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In Senior Care and Services

August 19, 2024

Sent via email mhcc_regs.comment@maryland.gov
Ben Steffen,
Executive Director
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, Maryland 21206

RE: COMAR 10.24.20: *State Health Plan for Facilities and Services: Comprehensive Care Facility (Nursing Home) Services* and COMAR *10.24.01: Procedural Regulations for Health Care Facilities and Services.*

Dear Mr. Steffen:

On behalf of LifeSpan Network, we appreciate the Maryland Health Care Commission (MHCC) releasing draft regulations for comment on COMAR 10.24.20: *State Health Plan for Facilities and Services: Comprehensive Care Facility (Nursing Home) Services* and COMAR 10.24.01*: Procedural Regulations for Health Care Facilities and Services.* As noted, many of the recommendations and changes contained in these draft regulations are the result of the Nursing Home Acquisitions Transparency Workgroup and the subsequent, enacted legislation, both of which LifeSpan was a key stakeholder. At the onset, LifeSpan does request that the MHCC hold a meeting to further discuss these points and other comments received in response to this draft. Below are items that we believe need to be addressed from the redlined version of the draft documents.

Statutory authority for the State Health Plan is derived from various sections of the law, including Health-General Article §§ 19-114, 19-118(a)(2), 19-120 and 19-120.2 (effective October 1, 2024). COMAR 10.24.20 is divided into two sections – narrative and compliance regulation. Both are equally important. Regarding the narrative, there are sections that we believe state opinion rather than fact and are not properly supported by the literature but are used to support the desired outcome of the proposed regulation. Specifically, page 3 of the narrative discusses COVID infection and makes the affirmative statement that nursing homes had "increased rates of infection due to close proximity living, and close contact with staff." In actuality, the only article cited (authored by a non-clinician) states that "higher case rates ***may be*** attributed to the highly transmissible nature of Omicron and the nature of congregate care settings." (emphasis added). The narrative fails to acknowledge the other possible factors such as the transmissibility of Omicron and the age and acuity of the residents. It also omits the fact that the State required

nursing homes to admit COVID positive residents directly from hospitals, which does not then support the assertion of "close proximity living and close contact with staff." In addition, on pages 6-7, there are statements made regarding infection control that cite the Nursing Home Acquisition Transparency Workgroup but there are no recommendations contained in the report specific to infection control and the Workgroup's commentary differed on root causes.

Apart from the above statements, we would also request that on page 7 the first sentence regarding the use of electronic health records be removed since it sets a negative tone but is contradicted by the second sentence confirming that 99% of nursing homes now use an electronic record. Lastly, on page 9, if the narrative is going to reference the minimum staffing federal rule then there should be statements made regarding that Maryland already requires 3.0 hours but allows it to be satisfied by the use of LPNs and other appropriate health care professionals and that Maryland has historically staffed above 3.0 hours.

Regarding the policy statements and the corresponding draft regulations, we have concerns regarding the following areas.

Policy 1.2 Multi-Bed Rooms

This has been an area of substantial discussion. The Nursing Home Acquisition Transparency Workgroup recommended "[t}he Commission shall expand its authority to require an acquiring entity of a nursing home to eliminate or reduce, ***to the maximum extent possible***, the number of multiple-bed (3+ beds) rooms within three years from the acquisition date. These transitions shall be incremental and implemented with appropriate planning." Subsequent legislation, upon acquisition, requires the reduction of rooms that contain more than two beds but provides for a waiver. First, the policy statement, for accuracy, should reflect the waiver rather than be an absolution in the elimination of multi-bed rooms. Second, in reviewing the draft regulations, page 30 stipulates the waiver process for when a nursing home may not be able to reduce multi-bed rooms.

(3) Waiver of requirement to eliminate rooms containing more than 2 beds. The Executive Director may grant a waiver, partial waiver, or extension of the requirement under §B(2)(a) of this regulation, if a person who acquired the nursing home can demonstrate that:

(a) The requirement would:

(i) Impose significant financial loss;

(ii) Unreasonably reduce the number of nursing home beds in the jurisdiction; or

(iii) Impede access to underserved or difficult-to-place residents; and

(b) The person has taken reasonable steps to reduce the room density, which may include limiting new admissions and reconfiguring room assignments to avoid assigning more than two residents to a room.

