18%) have authority to serve 11 or more jurisdictions, only five agencies (10%) actually served at least one client in 11 or more jurisdictions.

Availability of and access to HHA services is a function of both the supply of agencies and the geographic distribution of agencies. Table 3, in the Appendix, illustrates the variations in the geographic distribution of HHAs, as measured by the number of agencies per jurisdiction across Maryland. The majority of agencies are located in the Baltimore metropolitan area,[8] Montgomery, Prince George's, Carroll and Frederick Counties. Client use rates per 1,000 population (all ages) ranged from a regional low of 12.92 in Southern Maryland to a regional high of 23.66 on the Eastern Shore (refer to Table 4 in Appendix).

Availability of HHA services may partly depend on the capacity of an agency, based on the number of clients a single agency can serve. Since home health is a client-based rather than a facility-based service, there is more flexibility with agencies being able to expand staffing resources to absorb additional clients. Moreover, there is no standard national measure for determining a minimum or maximum number of home health clients per agency. Variations in average caseloads across Maryland's jurisdictions (refer to Table 3 in Appendix) may be reflective of differences in referral patterns to home health agencies from hospitals, physicians,

[6] Of the six specialty agencies, four are CCRC-based agencies with their authorization limited to serving only the residents of its CCRC. The remaining two specialty agencies have authorization to serve only pediatric clients and mother/newborn dyads in specified jurisdictions.

[7] HHAs reported as hospital-based agencies include: Carroll Home Care; Frederick Memorial Hospital Home Health; HealthSouth Chesapeake Rehabilitation Home Health; Meritus Home Health; Shore Home Care; and Western Maryland Health System Home Care. Of the six, five are general acute hospital-based agencies.

[8] Baltimore metropolitan area includes the following five jurisdictions: Anne Arundel, Baltimore, Harford and Howard Counties, and Baltimore City.

and nursing homes. Furthermore, the availability of alternative delivery sites of care, as well as the presence of a caregiver at home, may be other factors contributing to the geographical variations.

Utilization of HHA Services in Maryland

The Commission's annual HHA Survey collects statewide data on the utilization of home health agency services in Maryland. Highlights from the data analyses for the Fiscal Year 2013 reporting period are summarized below.

▪ Statewide Profile of HHAs and Clients in 2013

In 2013, 56 licensed home health agencies served a total of 106,375 clients (unduplicated count) with an overall average of 16.4 visits per client reflecting a statewide total of 1,746,559 visits. Age distribution of clients and visits[9] is consistent with the finding that the majority of clients (72.1%) and visits (83%) were Medicare beneficiaries. About 22.1% of total HHA clients were covered by private insurance (including HMOs), and about 4.7% were covered by Medicaid. More than half of HHA clients were female (59.8%). Breakdown of HHA clients by race included: White (58.7%); African-American (22%); Hispanic (2.1%); Asian (1.3%); and 15.9% were categorized as either unknown or other (refer to Table 5 in Appendix).

▪ Statewide Trend Analyses: 2004 to 2013

The number of HHA admissions increased 20.5% from 93,462 in 2004 to 112,602 in 2013, concurrent with an increase in the number of licensed HHAs from 51 to 56 (refer to Figure 1 in Appendix). However, there was not a steady increase in admissions from 2004 to 2013. Use declined by 4.5 percent between 2006 and 2007. The number of admissions increased in 2008 and 2009 without reaching the 2006 volume. From 2009 to 2012, there was a steady increase in admissions, with a leveling off from 2012 to 2013. Similarly, while there was an overall increase in total number of both clients (unduplicated count) and visits from 2004 to 2013, there was not a steady increase (refer to Figure 2 in Appendix). There was a 16.3% overall increase in clients from 2004 to 2013 and a 35.9% increase in visits over the same period. However, similar to fluctuations in the number of admissions, there were also fluctuations in the number of clients (refer to Figure 2 in Appendix).

Some of the decline in utilization reported between 2004 and 2007 and the increase from 2007 to 2013 may have been due to a combination of factors that include: changes in Medicare's home health agency prospective payment system (HH PPS) rate updates and reimbursement policies;[10]

[9] In 2013, distribution by age for clients and visits was as follows: 0-44 years, 7.5%clients and 3.7% visits; 45 – 64 years was 21.4% clients and 18.3% visits; 65+ years was 70.1% clients and 77.8 % visits; with other and unknown reporting 1.0% clients and 0.2% visits.

[10] Since its implementation, HH PPS has undergone changes by CMS's rule-making process; update notices have been published in the *Federal Register* every year to primarily revise the HH PPS base rate to account for changes in

new CMS requirements for a physician's documentation of a client's eligibility for HHA services to address, in part, concerns over increasing national Medicare fraud and abuse; entry of new providers through acquisitions of existing agencies, as well as Certificate of Need (CON) approvals for additional new agencies in three jurisdictions; and implementation of the ACA in 2010.[11]

From 2004 to 2013 there were shifts in the distribution of admissions by agency type (refer to Table 6 in Appendix). Admissions to freestanding HHAs increased from 69.5% to 85.9%, while the proportion of admissions to hospital-based HHAs declined from 17.9% to 10.4%. This shift from hospital-based to freestanding agencies was due to the entrance of new providers, both through CON approvals and acquisitions. There was also a decline in admissions to HMO-based agencies, from 10% to 0% due to the acquisition of all four HMO-based agencies by a freestanding (non-HMO-based) HHA.

HHA admissions by referral source show that hospitals continue to be the primary source of referrals, with 54.8% of admissions in 2004 and 53.6% in 2013 (refer to Table 7 in Appendix). Other major sources of referrals in 2013 include private physicians (18.7%) and nursing homes (13.6%).

HHA discharges by disposition show that the vast majority of clients have consistently been discharged with home care goals met, with a slight decline in the percent distribution of all discharges from 69.6% in 2004 to 69.2% in 2013 (refer to Table 8 in Appendix). The largest proportion of discharges transferred to another setting were those home health clients transferred to an acute care hospital, from 7.6% in 2004 to 9.7% in 2013. Clients who no longer met reimbursement criteria accounted for the third highest proportion of total discharges from home health care, but declined from 9.1% in 2004 to 8.0% in 2013.

Financing of HHA Services in Maryland

▪ Payer Mix of HHA Services

Medicare continues to be the primary payer source for home health agency services, and is the payer for 72.1% of total Maryland clients and 83.0% of Maryland visits in 2013 (refer to Table 9 in Appendix). This directly relates to the differences in the average number of visits per client for Maryland's Medicare enrolled clients (average of 18.9 visits per Maryland's Medicare client)

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the home health market basket. CMS continues to monitor whether case-mix growth is due to "real" change in service utilization or "nominal coding changes," and has made adjustments to HH payment amounts accordingly.

