MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

Hospice Work Group
July 11, 2022
Meeting Summary

Attendance:

Regina Bodnar, Carroll Hospice
Michael Brady, Hospice of the Chesapeake
Pat Cameron, Medstar Health
Christopher Chekouras, Talbot Hospice
Erin Davis, Maryland Hospital Association
Monica Escalante, Coastal Hospice
Peggy Funk, Hospice & Palliative Care Network of Maryland
Altonia Garrett, Accentcare Hospice (formerly Seasons Hospice)
Carlos Graveran, Frederick Health
Heather Guerieri, Compass Hospice
Danna Kauffman, Schwartz, Metz, and Wise
Cordt Kassner, Hospice Analytics
Heather Kirby, Frederick Health
Ernesto Lopez, Hospice of Washington County
Kara Rawlings, Hospice of St. Mary's
Jane Sacco, Medicaid
Sarah Simmons, Calvert Hospice
Jarrod Terry, Medicaid
Renee Webster, Office of Health Care Quality

MHCC:
Ben Steffen
Linda Cole
Stacy Howes
Theressa Lee
Paul Parker
Catherine Victorine
Cathy Weiss

Welcome and Introduction:

Ben Steffen welcomed the members of the Hospice Work Group to the meeting and said that he looked forward to the discussion and interaction. Linda Cole reiterated the welcome and told members to put questions into the chat box or raise their hands so staff can respond.

Background:

Ms. Cole reminded the group that Hospice Work Group meetings were held during 2018-2019. This is a continuation of that process. She expressed awareness of the impact of COVID on the ability of hospices to provide services, both in the home and other settings. Ms. Cole stated that data collection is ongoing. Survey data for 2019 and 2020 have been posted; part I data collection for the FY 2021 survey has been completed. She also referred to innovative approaches to integrated hospice and hospital care approved for Gilchrist Hospice and Luminis Health.

Ms. Cole presented trends in Maryland hospice use rates. She noted that the decline in use rates in 2020 is consistent with national trends. This is not due to a decline in hospice utilization, but rather an increase in the denominator (total deaths) due to the huge number of COVID deaths.

Quality Measures:

Stacy Howes then presented updates to quality reporting. The Hospice Item Set (7 items) and the CAHPS (8 items) continue. New quality measures include the Hospice Care Index (10 items), and Hospice Visits in the Last Days of Life (HVLDL), which will be added from claims data. The data will be added to Care Compare in August 2022.

Mr. Steffen asked if the new measures will be posted in August 2022, and what time period the measures are based on. Dr. Howes replied that it will be based on the third quarter of 2021. This data will be posted on the Commission's website about 6 weeks after it becomes available.

Issue Briefs:

Ms. Cole reviewed the Issue Briefs, which had been previously distributed. She mentioned that there are 12 sole provider jurisdictions, which by definition do not offer consumer choice, should a consumer wish to change providers. Some options include expansion of existing hospices into neighboring jurisdictions, as well as criteria for new providers. There is also an opportunity to create multi-jurisdictional regions of minimum population size to encourage providers to serve patients in these smaller jurisdictions.

In terms of quality measurement, as Dr. Howes reported, new measures are being developed and updated. This was not available for the previous update to the Hospice Chapter of the State Health Plan. Discussion can focus on how “good quality providers” may be defined.

Regarding need projection, Ms. Cole pointed out the pros and cons of the existing need projection methodology. It is based on historical use rates and includes a compound annual

growth rate to address growth of existing providers. It uses the 35+ population, which includes over 95% of hospice users. However, hospice is not a "bricks and mortar" facility and services can be expanded or contracted. The current approach continues to show need in Baltimore City and Prince George's County, which are areas of low use rates and high population.

Proposed Need Determination:

Dr. Howes then presented a possible new approach to determining need for additional hospice services. This approach is similar to that used in the Home Health Agency Chapter of the State Health Plan. This recommended approach would use measures from the Hospice Item Set and CAHPS now but could include new measures in the future.

Dr. Howes explained how she scored quality measures and then summed the score to create a single CAHPS score and a single HIS score for each hospice. Scores are then compared to the state average. Hospices that scored 0,1, or 2 on EITHER CAHPS or HIS (56%) could be used to determine jurisdictions where expansion may be needed. Hospices that scored 0,1, or 2 on BOTH HIS and CAHPS could be excluded as potential applicants for expansion. This is presented as a possible approach to incorporating quality measures for discussion by the group.

Questions and Discussion:

Sarah Simmons noted that the HIS individual items are no longer available as of May 2022. Dr. Howes responded that the composite measure could be used.

