Discussion Outline for Meeting of CCFs and Home Health Care Providers

Phase II: Formulate recommendations for CON program modernization

August 10, 2018

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SEGMENT 1: Comprehensive Care Facilities

A. Scope of CON regulation

Questions: Are the current requirements for a CON appropriate and purposeful? Should additional circumstances/projects be exempt from CON review?

Consider current CCF initiatives requiring CON

- Opening a new facility
- Relocating a facility
- Relocating a number of licensed beds
- Addition of beds
- Admission of non-community members into CCRC-based CCFs
- Projects that exceed the capital threshold

Varied viewpoints submitted during Phase I:

- *Maintain CON requirement for CCFs*
- *Exempt projects if no increase in bed capacity*
- *Increase capital threshold, but do not eliminate capital threshold*
- *Consider the "unchecked competition" from assisted living facilities that are not subject to CON process*

B. Needs-based review standards: bed capacity

Are the needs-based review standards/methodologies appropriate?

Viewpoints submitted during Phase I:

- *Utilize occupancy standards*
- *Update bed need methodology in context of assisted living and community-based alternatives*
- *Utilize waiver beds as an important "safety valve" in the effective use of existing inventory*
    - *Waiver beds should be "rounded up" when available instead of "down"*
    - *Permit use of waiver beds in new space created under a project that does not require a CON*
- *In context of continuing care retirement communities*
    - *Modify/eliminate direct admission restrictions of non-community residents into nursing homes if a bed capacity is 10% or less of its independent living units.*

C. Compatibility of CON regulation with the Total Cost of Care All Payer Model

How might the CON process support the goals of the Total Costs of Care model and encourage more integrated / innovative models of post-acute care?

- **What changes/allowances could be made to support these objectives?**
- **What review criteria should be included/modified to support models that promote these goals?**

D. Role of CON regulation in promoting quality of care

How can quality metrics be effectively used in the CON process? How can the application process better leverage publicly available State/Federal data and patient survey findings? What are the most relevant metrics to use?

Viewpoints submitted during Phase I: "Overreliance on the Five Star system"

- *There is opportunity to utilize other available measures*
  - *Example: Observed vs. expected readmissions and ED visits (unclear what this is).*
  - *Suggested using the Medicaid Pay for Performance Measures, though those are based primarily on long-stay residents.*
- *Incorporate use of telehealth and EHRs as proxies for quality.*
- *Note from MHCC staff: Current MHCC plan does not use negative CMS Five Star performance as a barrier to docketing a CON application. A proposed draft State Health Plan would use CMS Five Star performance as one factor in CON review.*

Viewpoints submitted during Phase I: Unnecessary duplication

- *CON process does not need to duplicate Licensing role and review process; CON application requirements can be reduced (See below "Information requirements").*
- *Challenges with update of regulations exist, OHCQ has not been able to update its CCF regulations for the past 2 years.*

E. Access to Care for Medicaid patients/Medicaid burden-sharing requirements

- **Should the Medicaid Memorandum of Understanding requirement continue to be used as part of the CON review to set minimum required levels of Medicaid participation?**

Viewpoints submitted during Phase I: Use of Medicaid Memorandum of Understanding is "outdated"

- *Modify/Update the standard for setting minimum required levels*
- *Eliminate the requirement for CCFs; "no evidence of barriers;" and "frustrates innovation"*

F. Information requirements & application review process: Aligning/Streamlining

How can the requirements and the review process be more aligned with the type and scale of a project?

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How can the application process be modified to be more efficient/produce more timely responses?

How can process(es) be streamlined to minimize delays in the review process and project implementation?

Viewpoints submitted during Phase I: Application submission

- *Eliminate duplication of authority to minimize initial CON application requirements*
    - *Eliminate duplication of primary roles/functions across CON authority and Licensing under the Maryland Department of Health (see above: "Quality")*
    - *Eliminate duplication of primary roles/functions/requirements across CON program and other agencies: Eliminate requirements for detailed drawings and specification and consideration of technical building/design requirements as required by OHCQ, County Health Departments and State Fire Marshal*
- *Permit acquisitions without requirement for determination of non-coverage*
- *Streamline process for CON exemption*
- *Facilitate application submission*
    - *Permit electronic submission of application*

Viewpoints submitted during Phase I: Application review

- *Reduce time associated with docketing an application and completing the review process*
    - *Completeness: Impose time limit for completeness review*
    - *Expedited review: Define projects that qualify for an expedited review process*
    - *CON Exemptions: Streamline the process*

- *Allow for greater flexibility around project modifications*
    - *Permit capital cost increases so long as notice to the staff is given and the applicant is prepared absorb increased costs without an increase in rates*
    - *Allow changes to composition of ownership during application review process*
    - *Accommodate easier project modifications as long as total bed complement/proposed services remain the same*
        - *Example: New facility projects should have 48 month performance requirements with the continued availability of 6 month extensions of each performance requirement*

Viewpoints submitted during Phase I: Project implementation

- *Remove constraints on implementation schedule to allow for phased implementation*
    - *Amend regulations to explicitly state the filing of administrative or judicial appeals of all zoning, permitting and other local approvals required in a project's development should trigger an automatic stay of applicable performance requirements*
- *Modify post-CON performance requirements*
    - *Permit extensions of each performance requirement across a 4 year period*
    - *Allow for a "stay" of performance requirements if there is a filing of an administrative or judicial appeal of zoning, permitting, or other local approval required by project development*

SEGMENT 2: Home Health Agencies (HHAs)

A. Scope of regulation: HHAs

Are the current requirements for a CON appropriate and purposeful? Should additional circumstances/projects be exempt from CON review?

