Draft Meeting Summary
Certificate of Need (CON) Modernization Task Force
Maryland Health Care Commission
Meeting of Friday, August 10, 2018
MHCC Offices, 4160 Patterson Avenue, Baltimore, MD

Committee Members in Attendance
Randolph Sergent, Chair
Regina Bodnar
Ellen Cooper
Lou Grimmel
Elizabeth Hafey
Adam Kane
Mark Meade
Ben Lowentritt
Jeff Metz
Brett McCone
Richard Przywara
Barry Ray (for Ann Horton)
Andrew Solberg
Renee Webster
Dawn Seek (for Ann Horton)
Michael O'Grady (by phone)

MHCC Staff in Attendance
Linda Cole
Paul Parker
Megan Renfrew
Ben Steffen
Suellen Wideman

MHCC Consultants in Attendance
D. Patrick Redmon
Samantha Sender
Thomas Werthman

Others in Attendance
Pat Cameron
Joe DeMattos
Barbara Fagan
Peggy Funk
Danna Kauffman
Anne Langley
Paul Miller
Howard Sollins (by phone)
Pegeen Townsend
Rebecca Vaughn

Nison Weisbord
Jennifer Witten

Agenda Item 1: Call to Order, Welcome and Introduction

Chairman Randolph Sergent opened the meeting shortly after 9 am. He offered, as a preface to the discussion, his view that, while specific positions on changes in CON regulation are important, data, and the reasoning behind the positions taken are of particular importance in order to have a set of recommendations that can be supported by the Commission.

Task Force members and staff in attendance identified themselves.

Agenda Item 2: Approval of the June 29, 2018 Task Force Meeting Summary

The Task Force was asked if there were any comments on the June 29, 2018 meeting summary. No comments were received.

In an effort to aid discussion, a series of slides was presented at the meeting, with general CON principles, questions about CON, organized by service type, Comprehensive Care Facilities (”CCF” or Nursing Homes) and Home Health Agencies (“HHA”), proposed CON reforms by services types, and comments from stakeholders. There was also a section of “cross-cutting” recommended reforms, affecting the CON process, generally. These sections included:

- Principles to Guide CON Reform
- A general discussion section provided a series of questions addressing CON reform, pertaining to CCFs and HHAs
- Potential CON reforms for CCFs and HHAs
- Potential cross-cutting recommendations
- Recommendations from the Health Facilities Association of Maryland and he Maryland National Capital Homecare Association

Dr. Patrick Redmon and Mr. Sergent presented the slides to the Task Force, with discussions pertaining to each section following.

Agenda Item 3: Guiding Principles for CON Reform: A framework for thinking about changes in CON

The MHCC staff presented a slide titled Principles to Guide CON Reform, which was generated following the discussion about the goals of CON at the June 29 meeting. Following that meeting, MHCC staff recommended focusing on the goals for CON reform, proposing principles for success, TCOC alignment, affordable, high quality, and safe care, regulatory reform, and internal coherence. The following principles were presented:

1. **Promote the availability of hospital and long term care services in all regions of Maryland. Assure appropriate availability of specialized services that require a large regional service area to assure viability and quality.**

Commenters noted the need to broaden these services, recognizing the need to reduce avoidable hospitalization. "All regions" did not refer to expansion, rather a thoughtful regulation.

2. **Complement the goals and objectives of the Maryland Total Cost of Care (TCOC) Model.**

3. **Provide opportunities to enter the Maryland market for innovators committed to the delivery of affordable, safe, and high-quality health care.**

Commenters noted that this principle needs to encompass verification of new entrants as "good" providers with acceptable "track records."

4. **Minimize the regulatory requirements for existing providers to expand existing capacity or offer new services when those providers have demonstrated an ability to deliver affordable, safe, and high-quality health care in other Maryland jurisdictions.**

5. **Reduce the burden of complying with regulatory requirements by eliminating duplication with other Maryland organizations and narrowing CON standards to those necessary for assuring that delivery of health care will be affordable, safe, and of high-quality.**

6. **Maintain meaningful review criteria and standards that are consistent with the law and understandable to applicants, interested parties, and the public.**

Jeff Metz pointed to the importance of reducing the burden of the CON project review process. Mr. Sergent noted the mandate to reform CON is a broad mandate, and not just Commission reform of the CON process. Further, there should be quality-related standards for CON, as a license may not be enough. Quality is front-and-center in the process.

