Law Offices of JAMES A. FORSYTH
11604 Garrison Forest Road, Owings Mills, Maryland 21117
Tel (443) 928 7936 e-mail: jaforsyth@comcast.net

July 13, 2018

Ms. Linda Cole, Chief
Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

By email & U.S. Mail

Re: Lorien Health Services' Comments on Draft Update SHP Chapter CCF Services

Dear Ms. Cole:

I represent Lorien Health Services ('LHS'). I submit LHS's Comments on the Draft Update of the SHP Chapter – Facilities and Services: CCF Services, due today.

My client thanks you for providing it this opportunity to submit its views.

Very truly yours,

James A. Forsyth, Esq.

JAMES A. FORSYTH
Attorney for Lorien Health Services

JAF/met
Encl.

cc: Louis G. Grimmel, Sr., CEO, Lorien Health Systems
J. Wayne Brannock, COO, Lorien Health Systems

LORIEN HEALTH SERVICES' COMMENTS ON DRAFT UPDATE OF STATE HEALTH PLAN CHAPTER – FOR FACILITIES AND SERVICES: COMPREHENSIVE CARE FACILITY SERVICES (COMAR 10.24.20)

Lorien Health Services, a multi-facility provider of comprehensive care ('nursing facility'), assisted living, and residential care services in Central Maryland offers these Comments on the Draft Update of the Comprehensive Care Facility Services (CCFS) Chapter of the SHP as follows.

General Comment: Lorien is very concerned that the MHCC Staff proposes to make very substantial changes to SHP provisions governing the review of CCFs while the CON Modernization Task Force, which includes representatives of the CCF sector, has still not completed its work. Lorien understands that issues related to the use of the 5-Star Rating System and continuation of the Medicaid MOU requirement are still under consideration by the Task Force and Work Group. Lorien believes that such a robust update of the CCFS Chapter would be more appropriate pending completion of the CON Task Force work and additional public input is gathered on use of the 5-Star Rating System, continuation of the Medicaid MOU, as well as inserting mandatory design requirements into the CON review process.

B. Statement of Issues and Policies.

(1) *Comprehensive Care Facility Design* – Lorien opposes incorporating mandatory FGI Guidelines within the CON process. Design requirements are properly within the regulatory purview of OHCQ which administers CMS guidelines. This change would require MHCC to micromanage facility design which it is not equipped to do. (*See response to .05A(4) at p. 4*)

(2) *Consumer Choice* – Lorien agrees with the intent of Policy 2.2 which provides: "The Commission will require that an applicant seeking a Certificate of Need to establish, expand, renovate, or replace a CCF serve an equitable proportion of Medicaid eligible individuals in the jurisdiction or region." However, this policy should not be used to continue the requirement of maintaining the Medicaid MOU requirement since there is no evidence that this patient population is being denied access to services.

(3) *Quality of Care* – Lorien agrees that the MHCC should continue to consider Quality of Care issues in CON reviews. However, given questions about the proper interpretation and application of the 5-Star Rating System / Nursing Home Compare, Policy 3.1 should not be adopted pending further study.

(4) *Comprehensive Care Facilities in the Continuum of Health Care* – Lorien fully supports Policy 4.0 aim of encouraging hospital and CCFs to work together as critical components of the

continuum of care. However, this policy should not be used to disadvantage CCFs in the CON review process as long as they have shown good faith efforts to enter into such relationships with acute care providers. Likewise, Lorien supports the goals of Policy 4.1 under which the MHCC will encourage CCFs to work with other post-acute providers to improve overall quality of care and provide care in the most appropriate and cost-effective setting. Again, this policy should not be used to disadvantage CCFs in the CON review process as long as they have shown good faith efforts to enter into such relationships with other post-acute care providers.

.04 Procedural Rules: Comprehensive Care Facilities.

A. *Comprehensive Care Facility Home Docketing Rules* – Lorien is opposed to the current worded provisions of sub sections (2)(a) insofar as the language includes *former* owners or senior managers or operators of the management company of any related or affiliated entity within the last 10 years. Such a bar to docketing is overly broad as it relates to formerly associated individuals or entities. Further, it would prohibit docketing and approval of proposed projects which are meritorious and address improved quality of care and public needs.

B. *Docketing Rule Exceptions* –Lorien is opposed to the docketing of Applications to add capacity when the SHP Bed Need Methodology does not identify a need for additional beds, as follows.