We appreciate the adoption of this waiver process, but we think that there should also be an acknowledgement of physical or legal space constraints, given the current structure of many of

the nursing homes. This would then also be consistent with the language in Draft Regulation 10.24.01. In addition, we are concerned with subsection (b) and how it will be applied given that both subsections (a) and (b) must be satisfied in order to receive the waiver and could have the effect of negating the ability to receive the waiver and/or causing the financial constraint that the waiver seeks to avoid.

Policy 2.2 Medicaid Memorandum of Understanding

There needs to be a greater discussion regarding the continued requirement for the Medicaid memorandum of understanding ("MOU"). When the MOU was first instituted back in the 80's, the initial purpose of the MOU was to ensure that Medicaid recipients had access to nursing home beds. This is no longer a concern. Historical data demonstrates that occupancy has continued to decline, brought about by several factors, including the development of more care options. Presently and there is no data to believe otherwise in the future, the nursing home industry operates with available capacity, negating the need for the continued MOU. Unfortunately, there are times where a nursing home that accepts Medicaid but has low Medicaid penetration is unnecessarily penalized by this requirement. As long as the nursing home accepts Medicaid and there is not evidence that the nursing home denies admissions, then not meeting the standard should not be a hindrance. Again, we believe that this warrants a greater discussion.

Additional Concerns

Overall, the draft regulations continue to rely heavily on the 5-Star Rating System. However, while this measurement may have been appropriate prior to COVID, we have serious concerns with its use continued given the fact that OHCQ is notably delayed in conducting annual surveys. At this time, there are nursing homes that still have not been surveyed for four years. Any licensure survey that is currently being conducted or has been completed in the last few years is aggregating three or four years of deficiencies, which is artificially lowering ratings. Because of this, we support the provision on page 24 allowing a facility to provide documentation on why it can still meet quality metrics despite being below 3-stars. However, the language is confusing on how the nursing home is required to demonstrate that it can meet quality standards and should be more focused and concise. A discussion on this point is warranted.

On page 26, acquisition is referenced as: (a) transfers of stock or assets of the owner of the real property and improvements, bed rights, or operation of the nursing home, or any combination thereof; (b) an affiliation agreement between non-profit entities that changes the person who controls a nursing home's operation or assets; and (c) a lease agreement that changes the person who controls a nursing home's operation or assets. However, the legislation is more limiting in that it only includes: (1) a transfer of stock or assets that results in a change of the person that controls a health care facility; or (2) the transfer of more than 25% of stock or ownership interest in a health care facility. As indicated, there is no corresponding standard for a lease agreement or the transfer of real property. The draft regulation must track the legislation rather than broaden it.

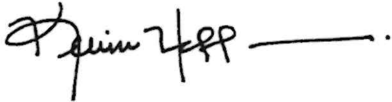
On page 27, we are concerned over the language – "*c) Affirm that the services provided will not change as a result of the proposed acquisition.*" This assumes that any change is negative whereas the opposite may be the case and that change is needed.

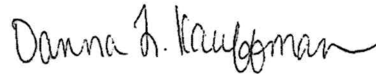
On that same page, we also recommend removing the catch-all phrase, which was not included in the legislation. More importantly, in order to advance negotiations and put together a change of ownership deal consistently and up-front information is essential. The draft regulation itself is very comprehensive.

Lastly, there needs to be greater clarity regarding the continued exceptions that currently exist and whether these requirements will be interpreted to apply to them, such as within a CCRC.

On behalf of our members, we appreciate the opportunity to comment on the draft regulations. Please note that these are our initial comments. We will continue to review and look forward to reviewing any additional comments received from other interest groups. As indicated above, we do believe that a discussion is warranted on these points and other points that may be raised and look forward to having a meeting scheduled. Thank you and do not hesitate to contact us with any questions or comments.

Sincerely,





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cc: Paul Miller, LifeSpan Network