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In Senior Care and Services

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Sent via email: linda.cole@maryland.gov

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Long-Term Care Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: COMAR 10.24.20: *State Health Plan for Facilities and Services: Comprehensive Care Facility Services*[1]

Dear Ms. Cole:

On behalf of LifeSpan Network, below are comments to COMAR 10.24.20 *State Health Plan for Facilities and Services: Comprehensive Care Facility Services*, as promulgated in the Maryland Register on December 7th. LifeSpan remains opposed to these revisions, mainly due to the docketing exceptions. We strongly believe that these exceptions undermine the Total Cost of Care (TCOC) and will decrease, not increase, quality for Maryland nursing facility residents.

LifeSpan does recognize and appreciate the changes that the Maryland Health Care Commission (MHCC) made to the original draft, such as the elimination of the provision regarding shell space, the ability to present evidence regarding former owners, and changing the time frame for reviewing the Federal 5-Star Rating to the last five refreshes of data. LifeSpan continues to question the need to maintain the Medicaid Memorandum of Understanding, especially when no evidence has been presented by the State to demonstrate that Medicaid recipients are not being admitted into nursing facilities solely because of payor source. However, this issue is secondary to the concerns that we outline below regarding the docketing of applications and the use of the 5-star rating as the main quality metric.

[1] Throughout this letter, the commonly referred to term "nursing facility" is used for comprehensive care facility.

Page 8/9: Docketing Rule Exceptions

LifeSpan does not support the ability to docket an application or approve a certificate of need (CON) when there is no identified need in the jurisdiction. As stated in the proposed regulations, the MHCC cannot docket an application involving an increase in nursing facility bed capacity unless the jurisdiction in which the facility is, or will be located, has an identified need for additional beds. The proposed regulations alter this requirement by allowing for three docketing exceptions. The commonality of all three exemptions is that it allows the MHCC to docket an application ***without an identified need*** for additional nursing facility beds in the requested jurisdiction.

Granting the authority to docket an application eventually may lead to the approval of a CON despite no identified need in that jurisdiction for new beds, which essentially dilutes the very premise of the CON process. The CON process has long been based on identifying need in the community for the requested action. Simply stated, when health care services are unavailable to those in need in a particular jurisdiction, the MHCC authorizes the addition of new beds and/or new health care services. It is hard to comprehend why the MHCC would want to actively promote the development of additional nursing home beds and/or new facilities at a time when nursing home utilization is declining, and the State continues to emphasize the development of increased home-and-community based services.[2] As explained more below, rather than try to justify the development of new beds by using quality or the TCOC Model as the basis, the State should address the underlying issues and/or work with the industry on programs that align with the TCOC Model but are within the current need structure. Again, the nursing home industry should be incentivized to realign existing beds rather than add new beds to a system when there is no identified bed and there is declining nursing home utilization.

It is also important to note that it is unclear whether statutory change is necessary prior to the enactment of these proposed regulations. The Draft Decision Matrices distributed on October 12th at the CON Modernization Workgroup specifically listed three areas that would require statutory changes: permit docketing of apps for new facilities in jurisdictions that have failed MHCC quality standards; allow changes in bed capacity of more than 10% without needing a CON – expand the waiver bed rules; and permit docketing of apps in jurisdictions that have no need if proposal [is] well aligned with TCOC demonstration. The December 11th Final Report remains silent on the issue. Given the fact that a CON is needed to change bed capacity or to develop a new service, it is unclear how statutory authority is not needed.

[2] This is evidenced by the requirements contained in these revisions where an applicant must provide information to every prospective resident about the existence of alternative community-based services as well as other requirements (page 14 - .05 General Standards) and the continued work by the Maryland Department of Health to transition individuals from nursing homes to alternative community-based services through the Money Follows the Person Program and other waivers.

Regarding each of the three exceptions, LifeSpan's additional concerns are below.

1. **Allow the docketing of an application <u>without an identified need</u> for additional beds if more than 50% of the comprehensive care facilities in the jurisdiction had an average overall CMS star rating of less than three stars in CMS's most recent five quarterly refreshes for which CMS data is reported.**

While on its face, this exception appears to promote quality, it could easily have the unintended consequence of decreasing quality. This exception ignores the fact that 50% of the facilities in the jurisdiction could have a rating of 4 or even 5 stars. By allowing a new facility or new beds without any identified need will simply lower the census of all facilities in the jurisdiction, including high ranking homes. Lower census has a detrimental effect on nursing facilities. Rather than increasing the number of nursing facilities or beds in the jurisdiction, the State should focus its efforts on ensuring that those facilities that consistently score a 2 or 1 rating institute an improvement plan to increase scores. The residents in those facilities are entitled to the same quality of care as those that may be served under this exception.

2. **The Commission may docket an application by an existing freestanding comprehensive care facility with fewer than 100 beds that proposes a replacement facility with an appropriate expansion of bed capacity in a jurisdiction <u>without identified need</u> for additional beds if the applicant demonstrates:**

(a) Replacement of its physical plant is warranted, given the facility's age and condition; and

(b) The additional bed capacity proposed is needed to make the replacement facility financially feasible and viable.