Exception .04B (1) - Docketing exception .04B(1) allows for such intentional over bedding if more than fifty percent of the CCFs in the jurisdiction had an overall CMS 5 star rating of one or two stars in the most recent quarterly update for which CMS data is reported. This is a very brief period which, if at all, should be extended to a 2 year average especially since, as the MHCC knows, facility rankings can quickly change as a result of CMS policy changes, or other matters which can be corrected. Finally, both the Secretary, DHMH and OHCQ have effective regulatory tools to address chronically underperforming existing CCFs without over bedding jurisdictions or harming existing facilities as this proposed docketing exception would do. If additional regulatory tools are needed by the Secretary or OGCQ, Lorien supports authorizing them to ensure the community has access to quality services.

Exception .04B (2) - Docketing exception .04B(2) allows the MHCC to docket an application proposing the addition of comprehensive care facility bed capacity in a jurisdiction without an identified need for additional beds if the applicant submits one or more acceptable signed agreements between it and one or more acute general hospitals that meet certain HSCRC requirements regarding inter-facility partnerships with appropriate risk-sharing designed to lower TCOC, while meeting other requirements further described in the Exception. This provision fails to consider whether existing facilities are in fact capable of entering into such agreements with

hospitals, and opens the door to discriminatory actions against existing CCFs. This provision also would result in jurisdictional over bedding and very negative impacts on existing providers.

C. *Incremental Addition of Comprehensive Care Capacity* - Lorien opposes the provisions of subsection (3) (b) stating that the MHCC shall not authorize waiver beds for a facility that has patient rooms with two or more beds unless the facility agrees to eliminate or reduce to the maximum extent possible the number of multiple bed rooms as a result of the bed addition. This is a major policy change that instantly renders long acceptable semi – private, double occupancy resident rooms as obsolete. Such a change may also hamstring an existing CCF's ability to expand incrementally. The MHCC and OHCQ licensing standards have long allowed double occupancy room configurations while seeking to eliminate triple and quadruple bed rooms. The proposed change would, in effect, mandate private, single occupancy room configurations and negatively impact the operations of existing facilities. The language should be revised to permit double occupancy rooms while prohibiting 3 or more beds to a room.

.05 Comprehensive Care Facility Standards.

A. General Standards.

(1) Bed Need and Average Annual Occupancy – Lorien believes the standard at subsection (a) for approval of a proposed relocation of existing CCF beds should be amended to provide that an applicant may provide other evidence of need for the beds at the new site in addition to the currently stated list of evidence. This may be accomplished by amending the second sentence to state "This may include**, but is not limited to,** a demonstration of unmet needs by a particular patient population, high utilization of comprehensive care facility beds in the jurisdiction during the past five years, and the ways in which the relocation will improve access to needed services or improve the quality of comprehensive care facility care."

In addition, Lorien believes that the 5 year time period specified in subsection (a) in which high utilization of comprehensive care facility beds in the jurisdiction is measured is too long. Lorien states that the 5 year period should be reduced to the customary 2 year period by which occupancy has been measured, consistent with the time period specified in subsection (b) concerning the addition of beds to a facility by relocation of existing licensed or temporarily delicensed comprehensive care beds within a jurisdiction without a corresponding increase to the jurisdiction.

(2) *Medical Assistance Participation* – Lorien restates it view that the mandatory Medicaid MOU requirement should not be perpetuated absent evidence of a current access problem and while this issue is still under consideration by the Task Force and Work Group.

(4) *Appropriate Living Environment* - Lorien opposes including in subsection (a) (iv) mandatory FGI Guidelines for new construction projects within the CON process. Design requirements are properly within the regulatory purview of OHCQ which administers CMS recommended guidelines. This change would require MHCC to micromanage facility design which it is not equipped to do. Subsection (iv) requires the submission of detailed plans which would add substantial additional costs to the CON review process which has always required only the submission of concept drawings with much more limited details.

It must also be remembered that cluster / neighborhood designs or connected household designs involve duplicative design features (i.e. kitchens, dining, activity space etc.) which add substantial construction costs which must be carried by uncertain future Medicaid and Medicare revenue streams. Moreover, neighborhood designs are not just a matter of architecture since they also impact programmatic features which, in turn, directly relate to increased staffing requirements. Such mandatory requirements would place undue burdens on operators and increase costs. Lorien is greatly concerned that the insertion of such substantial design mandates in the CON process will have a severely negative impact on cost-effective economies of scale.

Regarding subsection (b), concerning renovation or expansion projects, Lorien opposes paragraph (iii)'s mandate that Applicants must eliminate any resident rooms where more than two residents share a toilet. This requirement may make such renovations or expansions infeasible. Instead, the current requirement should be retained that such projects must *reduce* the number of resident rooms where more than two residents share a toilet.

For the reasons stated in connection with its comments regarding subsection (a) (iv) above, Lorien also opposes the requirement under subsection (b) (iv) of submitting documentation that the applicant considered development of a cluster / neighborhood design or a connected household design, and, if the project includes an institutional model, document why the alternative models were not feasible.

