HFAM
Health Facilities Association of Maryland
Partners in Quality Care

November 14, 2018

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Ben:

I hope this letter finds you well, and as always, I thank you for all that you do. I was unable to make the meeting last week because of a meeting in Annapolis, however I have reviewed in detail the PowerPoint deck from the meeting. As you know, HFAM and LifeSpan are coordinating efforts on this front and we continue have serious concerns on what is proposed.

HFAM represents the majority of skilled nursing and rehabilitation centers in Maryland who provide the majority of both Medicaid and Medicare funded care in the long-term and post-acute care setting. On behalf of our provider community, HFAM remains opposed to the following recommendation – PowerPoint Recommendation #2:

"allow docketing of alternative models for post-acute care that is endorsed by the HSCRC staff as a viable approach for reducing the total cost of care consistent with HSCRC's TCOC model." Draft Report #2 – "create the ability for the waiver of CON requirements for a capital project that is endorsed by the HSCRC as a viable approach for reducing the total cost of care consistent with HSCRC's TCOC model and alternative models for post-acute care."

What is presently proposed, creating new post-acute care capacity absent demographic need for the first time in Maryland, could result in serious unintended consequences for Marylanders already receiving quality care in existing centers; these centers are already adapting and innovating in the Total Cost of Care environment.

The docketing exception as outlined will have a negative impact on current quality care innovation. This relates both to the exception where there is a certain Five Star ranking among a percentage of facilities in a jurisdiction or based on a hospital agreement that aspires to benefit efforts to constrain the Total Cost of Care. The harm of new capacity in the absence of need is indiscriminate and equally damaging to facilities that have been making substantial investments in physical plant, staff and services.

601 Global Way, Suite 100-103 ▪ Linthicum, MD 21090 ▪ www.HFAM.org
410.290.5132 ▪ 301.490.8413 ▪ Toll Free: 1.877.LTC.HFAM

This is particularly true in relation to the provision relating to hospital arrangements labeled as addressing the Total Cost of Care. The creation of new capacity without demonstrated need will have a negative impact on the current Medicare/Medicaid payer mix of existing quality post-acute and long-term care providers, ultimately lowering census, revenues and services of successful centers, creating a two-tier care environment.

Just as continuing the memorandum of understanding in what is currently proposed by MHCC is not supported by any particular lack of availability or policy objective, the proposed docketing exceptions attempt to solve an unidentified lack of innovation in the Maryland post-acute and long-term care marketplace. Trust me - especially in a Total Cost of Care environment, the best providers are focused on quality, innovation, credibility and partnership across the continuum of care.

HFAM and our members are actively involved with Secretary Neall, partnering with Maryland hospitals and other providers as the Maryland Model moves to a more integrated Total Cost of Care environment and we believe that the docketing exceptions for skilled nursing and rehabilitation centers are premature at this time. We also believe that these important innovations relative to CON will be best achieved if we reach consensus on draft rules prior to publication in the Maryland Register.

Pursuant to our letter to you on November 1, 2018 (attached), we appreciate the changes your team made to the draft as a result of our work together. We look forward to our continued positive partnership as we work together to get this important initiative to a mutually agreeable place that serves the future needs of Marylanders.

Be well,

Joseph DeMattos, MA
President and CEO

cc: Robert R. Neall, Secretary, Maryland Department of Health
Webster Ye, Deputy Chief of Staff, Maryland Department of Health
Tiffany Robinson, Deputy Chief of Staff, Office of the Governor
Katie Wunderlich, Executive Director, Health Services Cost Review Commission
Howard Sollins, Baker Donelson
Danna L. Kauffman, LifeSpan Network
HFAM Board of Directors

Keeping You Connected…Expanding Your Potential…
In Senior Care and Services

November 13, 2018

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: CON Task Force: Phase 2 Recommendations/Draft Report

Dear Mr. Steffen:

On behalf of LifeSpan Network, below are comments to the recommendations contained in the powerpoint presentation provided on November 9th to the CON Modernization Workgroup and in the Draft Report dated November 9th. On behalf of our comprehensive care facility members, LifeSpan remains opposed to the following recommendation --

Powerpoint Recommendation #2 – "allow docketing of alternative models for post-acute care that is endorsed by the HSCRC staff as a viable approach for reducing the total cost of care consistent with HSCRC's TCOC model." Draft Report #2 – "create the ability for the waiver of CON requirements for a capital project that is endorsed by the HSCRC as a viable approach for reducing the total cost of care consistent with HSCRC's TCOC model and alternative models for post-acute care.