First, it is unclear how the term "appropriate" would be determined as it relates to an expansion of bed capacity. Second, if there is no identified need in a jurisdiction, it is unclear how additional bed capacity would make the replacement facility financially feasible and viable given that census would simply be stretched among a greater number of facilities, which would hurt existing facilities and residents. Third, this exception is very much a complete dilution of the CON process given that it focuses solely on a facility's financial viability. However, LifeSpan would be supportive of allowing a relocation of a facility within the same jurisdiction without a CON but only if bed capacity remained "as is."

3. **The Commission may docket an application proposing the addition of comprehensive care facility bed capacity in a jurisdiction <u>without an identified need</u> for additional beds if the applicant submits one or more acceptable signed agreements between it and one or more acute general hospitals that, at a minimum:**

(a) Are approved by the Health Services Cost Review Commission;

(b) Fully detail an inter-facility partnership and an appropriate risk-sharing arrangement designed to lower the total cost of care for patients receiving comprehensive facility services following an acute hospitalization;

(c) Will not shift costs to Medicaid for comprehensive care facility services; and

(d) Provide that:

(i) The applicant and each partnering hospital will share risks if total cost of care reductions are not achieved; and

(ii) The applicant and each hospital will share rewards if cost reductions are achieved; or

(iii) The applicant will assume the entire risk if total cost of care reductions are not achieved.

Of the three exceptions, this is the most problematic. In addition to the concerns raised above, this exception is premature. The TCOC Model is set to begin on January 1, 2019, concurrent with the Episode of Care Improvement Program and the Primary Care Model. Currently, the State Innovation Group is examining additional payment models for post-acute care. LifeSpan and the nursing home industry are actively participating in this group. This language jumps the gun and places additional parameters on a nursing facility before the development of additional post-acute care models. The MHCC also points this out in the Draft Decision Matrices of the CON Modernization Workgroup in the Comprehensive Care Facilities grid – "what constitutes TCOC alignment has not been defined by the State or hospitals." It also ignores the fact that, while hospitals have been the conveners in current models, the TCOC Model will allow for non-hospital conveners in future models.

Again, the nursing home industry should be incentivized to realign existing beds rather than add new beds to a system when there is no identified bed and there is declining nursing home utilization. It is also important to point out the unfairness and the outright imbalance that the language itself presents – "the applicant will assume the entire risk if total cost of care reductions [are] not achieved." It is unclear why the nursing home should be solely responsible on its face without an accounting of the reasons why total cost of care reductions were not achieved.

<u>Page 16 - Quality Measures</u>

LifeSpan does recognize that the MHCC changed the reporting period for the 5-Star Rating system from the most recent quarter to the "most recent five quarterly refreshes." It is important to note that this is an "absolute" cut-off requirement and not simply information for consideration by the MHCC. The "most recent five quarterly refreshes" is a much fairer look-back period, given the reporting issues that the industry has had with the adequacy of the 5-star rating system.

However, LifeSpan still questions the use of the 5-Star Rating system. Maryland currently operates its own Pay-for-Performance (P4P) rating system through the Maryland Department of

Health, a system developed because of issues with the federal 5-star rating system.[3] For example, Maryland's P4P rating system takes into consideration a facility's staff retention rather than simply staff ratio. Often, this more accurately reflects the quality of care provided in many facilities, such as those in Western Maryland and other rural areas, where staff turnover is very low. As such, LifeSpan believes that Maryland's P4P rating system is a better indicator of quality and should either be used instead of the 5-star rating or in conjunction with the 5-star rating.

In conclusion, LifeSpan requests that the MHCC remove the three docketing exceptions and allow time for further study while the HSCRC continues to develop care redesign programs under the TCOC Model and replace the 5-Star Rating system with Maryland's P4P as the quality metric or, at the very least, incorporate it into the metric.

Thank you for your consideration into these issues.

Sincerely,

Danna L. Kauffman
Schwartz, Metz and Wise, PA
On Behalf of LifeSpan Network

Sincerely,

Paul N. Miller
Senior VP of Operations and Products
LifeSpan

cc: Ben Steffen, Executive Director, MHCC
Tiffany Robinson, Deputy Chief of Staff, Office of the Governor
Robert R. Neall, Secretary, Maryland Department of Health
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Nelson J. Sabatini, Chair, Health Services Cost Review Commission
Katie Wunderlich, Executive Director, Health Services Cost Review Commission
The Honorable Cheryl Kagan, Co-Chair of the AELR Committee
The Honorable Samuel Rosenberg, Co-Chair of the AELR Committee
The Honorable Shane Pendergrass, Chair of the House Health and Government Operations Committee
The Honorable Dolores Kelley, Chair of the Senate Finance Committee

[3] Maryland's P4P system is approved by CMS.