Agenda Item 4: Comprehensive Care Facilities (CCFs or Nursing Homes)

Paul Parker provided a brief review of the key policy objectives implemented through MHCC's current approach to CON regulation of CCFs: maintaining high CCF bed occupancy; requiring most CCFs to serve Medicaid patients at a level considered adequate for "fairness;" reducing the inventory of rooms with three or more beds, shared bathrooms, and shared climate control; and limiting direct competition for admissions from the general public between continuing care retirement communities and freestanding CCFs.

Dr. Redmon presented the following topics and accompanying questions pertaining to CCF. Task Force commentary relevant to each topic appears below the bullet. :

- **Scope of CON regulation**

Comments and question around this point included: are the current regulations appropriate? What is the rationale for limiting nursing homes through CON?

Mr. Metz emphasized his faith in free markets, but noted that nursing home margins are pretty thin, and that there is expectation that nursing homes serve Medicaid populations. Without CON, occupancy rates will fall and facilities will have less ability to take on Medicaid beneficiaries.

Mr. Parker asked for an identification of the downside of allowing nursing home capacity to grow on an unregulated basis. Is there a realistic expectation that utilization will increase simply because bed supply increases?

Barry Ray noted the concern that hospitals are discharging patients in greater numbers to their homes, rather than nursing homes, causing a fall in nursing home bed occupancy and the hurting financial viability of CCFs. With consumers' preference for new versus old buildings, existing providers who cannot afford to modernize will be hit hard by this change. In the future, how will patients be affected if the number of facilities increase but utilization drops, creating problems with assuring safe patient care?

Adam Kane noted that Medicare utilization is now a major concern in Maryland because of the coming TCOC model. A key question is whether there is a link between CON regulation and utilization, and CON regulation and costs for comprehensive care facility services.

- **Needs-based review standards: bed capacity**

- **Compatibility of CON regulation with the Total Cost of Care (TCOC) Model**

Mr. Sergent emphasized that the populations in nursing homes is different and people will die without access.

Ben Steffen stated that patients of lower acuity have migrated to alternative sites of care. Skilled nursing facilities are under pressure because of the heightened acuity of their patient populations resulting from this transition while also under pressure to lower the length of stay.

Mr. Ray noted that, in the circumstance of bundled payments, simpler patients are going home after their hospital stay, while more complex patients are going to CCFs. The implications of this change is unclear, and therefore, the CON process should be maintained.

Andrew Solberg noted that hospitals are in a holding pattern, mot sure what they need from CCFs to reduce the total cost of care. He asked how financial incentives would be integrated.

Brett McCone framed the question as how to share risk between providers in acute and post-acute settings. He also offered the opinion that CON regulation should be modified to encourage innovative approaches by multiple partners working together along the continuum of service and matching services to the best setting necessary for safe and affordable care. He noted that only hospitals are at risk under the payment model reform that has occurred so far and are, thus, the only sector being held accountable.

Lou Grimmel stated that the Task Force should focus on the TCOC model as governed by the contract between HSCRC and CMS. He questioned what the hospitals want or need from post-acute care providers.

Mr. Kane noted there are no clear answers. CON regulation serves to control Medicaid costs and occupancy. Now, there is concern from the Medicare side - does greater utilization increase or

decrease costs? This is all very fluid, and requires a flexible approach in CON regulation. What services can be expanded in the nursing home setting in a cost effective way?

Another commenter asked what services could be moved from the hospital to a CCF, with assurance of quality, safety, and cost effectiveness.

- **Role of CON regulation in promoting quality of care**

Mr. Ray argued that CON regulation has a positive effect on staffing and quality.

- **Access to care for Medicaid patients/Medicaid burden-sharing requirements**

A commenter asked, "What is the rationale for the Medicaid Memorandum of Understanding (MOU) requirement committing CCFs to a minimum level of Medicaid participation? What would be the result if no MOU requirement was in place?

- **Information requirements and application review process: aligning/streamlining**

One Task Force member recommended that MHCC support innovation in care delivery by making it easier for innovators to add or establish services at a CCF if they can demonstrate reductions in the cost of care. These actions could further encourage innovation under the TCOC Model.

Mr. Parker noted that regulating bed capacity, the chief mechanism of CON regulation of CCFs may not be linked to controlling the total cost of care, pointing out his view that capacity does not create demand.

In the context of construction and inspection, one commenter asked that the process be streamlined, and converted into an online application as soon as possible. The process should treat applicants like customers, and have specific, quick responses, getting past long waits in the process, which produce an unnecessary cost of doing business.