[11] Section 3401(e) of the Affordable Care Act (ACA) amended Section 1895 (b)(3)(B) of the Social Security Act which sets forth how Medicare HH payments be updated by the applicable market basket percentage increase, providing that "[a}fter determining the home health market basket percentage increase…the Secretary shall reduce such percentage … for each of 2011, 2012 an 2013, by 1 percentage point." Therefore, the HH market basket was reduced by 1 percentage point for CYs 2011, 2012 and 2013. For CY 2014, there is no such percentage reduction; the HH PPS market basket update for CY 2014 is 2.3 percent.

as compared to total Maryland clients (average of 16.4 visits per total Maryland client). (Refer to Table 10 in Appendix).

Private insurance companies (including Blue Cross and other commercial insurance) have had an increasing share in the financing of HHA services in Maryland. From 2004 to 2013, private insurance companies had the highest increase in both the number of clients (49% increase) and visits (67.2% increase). The second greatest increase was for Medicare, which had a 32.8% increase in clients and a 51.2% increase in visits for the same period (refer to Table 11 in Appendix).

Medicaid has consistently paid for a lower proportion of HHA services, 4.7% of clients in both 2004 and 2013. HMOs have had a major decline in paying for HHA clients, changing from 11.9% of clients in 2004 to 4.3% of clients in 2013.

▪ Medicare Reimbursement for HHA Services

Medicare shifted away from a cost-based, retrospective payment approach, moving initially to an interim payment system (IPS) and eventually to a prospective payment system (PPS), effective October 2000. The first fiscal year under which all Maryland HHAs operated under PPS was FY 2002.

Because Medicare is the primary payer for HHA services, changes in Medicare reimbursement have a major impact on how HHA care is provided. Medicare's HH PPS reimburses HHAs for a 60-day episode of care through a prospective payment founded on a nationally standardized base rate.[12] This base rate is updated annually to address changes in the home health market basket and undergoes various adjustments for case-mix, wage index, and other factors. Home health patients with low utilization, defined as having four or fewer home health visits per episode, are reimbursed under the Low Utilization Payment Adjustment (LUPA) on a per-visit, per-discipline payment rate.[13] Additional outlier payments are made available to agencies with unusual variations in the type or amount of medically necessary care. Partial episode payments (PEP) are a third type of case-mix adjustment for those episodes with actual utilization costs which exceed the total episode payment.[14] PEPs are also applied as a pro-rated payment if a patient is transferred to another HHA in the middle of a 60-day episode, or if discharged early but then

[12] The CY 2014 national standardized 60-day episode payment rate is $2,869.27; the proposed CY 2015 rate is $2,865.57

[13] The CY 2014 national LUPA per visit payment rates by discipline are: home health aide ($54.84); Medical Social Services ($194.12); Occupational Therapy ($133.30); Physical Therapy ($132.40); Skilled Nursing ($121.10); and Speech-Language Pathology ($143.88). Implemented in CY 2014, LUPA add-on payment amounts for skilled nursing, physical therapy and speech-language pathology are made when that discipline performed the initial assessment visit.

[14] If the imputed episode cost, estimated from actual service utilization, exceeds the total episode payment by more than a fixed amount, the agency receives some portion of the excess. U.S. Department of Health and Human Services, "Report to Congress: Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program," (2013); page 13.

returns to same agency within the 60-day timeframe. A conversion factor for Non-Routine Medical Supplies (NRS) was created in 2008 to address concerns about the high cost of supplies for certain patients; a classification system categorizes high cost NRS users across six severity levels with associated payment weights. [15]

Information on patient characteristics and resource use is collected on the Outcome and Assessment Information Set (OASIS) instrument. The combined information gathered on a patient's clinical status, functional status, and therapy utilization, as well as the number of past home health episodes at the time of the given episode, are assigned to one of the 153 Home Health Resource Groups (HHRGs).[16] Each HHRG is assigned a weight relative to the average episode which, in turn, is multiplied by the base payment to account for a patient's relative use of HHA services.

CMS has historically made changes annually to the 60-day national episode rate, the national per-visit rates for each of the six disciplines, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for HHAs. Such adjustments to the base rates are partly premised on review of HH claims data and monitoring of changes in case-mix and patient utilization to determine whether such case-mix changes are "real" or due to "nominal case-mix" changes.[17]

Medicare's payment methodology for high use of therapies (14+ visits) seemed to have had an impact on number of visits and costs per discipline in Maryland, as illustrated in Figures 3 and 4, (in Appendix) respectively. CMS realigned the incentives (and disincentives) for paying for therapy services by lowering the case-mix weights for high therapy episodes (14+ visits) and increasing weights for episodes with little or no therapy. CMS recalibrated the HH PPS case-mix weights to address incentives that existed in the HH PPS to provide unnecessary therapy services. In the final 2015 PPS rule, CMS simplifies therapy reassessment by requiring a qualified therapist (instead of an assistant) from each discipline to conduct a patient reassessment at least every 30 calendar days, regardless of the number of therapy visits provided. This CMS policy change is intended to lessen the burden on HHAs of counting visits so that therapists can focus on providing quality care for their patients.[18]

Section 2121 of the ACA mandates additional changes to Medicare's payment for home health services. Beginning in CY 2014, adjustments to the national 60-day episode payment amount, as

[15] The CY 2014 NRS conversion factor is $53.65 and CY 2014 NRS payment amounts for the six severity levels are: $14.47 (Level 1); $52.27 (Level 2); $143.31 (Level 3); $212.92 (Level 4); $328.33 (Level 5); and, $564.69 (Level 6). An average NRS payment per episode of $48.38 is estimated for CY 2013. (*Federal Register*, Volume 78, No.231; December 2, 2013; page 72281)

[16] In 2008, the original set of 80 HHRGs was increased to the current set of 153 HHRGs.

[17] *Federal Register*, Volume 78. No. 231; Monday, December 2, 2013. Department of Health and Human Services; Centers for Medicare & Medicaid Services; 42 CFR Part 431, page 72259.