At the same time the Maryland Health Care Commission (MHCC) convened the CON Modernization Workgroup, it also put forward revisions to COMAR 10.24.20 *State Health Plan for Facilities and Services: Comprehensive Care Facility Services*. As such, the provisions contained in the State Health Plan provide greater insight into the details of this recommendation as it relates to comprehensive care facilities. The above recommendations omit the simple fact that, at least for comprehensive care facilities, the "alternative models" would not need to be based on any identified bed need for the service in the jurisdiction.

The CON process has long been based on identifying need in the community for the requested action. Simply stated, when health care services are unavailable to those in need in a particular jurisdiction, the MHCC authorizes the addition of new beds and/or new health care services. LifeSpan strongly believes that this premise should be continued and that the nursing home industry should be incentivized to realign existing beds rather than add new beds to a system

when there is no identified bed need. The MHCC has already pointed out that nursing home utilization is declining. Why would the MHCC want to encourage more beds rather than a realignment when utilization is declining, and the State also continues to emphasize the development of increased home-and-community based services.[1]

Equally important, this recommendation is premature. The TCOC Model is set to begin on January 1, 2019, concurrent with the Episode of Care Improvement Program and the Primary Care Model. Currently, the State Innovation Group is examining additional payment models for post-acute care. LifeSpan and the nursing home industry are actively participating in this group. The MHCC itself points out in the Draft Decision Matrices of the CON Modernization Workgroup in the Comprehensive Care Facilities grid – "what constitutes TCOC alignment has not been defined by the State or hospitals." **LifeSpan would recommend that rather than include this under "Immediate Regulatory Reforms," it should be further studied under the Stakeholder Innovation Group as additional care redesign programs are examined and implemented.**[2]

Thank you for the opportunity to comment.

Sincerely,

Danna L. Kauffman
Schwartz, Metz and Wise, PA
On Behalf of LifeSpan Network

Sincerely,

Paul N. Miller
Senior VP of Operations and Products
LifeSpan

cc: Maryland Health Care Commissioners

[1] This is evidenced by the requirements contained in the State Health Plan revisions where an applicant must provide information to every prospective resident about the existence of alternative community-based services as well as other requirements (page 14 - .05 General Standards) and the continued work by the Maryland Department of Health to transition individuals from nursing homes to alternative community-based services through the Money Follows the Person Program and other waivers.

[2] It is also important to note that it is unclear whether statutory authority exists for this regulation. Ironically, in the Draft Decision Matrices distributed on October 12th at the CON Modernization Workgroup, the MHCC stated that "permit docketing of apps in jurisdictions that have no need if proposal well-aligned with TCOC demonstration" requires statutory changes. However, now, the MHCC Draft Report concludes that it does not need a statutory change but recognizes that it is contained within the revisions to the State Health Plan.

NOTE: Comments were sent via email, converted to a document by MHCC

FROM: Anne Horton

TO: MHCC

SUBJ: MNCHA Comments on the Draft Report Overview

DATE: November 14, 2018

Thank you for the opportunity to comment on the proposed recommendations for CON modernization. Our comments come from the content of the PPT slide deck distributed last Friday at the task force meeting.

Please let me know if you would like to discuss this via phone to provide clarity on our questions.

Again, we greatly appreciate the opportunity to comments.

Kind Regards,
Ann Horton

Slide 10
Recommendation 1a (i). suggests eliminating "extraneous standards or standards with low impact" including charity care.

Comment: MNCHA strongly believes that all home health providers approved in Maryland should be required to demonstrate a track record of charity care, and that the provision of charity care should be a requirement to do business in Maryland.

Slide 11
Recommendation 1b (b.a) calls for an abbreviated review process for all uncontested projects that do not involve establishment of a healthcare facility.

Comment: Can you please clarify whether or not this would include the expansion of an existing home health agency into a new county? And, if yes, can you define "establishment" in the context of home health?

Slide 13
Recommendation 1d (2) indicates that the review of changes in approved projects a staff review function, including changes to medical services approved to be provided by the facility.

