Discussion Guide for September 7, 2018 Meeting of the CON Modernization Task Force

HOSPICE SERVICES

Problems/Issues Identified in Phase 1:

- ***The scope of hospice Certificate of Need (CON) regulation may be outdated. In particular, the use of a capital expenditure threshold should be reconsidered.***

REFORM OPTIONS FOR DISCUSSION:

1. Eliminate use of capital expenditure thresholds in defining a hospice services project that requires CON approval.

Discussion: It is unlikely that this reform would substantially change CON regulation of hospices. It is possible that a hospice might undertake a general inpatient facility or hospice house project with a capital expenditure of $6 million + (the current threshold). However, in many cases, such projects would require CON approval anyway because they would involve a change in the bed capacity of a health care facility. This reform would allow hospices to invest in alteration of inpatient facilities, in cases where bed capacity is not changing, without CON review requirements and invest in hospice houses, which are not facilities subject to CON regulation, without CON review requirements.

2. Eliminate both use of capital expenditure thresholds in defining a hospice services project that requires CON approval and eliminate requirements that a change in bed capacity by a hospice requires CON approval.

Discussion: This would mean that established general hospices would be free to develop their own general inpatient care facilities and hospice house facilities without any CON requirements, effectively removing any real capital project requirements that might apply to hospices. The merit of this idea lies in allowing general hospices autonomy in deciding whether they have the capability and critical mass of patients to provide inpatient care with their own resources, giving them more control over the continuum of hospice care their patients might need. Applicants to establish new hospices could propose including their own inpatient care facilities as part of their applications or wait to expand later, without needing a CON.

- ***There may be a more efficient means for preserving a key value perceived in CON regulation of general hospices, constraints on the total supply of hospices and the entry of new hospices into Maryland.***

REFORM OPTIONS FOR DISCUSSION:

1. Eliminate CON regulation of hospice services and replace with statutory and regulatory reform of hospice licensure requirements and limits on the rate of growth of new licenses.

Discussion: This reform would require empowerment of the Maryland Department of Health (MDH) to deny licenses to operate hospices to persons who have an unacceptable track record with respect to a history of abusive or fraudulent behavior of any kind based on a rigorous review of each applicant's business record and character. Additionally, MDH could be empowered to deny licensure to persons with a history of poor performance in operating health care facilities based on their track record of problems with facilities licensure, certification, accreditation, and criminal and civil litigation, and/or their rating on performance measures. These changes would serve as an alternative to CON regulation for achieving the objective of keeping "bad actors" out of the Maryland market.

Secondly, this reform would require Maryland to restrict the number of new hospices that MDH could create over time. To be equitably administered, this might require MDH to have a scheduled process for filing applications for new licenses, completing the character and competence review to qualify applicants, and then using a lottery to select the applicants who would receive a license for that licensing cycle. This change would preserve a key concern of the hospice industry with eliminating CON regulation, limiting the rate at which the competitive landscape might change. It would keep Maryland from being inundated with new hospice providers and allow the existing health care system with time to adjust to new market entry.

MHCC could play a role in this reform by assisting MDH in the character and competence evaluation and strengthening its role in evaluating and proliferating information of performance of hospice service providers.

2. Maintain CON regulation of hospice services and provide no opportunity for new market entry, thus eliminating the inefficiency of CON regulation as a "gatekeeper." Allow existing hospices to expand at will, so long as they are accredited, licensed, and Medicare-certified in good standing.

Discussion: The first part of this option describes the posture of CON regulation for much of the last 20 years. The supply of hospices will not grow, keeping "bad actors" out along with anyone else, and this would be accomplished in an efficient way, since no applications will be accepted for review. To balance this competition-squelching approach, Maryland could allow liberal

expansion of existing hospices who are accredited, licensed, and Medicare-certified in good standing, to new jurisdictions without any other requirements having to be met.

- ***The State Health Plan does not account for nor facilitate total cost of care improvement across the full care continuum.***

REFORM OPTION FOR DISCUSSION:

Empower MHCC to waive CON regulation requirements for a hospice service project requiring CON approval if the project is proposed as part of a collaborative effort by a general hospice and other providers aimed at reducing the cost of health care services and the waiver is endorsed by the Health Services Cost Review Commission.