[18] Fact sheets: CMS announces payment changes for Medicare home health agencies for 2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-10-30.html

well as the LUPA amount and other applicable amounts, were required to reflect factors such as: changes in the number of visits in an episode; the mix of services in an episode; the level of intensity of services in an episode; the average cost of providing care per episode; and other relevant factors.[19] These rebasing adjustments are meant to align payments with actual costs, and must be phased-in over a four-year period in equal increments, not to exceed 3.5% of the Calendar Year 2010 payment rates.[20]

The cumulative impact of these changes projected for CY 2015 results in an overall net reduction of $60 million, or by 0.3 percent, in HH PPS payment rates compared to CY 2014.[21] According to CMS' fact sheet[22] regarding its payment changes for Medicare home health agencies for CY 2015, this payment decrease reflects the combined effects of the 2.1 percent home health payment update ($390 million increase) plus the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor (2.4 percent or $450 million decrease), for a net overall reduction of $60 million.

CMS' concern regarding escalating national Medicare fraud and abuse, coupled with increasing HHA costs, have spurred the federal government to consider revamping the way Medicare pays for HHA services. The ACA required the development of a plan by the U.S. Department of Health and Human Services (HHS) to consider the steps required in designing and implementing a value-based purchasing (VBP) program for HHAs. CMS' report to Congress describes its current efforts underway to improve quality and payment efficiency, and considers shifting away from reimbursing HHA services based on utilization and quantity of services provided, and towards linking payment to performance. A value-based purchasing approach would reward HHAs based on better value, outcomes, and patient-focused care that considers HHAs' quality and performance.

Quality Assurance Mechanisms for HHAs

▪ Oversight and Certification Surveys

In Maryland, Medicare-certified HHAs are under much stricter quality oversight and compliance requirements than are other types of home care providers that are not eligible to be Medicare-

[19] *Federal Register*, Department of Health and Human Services; Centers for Medicare & Medicaid Services; 42 CFR Part 431; Volume 78, No. 231, December 2, 2013.
[20] Consistent with the Affordable Care Act's mandates, HH PPS annual payment adjustments beginning CY 2014 through CY 2017 are as follows: a reduction of $80.95 to the national, standardized 60-day episode payment amount; increases to each of the six per-visit LUPA payment amounts (ranging from $1.79 for home health aides to $6.34 for medical social services); and, a reduction of $1.52 for the NRS conversion factor.
[21] Overall net reduction in HH PPS payment rates was 1.05 percent in CY 2014; three times greater than CMS' 0.3 percent rate reduction for CY 2015.
[22] Fact sheets: CMS announces payment changes for Medicare home health agencies for 2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-10-30.html

certified. Maryland's Office of Health Care Quality (OHCQ) is the CMS-designated State Agency (SA) responsible for the survey and certification of Medicare-certified HHAs, assuring that all Medicare Conditions of Participation (CoPs) are met, as well as all applicable federal, State, and local laws and regulations. CMS contracts with OHCQ and three CMS-approved accreditation organizations[23] to conduct initial Medicare certification surveys, recertification surveys, and complaint investigations. CMS also contracts with SAs to perform validation surveys of HHAs recently surveyed by accreditation organizations as a way to monitor the performance of accreditation organizations.

As of January 2015, of the 35 HHAs in Maryland that are accredited, 14 of them have deemed status, electing to obtain Medicare certification through an accreditation organization rather than by OHCQ. Medicare recertification surveys are conducted every 3½ years to verify compliance with Medicare CoPs, with HHAs having varying three-year certification cycles. The U.S. Department of Health and Human Services' Office of Inspector General published a study in April 2013 that sought to: identify whether SAs and accreditation organizations conducted timely recertification surveys of HHAs; and determine which HHAs received deficiency citations, corrected deficiencies, or had complaints lodged against them.[24] Findings from this study noted that, overall, recertification surveys were conducted on time for 98 percent of HHAs and 12 percent of HHAs were cited with at least one condition-level (serious) deficiency, which varied widely by SA and accreditation organizations. Of those HHAs with condition-level deficiencies, 93 percent corrected all deficiencies within the required timeframes. State-specific findings revealed that Maryland was one of nine states that did not cite any HHA with condition-level deficiencies, compared with eight states that cited condition-level deficiencies for 20 percent or more of the HHAs receiving recertification surveys.

▪ CMS' Home Health Quality Reporting Program

Promoting the delivery of high quality healthcare services is a priority concern for CMS. [25] Adoption of standardized measures regarding quality, coupled with public reporting on CMS' Home Health Compare website, enables consumers and providers to compare quality and performance information across all Medicare-certified HHAs. With input from the National Quality Forum (NQF) and other stakeholders, certain categories of quality and efficiency measures are selected and incorporated into CMS' Home Health Quality Reporting Program. HHAs are required to meet the quality data reporting requirements[26] to be eligible for the full HH market basket percentage increase. HHAs that do not meet the reporting requirements are

[23] The three accreditation organizations with CMS-approved deeming authority in Maryland are: Accreditation Commission for Health Care (ACHC); Community Health Accreditation Program (CHAP); and, Joint Commission.
[24] Department of Health and Human Services, Office of Inspector General; "Home Health Agencies Received Timely Surveys and Corrected Deficiencies as Required," April 2013, OEI-06-11-00400
[25] *Federal Register*, Volume 78, No. 231; December 2, 2013; page 72296.
[26] Quality reporting requirements are met by an agency's submission of OASIS assessments and HHCAHPS.

subject to a two percentage point reduction to the HH market basket increase determined and announced each year by CMS.

There are generally two types of quality measures collected and publically reported: process and outcome measures; and, experience of care measures. Each is discussed more fully below.

> Process and Outcome Measures

An HHA seeking Medicare certification is required to meet the Medicare CoPs including, but not limited to, compliance with requirements for collecting and reporting performance data for Medicare and Medicaid HHA clients, and using the OASIS instrument/data collection tool.[27] OASIS consists of data elements collected at the point of care that include the core items of a comprehensive assessment for the home care patient. The data are used for two major purposes: (1) measuring agency processes and patient outcomes for calculating quality measures for public reporting; and, (2) providing data on which provider reimbursement is calculated. Submission of OASIS assessments at both the start and end of an episode is required in order to calculate quality measures.[28]

There are numerous quality measures collected through OASIS.[29] A subset consisting of 20 quality measures (both process and outcome measures, as well as potentially avoidable event measures) plus the two claims-based home health utilization measures[30] are publically reported on the CMS Home Health Compare website and are updated on a quarterly basis.

Since the fall of 2011, the Commission's Consumer Guide to Long Term Care Services has reported the 22 Home Health Compare quality measures for each Maryland Medicare-certified HHA. Agency-specific scores are calculated for each of the 22 process and outcome measures, and are compared to Maryland and national average scores for the 2012 and 2013 reporting years. (Refer to Table 12 in Appendix). Such quality reporting on public websites allows greater transparency to the consumer of an agency's performance relative to that of others. Moreover, each HHA has data on how its performance compares with other agencies to potentially incorporate into its own internal quality improvement program. Comparing 2013 aggregate Maryland and national scores for the 22 process and outcome measures, Maryland

[27] The third iteration of OASIS data collection is commonly referred to as OASIS-C data.