Comment: Would this include an existing non-home health facility opening a home health agency?

Slide 14

Recommendation 2 calls for the a waiver of CON requirements and the allowance of docketing of “alternative models for post-acute care that is endorsed by the HSCRC staff as a viable approach for reducing the total cost of care consistently with HSCRC’s TCOC model."

Comment: We are seeking clarification to determine if and how this will impact home health, as the term *post-acute care* includes home health care services. If this is intended to pertain to the hospital-SNF relationship, we ask that staff clarify that point. I believe this was to be revised following the task force meeting, and request the revision for review.

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MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

November 14, 2018

VIA ELECTRONIC MAIL
Mr. Robert E. Moffit, PhD
Mr. Andrew N. Pollak, MD
Chairman & Vice-Chairman
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: CON Modernization Task Force—Comments on Draft Final Report

Dear Chairman Moffit and Vice-Chairman Pollak:

On behalf of the Maryland Patient Care and Access Coalition (MPCAC), I am writing to share MPCAC's thoughts on the draft Final Report that the CON Modernization Task Force has submitted to MHCC for the Commission's consideration. For nearly 15 years, MPCAC has been the voice of independent physician specialty practices in the State of Maryland that deliver integrated, high quality, cost-efficient care to patients in the medical office and ambulatory surgery facility (ASF) setting. With more than 300 physicians drawn from the fields of gastroenterology, orthopaedic surgery, urology, pathology, radiation oncology and anesthesiology, MPCAC's member medical practices treat more than 500,000 Marylanders each year in over 1,000,000 patient encounters. In addition, and of greatest relevance here, the physicians in MPCAC's member practices perform tens of thousands of procedures in ASFs and endoscopy centers each year.

Over the last year, MPCAC has been engaged on the topic of CON reform, submitting comments to MHCC and to the Task Force on the impact that CON has on ASFs. We acknowledge and appreciate the work of the Task Force and MHCC staff, but we believe the draft Final Report represents a significant missed opportunity to put forward bold proposals that would modernize CON as applied to ASFs.

In their June 25, 2017 letter to MHCC Executive Director Ben Steffen, Chairpersons Middleton and Pendergrass noted that the All-Payer Model "[c]alls for dramatic changes in health care delivery and spending, and the Certificate of Need (CON) program must also recognize these changes." The kind of "dramatic changes" needed to promote quality care, drive innovation and enhance competition cannot happen by modifying CON around the edges. Based on the Commission's early discussions, we had hoped that the Task Force would consider seriously the elimination of CON as applied to ASFs or, at the very least, exemption of ASFs with four or fewer operating rooms from CON regulation. Instead, the Task Force is recommending the smallest possible incremental step—an exemption from CON for ASFs with two operating

rooms—while proposing that hospitals be given even further leeway to open ASFs in competition with free-standing ASFs. We do not believe these are the types of bold proposals sought by Chairpersons Middleton and Pendergrass nor contemplated by the Commission.

MPCAC shares MHCC's commitment to modernizing the State's CON regulatory program that has been in effect for more than 40 years. As we have shared with the Task Force and with MHCC in prior comment letters, MPCAC believes that any effort to modernize the State's CON program should include significant reform of CON regulation as applied to ASFs. The Task Force's recommendations with respect to ASFs do not go far enough in modernizing an inherently anti-competitive regulatory regime that inhibits the shifting of high quality care to a lower cost care delivery setting. We urge the Commission to recommend to the General Assembly a bolder vision for CON reform as applied to ASFs than is contemplated in the Task Force's draft Final Report. In that regard, I am enclosing a short document that we ask the Commission to consider as part of its ongoing efforts to modernize CON as applied to ASFs.

Please feel free to contact me at ngrosso@cfaortho.com or (443) 520-5770 if MPCAC can be of assistance to the Commission as it continues its work on CON reform, particularly as applied to ASFs.