Lorien also opposes subsection (4) (c) requiring compliance to be demonstrated by the project's design architect certifying compliance with applicable FGI Guidelines, as well as a justification for any design elements that deviate from the FGI Guidelines. Again, design requirements are properly within the regulatory purview of OHCQ which administers CMS recommended guidelines. This change would require MHCC to micromanage facility design which it is not equipped to do. The submission of detailed plans would add substantial additional costs to the CON review process which has always required only the submission of concept drawings with much more limited details.

(5) *Specialized Unit Design* - For the reasons set forth in connection with the discussion of subsection A (4) *Appropriate Living Environment*, Lorien opposes aubsection (5) (d)'s requirement that an applicant shall "Demonstrate that the design of the comprehensive care facility is consistent with current FGI Guidelines and serves to maximize opportunities for ambulation and self-care, socialization and independence." (*see also* Comments regarding subsection (4) (c) above.)

(6) *Physical Plant for Renovation / Replacement* - For the reasons set forth in connection with the discussion of subsection A (4) *Appropriate Living Environment*, and A (5) above, Lorien opposes subsection 6 (b)'s requirement that an applicant must demonstrate how a proposed renovation or replacement of a comprehensive care facility will provide a physical plant design consistent with the FGI Guidelines. Such a mandated design may also prevent approval of an otherwise meritorious project.

(8) *Quality Rating* – Lorien objects to the blanket application of the CMS 5 Star Ratings as a complete proxy for quality evaluations as a condition of CON approval, and without consideration of any other relevant factors. Under subsection (8) (a), the failure to maintain 3 Star rankings at 70 percent of an applicant's facilities for whatever reason could preclude approval of a meritorious project. Further, the use of the most recent quarterly update instead of longer 2 year average, for example, would not necessarily present an accurate picture of overall quality care.

Lorien also objects to subsection (8) (b)'s requirement that an applicant that is an existing Maryland comprehensive care facility must document that it had an overall star rating of 3 or more stars in the most recent quarterly update for which CMS data is reported, unless the facility has been owned or operated by the applicant for fewer than three years. The CMS 5 Star Ratings system has inherent deficiencies and should not be used as a complete proxy for any analysis of Quality of Care without consideration of other relevant factors. Applicants should be allowed to introduce evidence of extenuating circumstances and/or other indicators of quality of care. Finally, if the 5 Star Ratings are to be used to any degree, a period longer than the most recent quarterly update should be considered, such as a 2 year average rating.

(9) *Collaborative Relationships* - Lorien states that providers of other services within the continuum of care sometimes prefer to enter into relationships based on simple letter agreements, as opposed to lengthy and expensive formal contracts. Therefore, Lorien believes the MHCC should revise the language in this standard's initial paragraph to state that the required collaborative agreements may be documented by means of "letters or contracts" instead of "letters and contracts".

Lorien is opposed to the imposition of blanket mandates requiring CCFs to demonstrate outcomes of effective collaboration with hospitals since a CCF s cannot control a hospital's willingness to collaborate with it. Instead, CCF applicants should be required to demonstrate their commitment by documenting good faith efforts to collaborate with a hospital in efforts to reduce inappropriate readmissions to hospitals, improve the overall quality of care, and provide care in the most appropriate and cost effective setting. Further, CCF applicants should be required to demonstrate good faith efforts to achieve the outcomes specified in subsections (9)(a)(i) and (ii).

Lorien opposes the wording of subsection (9)(b) which does not include any meaningful sub-standards or criteria by which a CCF's duty to collaborate with Medicare – certified home health agencies and hospices for post – discharge care can be evaluated. CCF applicants should only be required to document the existence of referral relationships and their practice of actually making such referrals on discharge through representations of discharge planners or other Staff, accompanied by required Affirmations under penalties of perjury.

Lorien strongly believes that since CCFs will ultimately be held accountable for TCOC issues, including reductions in inappropriate hospital re-admissions, improvements in quality of care, and provision of care in the most appropriate and cost effective setting, CCFs themselves must be allowed to provide home health care services to their discharged residents for at least the first thirty days following discharge. This is only logical since the CCF will have already established relationships with the resident and will also have intimate knowledge of the resident's status, condition, and particularized needs. These services, which would substantially enhance continuity of care, should be allowed to be provided under the current CCF licensure category, or as a result of legislative action to enable this substantial improvement in continuity of care.

(10) *Shell Space* - Lorien believes that this restriction on unfinished CCF shell space for which there is no immediate / current need or use should be eliminated. CCFs should have the flexibility to construct shell space at current costs for anticipated future needs if they so desire in their exercise of business judgment. Typically, the construction of such space would not affect Medicaid or Medicare reimbursements because such unused space is not reimbursable. Likewise, such space would not impact private pay rates which are set by the market.