[28] OASIS data is not collected for patients under age 18 years (regardless of payer source), patients receiving pre- and post-partum maternity services (regardless of payer source), and patients receiving only chore and housekeeping services. Failure to submit complete OASIS assessments is considered as failure to comply with the Conditions of Participation.

[29] There are three types of home health quality measures based on OASIS-C data: process measures, outcome measures, and potentially avoidable events. Process measures have been reported since October 2010. Outcome and potentially avoidable event measures have been reported since June 2011.

[30] Two Medicare claims-based utilization measures ("acute care hospitalization" and "emergency department use without hospitalization") were added to Home Health Compare in late 2012/early 2013. Two new claims-based measures were added on CASPER reports beginning CY 2014: (1) re-hospitalization during the first 30 days of a home health stay and (2) emergency department use without hospital readmission during the first 30 days of home health stay; these two new measures are not yet reported publically.

reports better scores than the nation on 11 measures; scores equal to the nation on 6 measures; and, scores worse than the nation for 5 measures.

On December 11, 2014 CMS announced its intent to publish a star rating for home health agencies on Home Health Compare starting in 2015. This is part of a larger plan to adopt star ratings across all Medicare.gov Compare websites. Star ratings are currently publicly displayed on Nursing Home Compare, Physician Compare, the Medicare Advantage Plan Finder, and are scheduled to be displayed on Dialysis Facility Compare and Hospital Compare in 2015.

The rationale for a star rating is consumer research indicating that symbols and summary data help consumers more quickly identify differences in quality and make use of the information when selecting a health care provider. In addition to summarizing performance, star ratings can also help HHAs identify areas for improvement. Language in the ACA supports this action, calling for "transparent, easily understood information on provider quality."

> Experience of Care Measures

Since 2011, HHAs have been required[31] to participate in the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. This survey gathers the consumers' perspectives regarding their experiences with the services/care received. The first public report of HHCAHPS results was released in April 2012.

Five measures – three composite measures and two global ratings – are derived from the HHCAHPS Survey with publicly reported data adjusted for differences in patient mix across HHAs. Each of the three composite measures consists of four or more individual survey items regarding one of the following related topics: patient care; communications between providers and patients; and, specific care issues on medications, home safety, and pain. The two global ratings are the overall rating of care provided by the HHA, and, the patient's willingness to recommend the HHA to family and friends.

Agency-specific scores are calculated for each of the five experience of care measures for the 2012 and 2013 reporting years, and are compared to the average scores for Maryland and the nation. (Refer to Table 13 in Appendix).

Comparing 2013 aggregate Maryland and national scores for the five experience of care measures, Maryland has scores equal to the nation on two measures and has scores that are worse for three measures.

[31] An HHA may request an exemption from participating in the HHCAHPS survey if it served fewer than 60 survey-eligible clients for the reporting year. For the CY 2012 reporting period, three Maryland agencies did not report on the HHCAHPS survey; all three were relatively new agencies.

CON Regulation of HHA Services in Maryland

As previously stated, home health agencies are the only type of home care provider required to obtain a Certificate of Need before seeking licensure.[32] An HHA is licensed under the rules found at COMAR 10.07.10, and is the only licensed home care provider[33] permitted to seek Medicare certification. Maryland's Office of Health Care Quality (OHCQ) is responsible for licensure and certification.[34] Medicare-certified HHAs must meet all applicable federal regulations for participating in the Medicare program, as well as State licensing rules.

While OHCQ's licensure regulations do not require an HHA to be Medicare certified, State Health Plan regulations (COMAR 10.24.08) require an HHA to be both Medicare- and Medicaid-certified.[35]

A CON is required to establish a new home health agency in Maryland and to expand the service area of an existing agency to a new jurisdiction. A CON is not required for the acquisition of an existing HHA[36]; however, acquisition of an HHA requires timely notification to MHCC in accordance with CON procedural regulations at COMAR 10.24.01.03.

Current CON Review Standards and Criteria

A CON applicant must address the consistency of its proposed project with the applicable standards in the State Health Plan, currently found at COMAR 10.24.08.10, as well as five other review criteria found at COMAR 10.24.01.08G. These criteria are need, the availability of more cost effective alternatives, viability, impact, and the track record of the applicant in meeting the terms and conditions of previously issued CONs.

The existing HHA Chapter contains standards for the review of proposed general and specialty HHA projects regarding the following:

Service Area	Cost
Financial Accessibility	Linkages with Other Service Providers
Information to Providers and the General Public	Discharge Planning

[32] Under Health-General §19-120(f), a CON is required before a new health care facility is built, developed, or established. Under Health –General §19-114(d) (vi), the definition of a health care facility includes a home health agency.

[33] Other types of home care providers include: Residential Service Agencies (RSAs) licensed under COMAR 10.07.05 and Nursing Referral Service Agency (NRSA) licensed under COMAR 10.07.07.

[34] An HHA license is valid for one year and is required to be reissued on a yearly basis, with a $350 license renewal fee. CMS-approved Accreditation Organizations (AO) may conduct certification surveys in lieu of OHCQ. Refer to prior section on "Oversight and Certification Surveys."

[35] Only general HHAs are required to be Medicare and Medicaid certified (COMAR 10.24.08.10A(2)), and accept clients whose expected primary source of payment is one or both of these programs.

[36] COMAR 10.24.01.03A(2) states "In an acquisition of a home health agency the purchaser may only acquire the authority to offer home health agency services in jurisdictions in which Commission records show that the facility being acquired either provided that service during fiscal year 2001, or was granted a CON after that date."

Time Payment Plan
Charity Care and Sliding Fee Scale
Quality
Financial Solvency
Data Collection and Submission

In addition, a specialty agency is required to address standards specific to its target population. For example, the existing HHA Chapter, at COMAR 10.24.08.10B(6)(a), requires a CCRC proposing to establish a specialty HHA to:

> (i) Serve exclusively the subscribers of the specified CCRC, who have executed continuing care agreements for the purpose of utilizing independent living units or assisted living beds within the continuing care facility, except as provided in COMAR 10.24.01.03K;
>
> (ii) Permit subscribers of the CCRC to receive these services from other home health agencies authorized by the Commission to provide services in the same jurisdiction; and
>
> (iii) Provide to the subscribers of the CCRC a list of home health agencies authorized by the Commission to provide services in the same jurisdiction ….