Dr. Redmon then presented a series of potential CON reforms for CCFs. Task Force commentary appears below each bullet:

- **Permit docketing of applications for new facilities in jurisdictions where existing facilities report an average of a two star or lower rating on the CMS Nursing Home Compare (NHC) five-star system**

Mr. Sergent supported the idea of a CON process that serves a "gatekeeper" function for quality and a number of Task Force members agreed.

There was significant disagreement as to the validity of the NHC rating system, with Task Force members representing CCFs stating the industry had concerns with the system's overall validity due to instability in the measures used and the questionable linkage of the rating system to the measurement of quality. Mr. Sergent clarified that he was not endorsing the NHC star system explicitly, just the quality gatekeeper function. One Task Force member from the industry noted that

a pay for performance model may be more objective. Mr. McCone noted the HSCRC measures hospital quality with lots of incentives supporting quality improvement.

- **Allow changes in bed capacity of more than 10% without needed a CON**

Mr. Parker explained the concept of "bed creep," by which CCFs are currently allowed to add 10 beds or increase existing bed capacity by up to 10%, whichever is less, every two years, if bed capacity does not change during that time period and the CCF has the physical space to deploy the beds. Mr. Sergent voiced support for this recommendation.

Dr. Ben Lowentritt noted that this feature of CON regulation benefits existing facilities to the possible detriment of facilitating new market entry.

- **Permit docketing of applications in jurisdictions that have no need if proposal is well aligned with the TCOC demonstration.**

- **Allow CCFs to provide home health or hospice services without needing an additional CON**

A number of commenters noted that the provision of services within a closed system will adversely affect patient choice.

<u>Agenda Item 5: Home Health Agencies (HHA)</u>

Mr. Parker provided a brief review of the key policy objectives implemented through MHCC's current approach to CON regulation of home health agencies (HHAs); limiting the number of HHAs, allowing expansion of HHA capacity to address insufficient consumer choice, insufficient choice of high performing HHAs, and high jurisdictional market concentration; limiting opportunities for expansion to average or better performers based on the CMS Home Health Compare rating system; and limiting the pace of expansion allowed based on the number of existing HHAs in the market.

Dr. Redmon presented the following topics and accompanying questions pertaining to HHAs.

- **Scope of regulation**
- **Needs-based review standards and other standards**
- **Compatibility of CON regulation with the TCOC Model**
- **Role of CON regulation in promoting quality of care**
- **Access to care – charity care requirements**
- **Information requirements and review process**

Dr. Redmon then presented a series of potential CON reforms for HHAs. Task Force commentary appears below, following the bulleted list:

- **Provide greater flexibility for existing operators**
- **Exempt from CON HHA review for any health facility that already has a CON as a health care facility (exemption for hospital, CCF, and hospice)**
- **Allow CCFs to provide home health or hospice services without needing an additional CON**

- **Limit CON standards to a review of the provider's history and quality of previous services**
- **Eliminate CON, and to the extent that provider quality if an issue, address provider quality through MDH requirements: obtain and receive a license from MDH, which will continue to provide appropriate license oversight.**
- **Eliminate CON-there is some evidence that home health is underutilized in CON states (in favor of CCFs). CON for CCF does not help reduce CCF utilization or promote appropriate home health utilization.**

Mr. Sergent asked if it is necessary to regulate home health agencies under the CON program. How does it help patients? Mr. Ray advocated for retaining the CON process in a streamlined version, offering that the necessary goal of CON is to "gate-keep," keeping out potentially bad providers.

Another commenter recommended that if a provider is able and capable of providing services, they should be allowed to do so.

Mr. Solberg noted some innovations do not relate to cost. They can address access, quality, or reductions in care disparities.

Given the nearness of the allotted time for the meeting, Mr. Sergent invited others in attendance to comment, if they wished. Howard Sollins, an attorney with Baker Donelson, provided the following comments. He noted that in the description of the key issues for discussion, there seemed to be a blending of changes applicable to the CON modernization process as well as the working draft of the CCF Chapter. CCFs are being treated differently than other providers. He suggested that the most effective approach for the Task Force would be to build on the Task Force discussion about over-arching principles that would apply to all the health care provider categories. He recommended the Task Force narrow the scope of the CON process, making it more efficient, making it more cost-effective, eliminating duplication of the role played by other agencies, and focusing on the impact of CON regulation on the Total Cost of Care model. MHCC should look at the various SHP chapters at the same time under the lens of these common principles versus singling out the CCF chapter for separate updating.

The potential cross-cutting recommendations will be addressed at future meetings.

Agenda Item 6: Adjournment

Mr. Sergent thanked all participants and ended the meeting at approximately 11:30 am.