HFAM
Health Facilities Association of Maryland
Partners in Quality Care

CON Modernization Task Force - Phase 2 @ Fri Aug 10, 2018

HFAM Key Points:

We are at the epicenter of a critical transformation of Maryland's health care delivery system. In a simultaneous and overlapping way, we are addressing, on a state level: the new Maryland agreement with the Centers for Medicare and Medicaid Services (CMS) to control the total cost of care, modernization of the certificate of need process and a reworking of the State Health Plan chapter governing comprehensive care facilities (CCFs). All of this is occurring while CMS plans to fundamentally change how CCFs will be reimbursed under Medicare Part A as skilled nursing facilities and CCFS are adapting to Maryland's revised approach to reimbursing them as nursing facilities under Medicaid. Calling this an "inflection point" does not adequately characterize these developments.

We have an opportunity to view these changes together and create new pathways of equal partnerships that bend or reduce cost while improving healthcare outcomes.

Guiding Principles

Collaboration leading to success under the CMS agreement on the Total Cost of Care

- Success will only be achieved through shared dialogue and a recognition of the capabilities, opportunities, challenges and roles of each part of the health care continuum, including CCFs.

- CCFs must be able to maintain and improve their capabilities to provide enhanced services, which enable them to be an alternative to avoidable hospitalizations.

- Arrangements for sharing both cost reduction efforts and the financial benefits of savings between hospitals and CCFs is important.

- While all elements of the health care delivery system need to be cost-efficient, recognize that in some cases increased costs in one area can support overall cost reductions. For example, when avoidable hospitalizations or enhanced discharge opportunities may help hospitals achieve savings even if it results in increased CCF utilization.

- All post-acute/long-term care services are not interchangeable. Effective home care is vital. At the same time, avoiding beneficial CCF utilization simply to achieve cost savings is risky for patients and ultimate drivers of cost.

- If an integrated health care delivery system is to be achieved, a unified approach to regulating of all parts of the continuum of care should also be explored.

Modernization of CON Process CCFs

- The wisdom and guiding principles identified in the Task Force should be applied generally and uniformly through updates to the applicable State Health Plan chapters.

- A simpler and less costly CON process should be a goal of the process. This includes a review and revision of the process for project changes, performance requirements and cost increases that do not increase costs to the health care delivery system.

- The process for CCFs undertaking beneficial capital projects should be more streamlined. The threshold for capital expenditures for CCFs should not be in the same, lower capital cost threshold category as all "non-hospital" projects.

- The Maryland Health Care Commission should not duplicate the role of other agencies. For example, the Office of Health Care Quality (OHCQ) should retain its role as the regulatory agency monitoring quality of care, the qualifications of health care facility owners and operators, and the change of ownership process. Similarly, OHCQ approves the designs of CCFs; the MHCC should not be dictating how CCFs should be designed.

- Modernization of the CON should include a waiver that allows current skilled nursing and rehabilitation centers to secure CONs for Home Health. Consumers want consistent care and increasingly post-acute providers will be held responsible for hospital readmissions over a longer timeframe. Allowing skilled nursing and rehabilitation centers not to handoff to another Home Health organization will reduce a reliance on secondary agencies, better integrate care, be a better consumer experience, and likely reduce hospital readmission.

Key Elements of the SHP CCF Chapter that Need to be Addressed

- See HFAM's comments on the informal draft of the CCF Chapter. As a few selected highlights from that letter:

- CON should be preserved.

- The CMS Five Star ranking system should be a source of information along with additional information about quality. Moreover, the five-star ranking information should simply be considered along with other appropriate quality information that is provided by an applicant. Data over a 24-month period should be used. It should not be used as a Plan Standard or review criterion but as informational.

- The Medicaid Memorandum of Understanding should be removed.

Key Elements of the SHP CCF Chapter that Need to be Addressed (continued)

- The CCF bed need methodology should be specifically explained in a "live" work session with sample calculations.

- Waivers of standards should be permitted based on applicant information.

- The acquisition process should not seek information unnecessary for the CON regulation process such as purchase price, market share.

- There should be no change to the current process for information disclosed by proposed owners or operators. As noted, OHCQ is responsible for this evaluation and no need for a change has been explained or demonstrated.

- Capital projects that improve facilities and do not increase costs to payers should not require a CON application; the waiver bed rules should be applied per the current statute and available to enhance capital improvements.

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