Current CON Docketing Rules

Under current docketing rules, at COMAR 10.24.08.09, review of a CON application to establish or expand a general home health agency cannot be initiated unless a jurisdictional net need forecast exceeds a volume threshold, as established through the methodology described in the following paragraph. However, for jurisdictions with fewer than three authorized general home health agencies serving residents in that jurisdiction that shows any positive net need, the jurisdictional volume threshold can be waived. This docketing rule was introduced in the last update of the HHA Chapter to recognize the desirability of additional consumer choice for Marylanders with two or fewer choices of HHAs. This rule allows for an HHA's expansion into a geographically adjacent jurisdiction that has fewer than three agencies, as long as the agency seeking expansion served at least 25% of total clients within its contiguous currently authorized jurisdiction.[37]

Current Forecasting Methodology

The current HHA Chapter uses statewide referral rates as the foundation for its projection of future demand for general home health agency services. This forecast is based on discharges from Maryland's acute general hospitals and nursing homes to home health agency services. Nursing home referral rates are calculated only for short-term residents, who stayed 30 days or

[37] Only one agency took advantage of this opportunity to expand; first into Dorchester County (CON in 2008) and then a year after being acquired expanded into Talbot County (in 2011).

less in a nursing home. Referrals from sources other than hospitals and nursing homes are assumed to be fifty percent of the combined referrals from hospitals and nursing homes. The methodology assumes that the proportion of referrals in each jurisdiction is equal to the proportion of admissions for that jurisdiction to estimate a base year number of referrals for the jurisdiction. This base year number of referrals is assumed to change consistent with projected population change in a given jurisdiction, with a target year six years beyond the base year.

HHA CON Reviews

A jurisdiction is identified as showing need for additional home health agency capacity only if the number of additional clients forecasted for the target year is greater than 400 clients. This 400 client threshold as a trigger for a review cycle is applied across all jurisdictions, regardless of the varying population size of the 24 jurisdictions and the varying number of HHAs operating within them. Three jurisdictions (Baltimore, Frederick, and Montgomery Counties) had a projected number of clients in the last forecast, published by MHCC in 2007, that exceeded this threshold. This need projection, which was for a 2010 target year, resulted in scheduled review cycles with multiple applicants in each cycle. During 2008 and 2009, CON applications were reviewed and CONs were awarded, as follows: in Baltimore County, three of 15 applications were approved, which included two new providers and expansion of an existing HHA; in Frederick County, two of 15 applications were approved, both expansions of existing HHAs; and in Montgomery County, four of 16 applications were approved and all were new providers in Maryland, although two of the successful applicants in Montgomery County were also the new providers approved for Baltimore County. Thus, for the State as a whole, this set of review cycles produced four new providers, an increase in total HHAs of approximately eight percent, and two existing HHAs were allowed to expand. One of these existing HHAs received two CON awards, allowing it to expand from its base in Carroll County to the adjoining Baltimore and Frederick Counties.

Survey of Other States' Methodological Approaches

Recently, Commission staff conducted a survey[38] of all states with CON programs regulating HHA services. The primary purpose of this survey was to ascertain other states' methodological approaches for forecasting need for HHA services. In summary, there are 37 states with CON regulations. Of these 37 states, 18 regulate home health agency services (including Maryland). Of the seventeen states that responded to the questionnaire, one noted that it had amended its CON statute to include HHAs, but had not yet developed any standards or a need methodology.

[38] Commission staff distributed a questionnaire to all states with CON programs in April 2012 via an alpha-interactive list-serve to all American Health Planning Association (AHPA) members. Survey questions included whether the state has a need methodology for forecasting HHA services. Initially, seven of the 17 states with a CON program for HHA services responded. Subsequently, during the months of November 2012 and January 2013, the remaining 10 states that did not initially respond were contacted by phone as well as by email.

Of the remaining sixteen states, five reported that they do not have a methodology for projecting need, with an applicant required to demonstrate need for a proposed project, but free to choose its own quantifiable approach. States that have explicit need projection methodologies generally fall into two broad approaches: projections based on historical demand for services; and projections based on a fixed, or "aspirational," target. The prevailing approach to planning for HHA services is to assess historical demand (observed HHA utilization) and project the trend forward, adjusting for population growth and demographic shifts, to identify a future demand for HHA services. For the purposes of CON regulation, this future demand is the basis for identifying need for additional providers, and triggers solicitation of applications for a given area or jurisdiction, as well as the subsequent CON application and review process if a certain volume threshold is met. An alternate approach is to identify a target level of services, based on empirical evidence or common practice, as the basis of need for future HHA services.

Among the 11 states that reported the existence of a methodology, Commission staff found considerable variation in approach, but almost all states used county as the basic geographical unit for the projection. Four states use a demand-based approach.[39] All four states use a historic trend of use rates to project forward a target year use rate, but three states adjust for population growth, while one[40] does not. The volume threshold for the level of need required before soliciting applications varied from 100 to 500 additional clients. Three states use an "aspirational" approach, with each state taking a different approach to estimating the target.[41] One of these three states uses an age-adjusted target; a second state uses a 10-state area average as the target; and a third state uses a visit per agency average as the target. The remaining four states indicated an assessment of need is part of the CON review process, but the approach to such an assessment was not described with enough clarity to summarize it in this report. Nine of the 11 states project need for HHA services on a county-specific basis and two effectively use planning regions, by summing county-specific projections for purposes of CON review.

[39] Four states use a demand-based approach: Alabama, Kentucky, New Jersey (proposed) and North Carolina.
[40] North Carolina does not adjust for population growth.
[41] Three states use an aspirational approach: Georgia, Mississippi, and Washington.

Issues Regarding Current CON Regulation of HHA Services in Maryland

Issue: Forecasting Need

The current forecasting model in the HHA Chapter was based on a conventional approach and data available at the time. With the availability of agency-specific process and outcome data, performance measures and quality information can now be incorporated into the replacement HHA Chapter.

Some limitations of the current approach for projecting HHA need in Maryland are:

- The current methodology relies on statewide assumptions based on number of clients referred from acute care hospitals, short-stays in nursing homes, plus other referral sources. The methodology does not consider potential jurisdiction-specific or age-specific variations;

- The existing forecast model assumes that the number of HHA clients will change consistent with the overall population;

- The referral-based model using statewide assumptions is fixed; projecting six years from the base year has tended to create a shorter planning horizon, given the time required to obtain reliable data for the base year and timeframe for promulgation of SHP regulations;

- There is no need forecast for number of agencies, although CON applications are often seeking to establish new HHAs. Instead, the methodology forecasts numbers of clients and there is no clear basis for translating need expressed as clients into need for agencies. This limitation is addressed in part by establishing a volume threshold in recognition of an existing agency's ability to expand (or contract) by enhancing (or reducing) staffing resources; and,

- The methodology uses the same 400 volume threshold for all jurisdictions regardless of size and number of HHAs in the jurisdiction. This threshold capacity assumption could potentially be of concern when applied for Maryland's smallest jurisdictions. Of the State's 24 jurisdictions, ten have fewer than 100,000 residents and six of those jurisdictions have fewer than 40,000 residents.