Discussion: This reform could be a generalized across the full spectrum of health care facility projects regulated under CON to allow maintenance of CON regulation as a tool for limiting capital spending for facilities and services that will or could increase the total cost of care while also allowing HSCRC to advise MHCC when it should get out of the way in order to facilitate reductions in the total cost of care or reducing the rate of increase in health care costs.

- ***The average period of time needed to docket a general hospice application and complete the review of an application is excessive.***

REFORM OPTION FOR DISCUSSION:

Empower MHCC to eliminate all or nearly all CON review criteria and standards. The regulatory process would involve identifying jurisdictions for expansion of hospice service capacity and approving all existing Maryland hospices that are accredited, licensed, and Medicare-certified in good standing to expand into those target jurisdictions and approving all applications from non-Maryland hospices that are accredited, licensed, and Medicare-certified in good standing to expand into those target jurisdictions (subject to limitations on the total number of approvals).

Discussion: This should allow for a quick regulatory process. It would need to be coupled with limitations on how many applications could be reviewed at any given time (review cycle) which would require some kind of lottery process for qualified applicants. This could involve different limitations of new hospice program establishment and fewer limits on expansion of existing hospice programs. A possible downside - it would limit opportunities for growth in hospice service capacity in Maryland to persons with documentable experience in providing hospice services.

- ***Charity care requirements for general hospices are not well-aligned with the level of need.***

REFORM OPTION FOR DISCUSSION:

Eliminate standards addressing charity care in the State Health Plan.

Discussion: Relatively small amounts of charitable care are reported by hospices. This suggests that eliminating consideration of charity care as an issue in project review will streamline the project review process without producing any substantial negative impact on the ability of Maryland citizens to obtain charitable care.

- ***State Health Plan methodologies for determining unmet need are either too complex, unclear, or, in the case of inpatient hospice beds, non-existent.***

REFORM OPTION FOR DISCUSSION:

Empower MHCC to eliminate all or nearly all CON review criteria and standards. The regulatory process would involve registering and approving all existing Maryland hospices that are accredited, licensed, and Medicare-certified in good standing to expand into any jurisdiction and approving all applications from non-Maryland hospices that are accredited, licensed, and Medicare-certified in good standing to establish new hospices (subject to limitations on the total number of approvals).

Discussion: This is a modification of a previously outlined reform, converting CON regulation of hospice services into a process for validating the qualification of applicants (which are limited to accreditation, licensure, and Medicare-certification in good standing) and conducting a lottery to limit the pace of growth of expanded hospice care capacity over time. It eliminates the requirement that MHCC target jurisdictions for expansion of hospice service capacity. Providers would be allowed to apply to expand or establish new hospices anywhere in Maryland. It has the same potential downside in that it would limit opportunities for growth in hospice service capacity in Maryland to persons with documentable experience in providing hospice services.

- ***Portions of the CON application are not fully applicable to hospice providers.***

REFORM OPTIONS FOR DISCUSSION:

1. **Revise the CON application form for hospice projects, with advice and counsel of an expert panel, to eliminate portions of the application not applicable to hospice providers.**

Discussion: If undertaken in isolation, this is a largely status quo reform. It could incrementally improve the regulatory process for applicants but would not fundamentally alter CON regulation of hospice services.

2. **As an alternative, implement one of the more comprehensive regulatory reforms outlined above that would eliminate all or nearly all criteria and standards and would, as a consequence, drastically simplify the application process.**

- ***Neither the application nor the review processes fully allow for the leveraging of publicly available State data, quality measures, and patient survey findings.***

REFORM OPTIONS FOR DISCUSSION:

1. **Revise the State Health Plan and the CON application form for hospice projects, with advice and counsel of an expert panel, to fully allow for the leveraging of publicly available State data, quality measures, and patient survey findings in the project review process.**

Discussion: If undertaken in isolation, this is a largely status quo reform. It could incrementally improve the regulatory process for applicants but would not fundamentally alter CON regulation of hospice services.