Carlos Graveran requested clarification of the goal of this meeting's discussion. Is it just to increase the number of hospices? He suggested that simply adding providers to Baltimore City and Prince George's County does not increase use rates. He said that the Hospice Network has been meeting and has talking points.

Heather Guerieri said that the Network would send their comments after the meeting. She stated that the hospices are on the same page as the state in wanting to improve the methodology and increase utilization of hospice services.

Reggie Bodnar said the hospices want something that is fair to providers serving communities, as well as the people living in the communities. She mentioned that data is available within her hospital system to show how hospitals are referring to hospices (11% from Carroll Hospital and 10.5% from Northwest Hospital). She can also see how many followed up and were admitted to hospice. Dr. Howes asked that she share this data with the work group.

In response to Mr. Graveran, Paul Parker noted that our objective is not simply to increase the number of hospices. The current Chapter has kept us "frozen in place" where no providers can come in and change the landscape. The 12 sole provider jurisdictions are a "sticking point" for Commissioners, who would like to see some process created by the work group.

Mr. Parker asked how opportunities could be created in a responsible way. Could smaller size jurisdictions be grouped into multi-jurisdictional regions in Western Maryland, Southern Maryland and the Eastern Shore to create choice for patients? Incorporating quality measures is a new approach, and he agreed with Ms. Bodnar that the addition of other data is also useful.

Monica Escalante said that hospices are collaborating with other provider types (nursing home, assisted living) and are also educating providers. She noted that the Eastern Shore has higher use rates than Prince George's County. She is also concerned about charity care provided in residential facilities.

Ernesto Lopez focused on Mr. Parker's use of the term "destructive competition." He noted that in Western Maryland the population base is small, and the mountains make travel across jurisdictions difficult. Clinical resources are also limited. He noted that the Hospice of Washington County works with Frederick Health. They also provide care in West Virginia and Pennsylvania. He stressed the need to work with health systems.

Ms. Guerieri stated that she has three rural jurisdictions with no hospitals and must rely on referrals from Anne Arundel, Talbot Counties, and Delaware. She noted the need for a culture shift in hospitals, nursing homes, assisted living.

Erin Davis noted that the Maryland Hospital Association (MHA) may have hospital discharge to hospice data, and she will investigate obtaining it and sharing it with the group. She said that a concern of MHA is equity of care. Mr. Steffen stated that the Commission wants to include a focus on health equity in each chapter of the State Health Plan.

Christopher Chekouras said that hospices try to work with hospitals to get referrals. He noted that some hospitals also own primary care physician practices.

Heather Kirby said that Frederick Health is working within the health system to show the impact of hospice on the total cost of care in Maryland. Hospitals can move patients out of the hospital and into hospice. She noted the need to include nursing homes (SNFs) as well.

Peggy Funk mentioned the difficulty of obtaining data on nursing home referrals to hospice.

Cordt Kassner said that his work focuses on Medicare claims data. He noted that the Maryland calculation of use rate does not match the MedPAC calculation. One is based on hospice deaths as a proportion of total (35+) population deaths, and one uses Medicare decedents as a proportion of total population deaths. He suggested that one approach to define access and determine need may be to use quality measures and use rates as a threshold.

Peggy Funk asked about operational timelines and CONs that do not go forward. Ms. Cole said that there are two separate issues. Once a CON is approved, a timeline can be established (e.g., 18 months) for the program to become operational in the community before another CON applicant can be considered. As far as CONs that do not become operational programs, these are not licensed and are not counted as existing providers.

Mr. Parker stated that the concept of a "provisional CON" is not within the MHCC statute. Once a program becomes licensed, there is no longer a CON and the oversight of its quality becomes the purview of the Office of Health Care Quality (OHCQ).

Mr. Parker stated that he hoped that a regional approach would dilute the impact on any one provider. Mr. Lopez stated that it might be easier for an existing program to expand in a rural region than for a new provider to enter the market.

Mr. Graveran stated that we could look at work done in other states. He mentioned a broad coalition that was successful in Arizona. Mr. Parker noted that Arizona is a non-CON state.

Mr. Kassner mentioned that there are single provider jurisdictions in other states, usually in rural areas. Maryland is not a state with many rural counties.

<u>Next Steps</u>:

Mr. Steffen said that he appreciated the collaboration with the hospice providers and that we look forward to receiving data from them. Ms. Cole also thanked the participants for a lively discussion and looked forward to receiving materials from the Hospice Network and MHA in order to structure discussion at the next meeting.