As discussed earlier, analyses of recent trends show fluctuation in utilization of HHA services that are influenced by changes in Medicare reimbursement policies. Changes in Medicare reimbursement levels and rules will continue to be a significant factor in shaping use of HHA services in Maryland. Furthermore, with recent changes in Maryland's hospital rate regulation system that became effective in January 2014, acute care hospitals should have incentives to partner with post-acute care providers in order to reduce hospital admissions and readmissions. The impact of such hospital payment policy changes on future demand for HHAs is uncertain,

but the Commission should prepare for potential change by examining how its need methodology can be more responsive to these dynamic times.

The issue regarding forecasting need outlined above served as the background for preliminary discussions with an HHA Advisory Group that was assembled by Commission staff in 2010. A possible new methodological approach was discussed for projecting need for HHA services based on a regression model of historical utilization. The group discussed the effects of the current referral-based approach for projecting HHA need, including use of a single year of statewide utilization without any adjustments for age or jurisdiction-specific variations in utilization. Factors noted by the 2010 Advisory Group as affecting the direction of change in use of HHA services included: anticipated cuts in Medicare reimbursement for HHAs[42] and for physicians; recalibration of CMS' case-mix weights for HH PPS; growth in the supply of Residential Service Agencies (RSAs)[43]; and certain provisions of the ACA including the face-to-face requirement for documentation of a patient's HHA eligibility to receive Medicare HH services. These preliminary discussions guided Commission staff to reconsider the existing HHA forecast model and assumptions, and to consider a new conceptual approach for regulating HHAs in Maryland.

Issue: Measuring Quality

The current HHA Chapter, at COMAR 10.24.08.10A(6), requires an applicant to address the following program-oriented CON review standard on quality:

> An applicant shall develop an ongoing quality assurance program that includes compliance with all applicable federal and state quality of care standards, and provide a copy of its program protocols when it requests first time approvals required by COMAR 10.24.01.18.

This subsection regarding quality was adopted[44] by the Commission before CMS developed its quality performance measures and the experience of care survey (HHCAHPS) and before the public reporting of such information on CMS' Home Health Compare website. Such data is now available.

[42] CMS issued rules that cut home health payment rates by 2.75% in 2008, 2009 and 2010; 3.79% in both 2011 and 2012; 1.32 % in 2013; 1.05% in 2014; and a proposed 0.3% rate reduction in 2015.
[43] According to OHCQ, the number of RSAs increased from 606 in 2008 to 1,058 in 2013; a 75% increase.
[44] The Home Health Agency Chapter of the State Health Plan for Facilities and Services (COMAR 10.24.08) became effective March 12, 2007.

Issue: Specialty Home Health Agencies

Since 1992, the Commission and its predecessor[45] have provided for two types of HHA designations in the applicable SHP chapter – "general" and "specialty." The current HHA Chapter, at COMAR 10.24.08.12B(42), defines a specialty HHA as an HHA that provides:

> (i) Services exclusively to a pediatric population;
>
> (ii) An array of services exclusively to a population group limited by the nature of its diagnosis or medical condition;
>
> (iii) To all population groups a highly limited set of services that can offer acceptable quality only through specialized training of staff and an adequate volume of experience to maintain specialized skills; or
>
> (iv) Services exclusively to the residents of a specific continuing care retirement community (CCRC).

A general HHA may provide a full range of home health services that are not restricted as a specialty home health agency. Maryland presently has six specialty HHAs -- four are CCRC-based and exclusively serving the community's residents and two serve pediatric clients and medically fragile children or maternal/newborn dyads.[46] Unlike general HHAs, specialty HHAs are not required to conform with the HHA Chapter's need projection. The filing of a letter of intent to establish a specialty HHA is done upon request by the applicant, and is not a scheduled review. Someone seeking to establish a specialty HHAs is required to "demonstrate quantitatively that there exists an unmet need that it intends to address." The demonstration of need for a specialty HHA must include, but is not limited to:

> (a) Identification of the characteristics and/or special needs of the client group to be served;
>
> (b) A detailed description of the types and quantities of specialty home health care services that the client group needs or is projected to need; and
>
> (c) An assessment of the extent to which the home health needs of the client group are or are not being met by existing home health service providers. [47]

Neither OHCQ, which is responsible for licensing and certification of HHAs in Maryland, nor CMS recognize the specialty HHA designation. Both general and specialty Commission-

[45] Maryland Health Resources Planning Commission, the predecessor to the Maryland Health Care Commission
[46] Of the two specialty HHAs that serve pediatric clients, one has served its projected volume while the other has consistently had very low volume.
[47] COMAR 10.24.08.10B(1).

designated entities are licensed and certified simply as home health agencies. A general HHA is not precluded from serving populations defined under the "specialty" HHA designation.

Historically, only a handful of applicants have sought to establish a specialty agency to serve pediatric clients. Of these few applicants, one has achieved its projected volume. This is partly due to the requirement by Maryland Medical Assistance (Medicaid) that an HHA have Medicare certification as an HHA in order to receive Medicaid reimbursement as an HHA. This presents a challenge for a specialty agency serving a non-Medicare patient population.

Issue: Market Entry and Expansion through HHA Acquisition

Although there were limited opportunities for HHA development through scheduled CON reviews, nonetheless, the Maryland HHA market has undergone substantial change in recent years. As of December 2014, 21 of the 50 general HHAs, or 42 percent, have entered Maryland by way of acquisition of an existing Maryland HHA. An additional 10 general HHAs expanded their authorized service areas through HHA acquisitions.

The current HHA Chapter does not address acquisitions. Minimal information regarding acquisitions is required under CON procedural rules, found in COMAR 10.24.01, applicable to all changes of health care facility ownership. The existing regulation, COMAR 10.24.01.03A(2), which was adopted in 2003, limits a buyer's ability to acquire the authority to serve jurisdictions that the HHA being acquired did not serve in 2001:

> In an acquisition of a home health agency, the purchaser may only acquire the authority to offer home health agency services in jurisdictions in which Commission records show that the facility being acquired either provided that service during fiscal year 2001, or was granted a Certificate of Need after that date.