Consider current HHA activities requiring CON

- Opening a new program/serving a new jurisdiction
- Projects that exceed the capital threshold

Viewpoints submitted during Phase I: CON requirement for home health services (varying opinions)

- *CON regulation for home health is valuable and should be maintained*
    - *Prevents oversupply of providers that can result in*
        - *Staffing shortages*
        - *Supply-induced demand/higher costs of care*
        - *Potential for fraud*
    - *Adequate competition exists*
    - *Larger, higher volume providers will achieve economies of scale and lower cost operations*
- *CON regulation for home health is not necessary and/or is detrimental*
    - *CON regulation creates barriers to entry for high quality providers*
    - *Public would benefit from high quality providers expanding into contiguous counties*
    - *Barriers result in confusion for patients/poor care coordination.*
    - *Note from MHCC staff: confusion may stem from OHCQ permitting agencies to be "home care" and not distinguishing Medicare-certified HHAs from RSAs and other providers.*
    - *Limited competition can result in market monopolies and lower quality of care.*
    - *Note from MHCC staff: to counter balance market concentration, MHCC already uses the HHI Index as a measure of concentration.*
    - *Greater competition could produce downward pressure on total cost of care*
    - *Note from MHCC staff: in the current plan, quality performance and not a needs-based formula is a requirement for docketing*
- *Regulate Residential Service Agencies that operate as home care agencies*
- *Permit expedited review for approved high quality providers who seek to expand to other jurisdictions*
- *Do not exempt consolidations from CON review*

B. Needs-based review standards; other standards

Are the review standards for HHA CON review appropriate?

Note from MHCC staff: Need-based methodology has been eliminated in Home Health Chapter of the State Health Plan.

Viewpoints submitted during Phase I:

- *Needs-based standards should not be applied; only quality standards should apply. See above.*
- *Impact on existing providers should not be a consideration*
    - *Existing providers should not have standing to oppose*
- *Quality review standards should include*
    - *Qualifications of Administrator/Director of Nursing*
- *Technology factors including use of EHRs, e-visits when appropriate, and remote patient monitoring. Require applicant to post a $250K surety bond*

- *"Reclaim" CONs from providers who are not actually operating program.*
    - *Use or lose rules would allow MHCC and other agencies to better assess actual capacity.*
    - *This change should apply to other services such as hospice.*

• C. Compatibility of CON regulation with the Total Cost of Care All Payer Model

How might the CON process support the goals of the Total Costs of Care model and encourage innovative models of post-acute care?

- **What changes/allowances could be made to support these objectives?**
- **What review criteria should be included/modified to support models that promote these goals?**

Viewpoints submitted during Phase I:

- *Exempt from CON HHA review any CON-approved health facility that seeks to also provide home health agency or hospice services.*
    - *Health care facilities are held increasingly accountable for the total cost of care and should be encouraged to provide these services.*
- *To adopt, a health care facility may need to document why it could not partner with existing agencies to provide such care.*

D. Role of CON regulation in promoting quality of care

How can quality metrics be effectively used in the CON process? How can the application process better leverage publicly available State/Federal data and patient survey findings? What are the most relevant metrics to use?

Viewpoints submitted during Phase I:

- *Eliminate duplication*
    - *Quality oversight of HHAs is an essential state responsibility, but OHCQ rather than CON may be a more effective vehicle to promote quality.*

- *Note from MHCC staff: OHCQ stated noted that CON and licensing are complementary in the current regulatory framework.*

E. <u>Access to Care – Charity care requirements</u>

Home Health Agencies are required to commit to provide charity care, and HHAs are required to make presumptive eligibility determinations for charity care within two days of a patient's initial inquiry. HHAs perform a minimal amount of charity care. Overall, less than one percent of patients receive any charity care benefits. Should charity care requirements continue to be a standard incorporated in the CON review process?

Viewpoints submitted during Phase I:

> *Establish a reasonable level of charity care, but eliminate the application process requirements. The application provides limited benefit to patients in need of charity and may deter agencies from expanding. The charity care form requirement could be eliminated in favor of an outcomes-based standard that commits a HHA to deliver a percent of HHA visits at low or reduced rates.*

F. <u>Information requirements & review process</u>

How can the requirements and the review process be more aligned with type and scale of a project?

How can the application process be modified be more efficient/timely?

Viewpoints submitted during Phase I:

- *Scale back requirements to focus on quality standards*
- *Note from MHCC staff: Current HHA Chapter of the State Health Plan already focused on quality standards*