2. **As an alternative, implement one of the more comprehensive regulatory reforms outlined above that would eliminate all or nearly all criteria and standards and would, as a consequence, drastically simplify the application process.**

- ***The primary roles and objectives of CON and facilities licensure, as implemented by the Maryland Department of Health, are potentially duplicative.***

REFORM OPTION FOR DISCUSSION:

Eliminate CON regulation of hospice services and replace with statutory and regulatory reform of hospice licensure requirements and limits on the rate of growth of new licenses.

Discussion: This reform, already discussed above, would clearly eliminate duplicative effort.

ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY (ICF) TREATMENT SERVICES

Problem/Issue Identified in Phase 1:

- ***The scope of CON regulation in the alcohol and substance abuse detoxification and treatment sector is unbalanced, only touching a very narrow part of the treatment spectrum.***

REFORM OPTIONS FOR DISCUSSION:

1. **Eliminate CON regulation of alcoholism and drug abuse intermediate care facility treatment services and replace with statutory and regulatory reform of the licensure and certification process.**

Discussion: By only regulating ICFs, CON regulation is probably stifling providers from considering this level of care (medically-monitored intensive inpatient withdrawal management and treatment) when they may be fully capable of offering it and meeting a demand for this level of care in their service areas.

Currently, there are likely to be substantive market limitations on the proliferation of this service given its costs and the limited ability to obtain full reimbursement for these costs under existing third party payor policies. The chief concern raised by existing providers when eliminating this service from CON regulation was proposed in the 2018 General Assembly session was the role of CON regulation as a "gatekeeper," serving to discourage "bad actors" from entering the Maryland market. This concern can be addressed by empowering the Behavioral Health Administration (BHA, a division of MDH) to deny licenses to operate ICFs to persons who have an unacceptable track record with respect to a history of abusive or fraudulent behavior of any

kind based on a rigorous review of each applicant's business record and character. Additionally, BHA could be empowered to deny licensure to persons with a history of poor performance in operating health care facilities based on their track record of problems with facilities licensure, certification, accreditation, and criminal and civil litigation, and/or their rating on performance measures. These changes would serve as an alternative to CON regulation for achieving the objective of keeping "bad actors" out of the Maryland market.

2. **Maintain CON regulation of ICF services and provide no opportunity for new market entry. Allow existing ICFs that are accredited, licensed, and certified in good standing to expand bed capacity, without a CON, by up to 40% of existing bed capacity or 40 beds, whichever is less, every two to three years.**

Discussion: This efficiently addresses the "bad actor" problem without requiring beefed-up oversight by BHA. It allows expansion of existing bed capacity to address increases in demand for services efficiently. Based on the existing "waiver bed" or "creep bed" provisions of CON law applicable to nursing homes and some types of hospital facility, expanding ICFs would only need to notify MHCC of their plans to expand. Four ICF projects are at various stages of review, but none have not been docketed. Three of the four are existing providers in the State.

RESIDENTIAL TREATMENT CENTER (RTC) SERVICES

- ***The scope of RTC CON regulation may be outdated. In particular, the necessity of including residential treatment centers in the scope of CON regulation is questionable given the way in which demand for this service has changed.***

REFORM OPTION FOR DISCUSSION:

Eliminate CON regulation of RTC services and replace, as necessary, with statutory and regulatory reform of the licensure and certification process.

Discussion: The number of RTCs operating in Maryland and licensed RTC bed capacity has declined by 50% since 2001. Existing RTC bed capacity is not highly occupied (estimated to be 68% in CY 2016). State juvenile justice authorities are the primary referral source for RTCs.

These facts indicate that this is a health care facility category that can be eliminated from the scope of CON regulation without harming the public interest. This reform should be accompanied by a consideration of whether BHA has the ability to prevent "bad actors" from seeking entrée to the Maryland market. If more authority and staffing is needed to assure that licensure applications from persons with questionable backgrounds and track records in operating health care facilities can be legally denied licensure, this authority and resources for

staffing should be provided to BHA. CON is too blunt and costly an instrument for the task at hand, which should be more efficiently and effectively handled by the licensing authority.