In September 2014, staff undertook a comparative analysis of authorized jurisdictions[48] with jurisdiction-specific utilization in 2001 and 2011/2012 to determine the magnitude and potential impact of the current 2001 HHA acquisition rule. Three general categories were created to profile this impact: (1) eight HHAs are authorized to serve jurisdictions that they did not serve in 2001, 2011, and/or 2012; (2) eleven HHAs are authorized to serve jurisdictions that they served in 2001, but did not serve in 2011 and /or 2012; and (3) seven HHAs are authorized to serve jurisdictions that they did not serve in 2001, but served in 2011 and/or 2012.

In addition, Commission staff has received some inquiries expressing concern that some recent buyers of HHAs have not continued to provide HHA services to all payer groups, as did the previous owner of the HHAs. Procedural regulations, at COMAR 10.24.01.03A(7), provide that

[48] Since January 2012, an HHA's authority to serve clients in certain jurisdictions has been specified on its HHA license issued by OHCQ. Authority to serve a jurisdiction does not necessarily equate to where services were actually provided in 2001 or since.

CON review is required if the Commission finds that a proposed acquisition will "result in a change in health care services…." However, the parameters of "change in health care services" that would require CON review in this context are not clearly delineated. Existing acquisition rules may be too limited if they can result in certain residents experiencing a reduced access and/or availability resulting from a new owner's business plan and objectives. Staff notes that some areas of the State have a limited number of HHA options for residents. Additional requirements for staff approval of an acquisition should be considered because certain transactions can have resulted in unanticipated changes in HHA service delivery, and have continued potential for altering access and availability of services.

Updating the HHA Chapter: A New Conceptual Approach

The issues raised above identified matters regarding the Commission's current regulatory approach. To address these issues, Commission staff has framed some broad new concepts for consideration, with staff's overall approach generally premised on the following overarching principles that the MHCC's regulation of HHA services should:

- Respond to the changing needs of the population and the HHA marketplace by enhancing consumer choice in concentrated markets;
- Respond to changes in the health care environment, particularly impact of the ACA and the new Maryland hospital all payer model;
- Permit growth through the expansion of existing HHAs with high levels of performance and permit gradual development of new agencies with documented experience in providing quality health care services;
- Create opportunities for HHA development in jurisdictions where there is a limited choice of quality HHA providers; and
- Streamline the CON review process by establishing docketing and procedural rules that promote a consumer-choice and performance-driven approach.

Forecasting Need: A Consumer Choice and Performance-Driven Approach

Staff recommends moving away from a strictly defined methodological approach for forecasting to a more dynamic approach to create opportunities both for existing agencies to expand, as well as for a new entrant to establish a home health agency. This shift away from forecasting need based on utilization and quantity of HHA services, as in the past, and towards a greater emphasis on quality and performance measures to increase consumer choice of quality providers, where needed, is parallel in concept to the federal government's proposed value-based purchasing program model for HHAs (also referred to as pay-for-performance, or P4P).[49]

Staff's suggested new approach would permit development of high quality HHAs in response to the changing needs of the population and the marketplace. Unlike the current forecasting model, this new approach would take into account market conditions of a jurisdiction including variations in population size and volume of HHA services provided, as well as either an applicant's proven record or its demonstrated capability to provide high quality HHA services.

[49] In general, a value-based purchasing program is intended to tie a provider's payment to its performance in such a way as to reduce inappropriate or poorly furnished care and to identify and reward those providers who deliver quality patient care. Department of Health and Human Services, Centers for Medicare & Medicaid Services; 42 CFR Parts 409, 424, 484, 488, 498 [CMS-1611-P] Proposed Rule for CY 2015; page 123

CON review would be performance-driven, when need for additional consumer choice of quality providers is identified.

▪ Combining Small Contiguous Jurisdictions

A less populated jurisdiction may be too small to provide a new HHA with a large enough client base to be sustainable. Staff's suggested new approach would permit the combination of certain contiguous jurisdictions in rural or remote geographic areas that are less densely populated and have concentrated HHA markets. CON review cycles could combine certain contiguous jurisdictions, accordingly to create an opportunity for an HHA applicant to serve more than one jurisdiction. This approach would reflect the reality of the existing Maryland HHA market, where most agencies are authorized to serve more than one jurisdiction.

▪ Qualifying Factors for a Jurisdiction and for an Applicant

Staff's new approach is conceptually based on identifying certain qualifying factors or triggers that can lead to consideration of an additional HHA to serve a jurisdiction. There would also be certain characteristics required for an applicant to be eligible to seek a CON to provide services in that jurisdiction. These qualifying factors would be used to determine whether an application for an HHA met requirements for docketing and the initiation of a CON review.

> Qualifying Factors for a Jurisdiction

Enhancing access for Marylanders in a jurisdiction with limited HHA choice is desirable, as premised in the current HHA Chapter's docketing rules[50] for jurisdictions with fewer than three agencies. Both the number of HHAs authorized and actually serving a jurisdiction and the volume of clients being served by those HHAs are factors to be considered. In a possible new approach, opportunities would be extended not only to jurisdictions with two or fewer HHAs, but also to a jurisdiction that has a highly concentrated market of HHA providers. A jurisdiction with limited market competition, where a disproportionate market share of clients are being served by a few agencies, could be measured by using a market concentration measure such as the Herfindahl-Hirschman Index.[51] Consideration of common or related ownership of the individual agencies within a jurisdiction could be an important factor, especially given recent HHA acquisition activities. Performance of existing agencies could be measured and monitored to assure access to quality HHAs. A jurisdiction with existing agencies that perform below selected Home Health Compare and HHCAHPS measurements could also trigger consideration of a new entrant into that jurisdiction.

[50] COMAR 10.24.08.09C.

[51] The Herfindahl-Hirschman Index (HHI) is a measure of the size of firms (HHAs) in relation to the overall HHA industry and an indicator of the amount of competition among them. It is defined as the sum of the squares of the market shares of all the HHAs authorized and actually serving a jurisdiction. Results can range from 0 to 1.0; a competition index of 1.0 indicates a monopoly or a totally concentrated market. Conversely, a competition index close to 0 generally indicates a fair share of the market among an increasing number of HHA providers and, thus, an HHA market offering greater access to a variety of HHA providers.

Combined together, these factors create opportunities for HHA development in jurisdictions where the market is concentrated and/or where there is limited access to high quality HHAs, while simultaneously avoiding additional HHA development in jurisdictions where there is consumer choice and access to a sufficient number of high quality performing agencies.