Sincerely,

Nicholas P. Grosso, M.D.
Chairman of the Board & President, MPCAC

Enclosure

cc: Randolph Sergent, Chair, MHCC CON Modernization Task Force
Ben Steffen, Executive Director, MHCC
Paul Parker, Director, MHCC Center for Health Care Facilities Planning & Development
Joe Bryce, Manis Canning & Associates

MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

MHCC CON Modernization
Ambulatory Surgery Facilities (ASFs)

Overview:

The opportunity to reform Maryland's CON program is a critically important issue, as the Chairs of the Senate Finance Committee and the House Health and Government Operations Committee recognized in their initial request to MHCC to develop recommendations for "modernizing" the State's 40-year-old CON program. A true modernization of the State's CON program presents an opportunity to align the State's regulatory scheme with the ongoing transitional shift in the delivery of health care. To facilitate this shift most effectively, we are convinced that any revamp of the State's CON program must have a clear focus on the removal of barriers hindering the delivery of high quality health care in cost-effective and accessible settings such as ASFs.

We sincerely thank the CON Modernization Task Force for its time and attention to this critical issue, but we believe the Task Force's draft Final Report does not go far enough in recommending the types of dramatic and transformative changes to the CON program that are necessary to promote access to the highest quality, cost-efficient and convenient care while eliminating artificial barriers to competition and innovation. We were encouraged by a number of key principals outlined in MHCC's Interim Report on CON Modernization back in June 2018, but believe the recommendations in the Task Force's November 9, 2018 draft Final Report fail to capitalize on a critical opportunity to carry out those key principles. We urge MHCC to keep those key principles at the forefront in considering the Task Force's draft Final Report and in MHCC's ongoing evaluation of the fundamental issues associated with the State's existing CON program.

Key Principals:

- ***Promoting Competition and Innovation***:
    - Industry comments that generally favor continuing CON for their particular facilities must be weighed in light of a natural tendency to protect existing interests to the potential detriment of new market entrants. *MHCC June 1, 2018 Interim Report at 5.*
    - The State must guard against the risk of maintaining CON regulation as a mechanism for protecting existing interests to the potential detriment of new market entrants to avoid stifling competition, innovation and opportunities for cost-reduction.

- ***Decreasing the Total Cost of Care***:

    - CON modernization needs to be examined through the prism of the All-Payer Model and, in particular, the Total Cost of Care model. *Interim Report at 1, 6-7*. In order to stay within the Total Cost of Care guardrails, it will be important to move more demand to the least costly setting in which demand can be handled appropriately. *Interim Report at 7*.
    - Academic and government studies have shown that shifting care into ASFs can result in significant cost savings when compared to similar services and procedures in other surgical care settings. Additional cost savings would also likely be achievable if barriers to creating larger, and perhaps multi-specialty, ASFs were removed to allow ASF operators to eliminate duplication of overhead and operational expenses.

- ***Protecting and Improving Quality and Safety***:

    - Literature shows that, in the abstract, the overall benefit of CON regulation is debatable and does not provide strong evidence that CON reduces health care costs or improves quality. *Interim Report at 6*. Health care quality is an issue that may be best addressed through licensure regulation, rather than the one-time, front-end review offered by CON regulation….[E]nsuring quality of health care and that "bad actors" remain outside of the system are appropriate regulatory goals but using CON regulation may be a problematic and inefficient approach. *Interim Report at 7-8*.
    - A robust licensure process, rather than front-end review through CON, is the appropriate mechanism for safeguarding quality care and for ensuring that health care facilities are operated soundly and under responsible ownership.
    - The current regulatory scheme that provides for an ability to establish ASFs with no more than one operating room outside the scope of the CON program likely impedes quality and safety improvements that would result from larger ASFs. Efficiencies and advances in peer review oversight, quality control, and inspection and accreditation processes would be more achievable in larger ASFs.

<u>Opportunity to Modernize the CON Program</u>:

- We believe it is time for Maryland to replace its CON regulatory framework—at least as applied to ASFs—with an alternative approach that ensures patient access to high quality care without creating barriers to market entry. Specifically, we believe that ASFs should not be subject to CON regulation, regardless of the number of operating rooms and, instead, should be subject to the "determination of coverage" process MHCC currently uses to evaluate physician outpatient surgical centers that contain one operating room. At a minimum, we believe that CON should be liberalized so that ASFs with four or fewer operating rooms are not subject to CON review and the use of a capital expenditure threshold should be eliminated. By removing barriers to creating larger, and perhaps multi-specialty, ASFs, operational efficiencies could be obtained to decrease the total cost of care and widespread implementation of quality and safety best practices would be more achievable.