> Qualifying Factors for an HHA Applicant

Eligibility of a potential applicant to submit a CON should be premised on its capability to provide high quality HHA services in a qualified jurisdiction. Demonstration of such capability could be based on whether the applicant is an existing HHA licensed in Maryland or in another state seeking to expand, or is an applicant seeking to establish a new HHA. Existing specialty agencies in Maryland not serving the general HHA population would not be eligible to expand under their existing authority. However, staff recommends that such specialty HHAs should be permitted to seek a CON to establish a new general HHA. Therefore, different qualifying factors specific for expansion by an existing agency and for establishment of a new agency should be proposed. Such qualifying factors would be used to determine whether an applicant for an HHA meets the necessary criteria that, in a qualifying jurisdiction, would permit initiation of a CON review. Possible docketing rules could include, for example, documentation of its financial resources and viability to expand or establish its HHA business in Maryland, with a commitment to serve a mix of all payer types from commercial insurers, Medicare, Medicaid and charity care.

Incorporate Quality and Performance Measures in SHP and CON Review

Quality measures publicly reported on CMS' Home Health Compare provide an opportunity for the Commission to implement a performance-driven review process and enhance its CON docketing rules, review standards, and preference rules. [52] As such, the HHA Chapter revision should incorporate the use of quantitative measures of quality and outcomes as part of CON regulatory oversight. Commission staff believes that the public interest is best served if CON regulation is structured to promote high level performance by HHAs using the most recent and best resources available to measure such performance.

Quality measures (process, outcome, and experience of care) can be examined over time for an individual HHA to determine a benchmark level of achievement, allowing evaluation of improvement (better quality scoring). Comparison of agency-specific scores with other Maryland HHAs, and with statewide and national average scores[53] would allow the Commission to assess the relative ranking of Maryland HHAs. (Refer to Tables 11 and 12.)

Home Heath Compare scores reflect how an agency performs across all of its authorized jurisdictions. It is not possible to measure performance in a single jurisdiction relative to an agency's performance in another jurisdiction. Furthermore, specialty HHAs exclusively serving

[52] The current HHA Chapter was adopted before quality measures were publicly reported on Home Health Compare
[53] Relative scores are anticipated to change with each quarterly reporting period.

pediatric and maternity patients do not submit OASIS data; therefore, no quality and performance measures are calculated for such agencies.

CMS' proposed star rating would become an additional measure available on Home Health Compare.[54] The criteria used by CMS to select measures for the star rating are noteworthy, because they reflect rigorous attention to the validity and reliability of the measures to show differences among HHAs.[55]

CMS selected the proposed measures to be included in the star rating based on the following criteria:

1. The measure should apply to a substantial proportion of home health patients and have sufficient data to report for a majority of home health agencies.
2. The measure should show a reasonable amount of variation among home health agencies and it should be possible for a home health agency to show improvement in performance.
3. The measure should have high face validity and clinical relevance.
4. The measure should be stable and not show substantial random variation over time.

Based on these criteria, CMS selected the following process and outcome measures to be included in the proposed star ratings:

Process Measures
Timely Initiation of Care
Drug Education on all Medications Provided to Patient/Caregiver
Influenza Immunization Received for Current Flu Season
Pneumococcal Vaccine Ever Received

[54] CMS began the process of stakeholder feedback on the proposed star rating methodology, including the measures proposed for inclusion in December 2014; additional opportunities for feedback are expected in early 2015. CMS did not announce a date for implementation of the HHA star rating, though mid-to late 2015 is projected for implementation.

[55] All Medicare-certified HHAs will be eligible to receive a star rating. HHAs must have at least 20 complete quality episodes for data on a measure to be reported on Home Health Compare. To have a star rating computed for Home Health Compare, HHAs must have reported data for 6 of the 10 measures used in the calculation.

Outcome Measures
Improvement in Ambulation
Improvement in Bed Transferring
Improvement in Bathing
Improvement in Pain Interfering With Activity
Improvement in Dyspnea
Acute Care Hospitalization

The proposed full methodology described by CMS for calculating the 5 Star Rating can be found at the following link: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-12-11-2.html.

The Maryland Health Care Commission will carefully monitor the CMS process for implementation of the Home Health Compare 5 Star Rating System for possible inclusion in the Maryland Consumer Guide to Long Term Care and for consideration in the HHA Chapter.

In addition, the Commission could select and publish a list of quality and performance measures beyond the 5 Star Rating measures, to be used in consideration of a CON application and in determining whether an HHA is delivering quality care. Measures selected would be those endorsed by a nationally recognized organization involved in quality and performance measurement such as the National Quality Forum (NQF). Such quality and performance measures could include process, outcome, patient safety, and experience of care measures. Quality measures evolve over time based on changes in the health care industry and in clinical practice. Therefore, it is expected that measures used in review of CON applications will be updated periodically with appropriate notification to providers.

Eliminate the Specialty HHA Designation

Staff believes that it is not necessary to continue the designation of HHAs by type of patients served. As described earlier, there is no evidence that general HHAs are precluded from serving such specialty type patients. Current specialty agencies would be grandfathered, with authorizations to serve as indicated on the agency's HHA license. A proposed new HHA seeking to serve a specified target population (i.e., only the pediatric population or a CCRC-based agency proposing to serve its own community residents exclusively) would be required to meet the same qualifying factors for both a jurisdiction and an applicant as other HHA applicants to determine whether it meets the criteria to allow it to file a CON application.

HHA Acquisitions: Remove Existing Restriction

Acquisition of an HHA in Maryland does not require CON approval. Current Commission regulations impose restrictions on granting an agency's authority for serving certain jurisdiction(s) to an acquiring agency. CON procedural regulations, at COMAR 10.24.01.03A(2), permit a buyer to acquire only the authority to offer HHA services in jurisdictions which the HHA being acquired actually provided HHA services in fiscal year 2001, or was granted a CON after that date. As described earlier, staff conducted a comparative analysis to ascertain the potential impact of the current 2001 acquisition rule for existing HHAs. Data showed that, under the strictures of this subsection, there are seven agencies that, if acquired, the buyer would not have authority to serve jurisdictions that the agencies served in 2011 and 2012 but did not serve in fiscal year 2001. Commission staff believes that, given the impact that this rule could have more than ten years after its adoption, it should be removed or nullified. New language could be adopted in the replacement HHA Chapter to address acquisitions and grant authority to acquire and serve jurisdictions consistent with the acquired agency's current HHA license.

Additional information for reviewing proposed HHA acquisitions should be required because these transactions have proven to be an important change factor in HHA service delivery with the potential for altering access and availability of services. It is important that the Commission understand fully the changes that are taking place and keep track of those changes. New requirements regarding proposed HHA acquisitions should be added in the replacement HHA Chapter.

Appendix