January 11, 2018

Paul Parker
Director of the Commission's Center for Health Care
Facilities Planning and Development
4160 Patterson Avenue
Baltimore, MD 21215

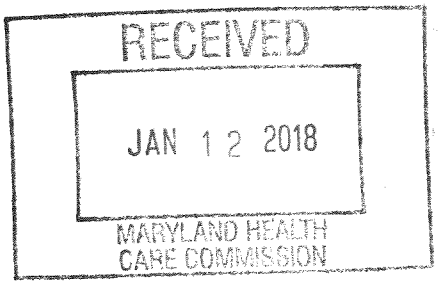
Dear Paul,

Please see attached for Seasons' response to the comment guidance related to the MHCC CON study. Please let me know if you'd like this electronically.

My e-mail address is: DForman@Seasons.org.

Sincerely,

Dean Forman, MBA
Executive Director
Vice President Operations



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COMMENT GUIDANCE - GENERAL HOSPICE SERVICES MHCC CON STUDY, 2017-18

Please consider your answers in the context of Maryland's commitment to achieve the goals of the Triple Aim[1] and its aspiration to bring health care spending under a total cost of care model beginning in 2019. Please provide a brief explanation of the basis for your position(s) in each area of inquiry beginning with the overarching question regarding continuation of general hospice CON regulation. All responses will be part of the Maryland Health Care Commission's public record for the CON Workgroup.

Need for CON Regulation

Which of these options best fits your view of general hospice CON regulation?

O CON regulation of general hospices should be eliminated. [If you chose this option, many of the questions listed below will be moot, given that their context is one in which CON regulation would continue to exist. However, please respond to Questions 12 and 13.]

O CON regulation of general hospice services should be reformed.

X O CON regulation of general hospice services should, in general, be maintained in its current form.

ISSUES/PROBLEMS

The Impact of CON Regulation on General Hospice Service Competition and Innovation

1. In your view, would the public and the health care delivery system benefit from more competition among general hospice programs?

No. Primarily, more hospice providers would cause increased competition for limited clinical resources and diminishing return on the achieved and to be realized economies of scale. Additional general hospice providers would drive up (redundant) fixed costs, which is one of the core benefits of a service based model. In addition, it would also drive up the cost of the health care oversight system by adding additional regulatory resources to oversee compliance and quality. In Maryland, the densely populated jurisdictions have significant competition presently, and utilization (delivery) trends are growing well alongside the new HSCRC reimbursement models. There has never been a

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time our agency, and to our knowledge of other agencies, has not been able to meet the need of an eligible hospice patient/family who desired hospice enrollment.

2. Does CON regulation impose substantial barriers to market entry for new general hospices or expansion of general hospice service areas? If so, what changes in CON regulation should be implemented to enhance competition that would benefit the public?

The CON provides necessary barriers to market entry and jurisdiction expansion. The densely populated jurisdictions have appropriate competition. More Rural jurisdictions which have a single provider, likely could not sustain a business model for new market entrants, due to the volume of need and the population sizes of their geographic areas. The rural sole provider reality, is not unique to Maryland, for the same population size/need reasons found here. It is something we see in many rural communities across the country, in both CON and non-CON environments.

3. How does CON regulation stifle innovation in the delivery of general hospice services under the current Maryland regulatory scheme?

As a national provider that operates in CON and non-CON states (19 states in total) there has been NO negative impact on innovation and NO experience to suggest that Maryland is less innovative regarding end of life care than non-CON states. In fact, there is MORE attention to quality and innovation afforded from scale and avoided distraction due to questionable practices that arise with oversaturation, as well as, instability of staff caused by inflated supply of providers. As an example, Seasons employs Board Certified Music Therapist as part of the IDG to add to quality and comfort at end of life. This is not a requirement of the Medicare Hospice Conditions of Participation. We also have dedicated resources to community education and deliver over 425 hours of education to over 4100 attendees. Seasons also contracts with hospitals, as well as, skilled nursing facilities to provide palliative care services in an innovation driven model. This model is leading to reduced readmissions and hospital mortality, complimenting the goals of the new total payer model in Maryland. In 2018 Seasons will be expanding its telehealth initiatives, bringing additional clinical assessments and physician interaction directly to the patient and caregiver on a more frequent and high-quality basis.

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[1]The Institute for Healthcare Improvement's "Triple Aim" is a framework that describes an approach to optimizing health system performance. It is this belief that new designs must be developed to simultaneously pursue three dimension: (1} Improving the patient experience of care (including quality and satisfaction) ;(2} Improving the health of populations, and; (3} Reducing the per capita cost of health care.

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4. Outline the benefits of CON given that hospice services do not require major capital investment, do not induce unneeded demand, are not high costs and usually do not involve advanced or emerging medical technologies.

The CON promotes innovation and the ability to scale to meet the demands of the community. Having a controlled number of licensed providers enables hospice to focus on key partnerships with hospital systems, skilled nursing homes, and assisted living providers to keep readmission and mortality statistics minimized. Thus, supporting the significant savings achieved in the all payor model in Maryland. Post-acute ambulatory end of life care requires massive labor, logistics investments, and infrastructure costs. Additional providers would add unnecessary competition for already competitive resources like Physicians (Board Certified), Nurses, Social Workers, HHA's, Volunteers, Chaplains and clinical operations leadership. All of which are difficult to hire and could factor against existing hospice providers ability to innovate, scale, and meet the needs of the community. It would also, as mentioned, create redundant fixed costs, adding to the overall delivery of care costs for payors. Here in Maryland, we are also seeing the demand and therefore expansion of Inpatient Hospice Services. Those services are far more capital intensive, in the traditional capital sense (brick/mortar), which is moving hospice further into of the capital investment arena.

Scope of CON Regulation

Generally, Maryland Health Care Commission approval is required to establish a general hospice, increase the bed capacity (general inpatient hospice care) of a general hospice, or expand the service area of an existing general hospice into new jurisdictions. For a more detailed understanding of the scope of CON and exemption from CON review requirements, you may wish to review COMAR 10.2f 01.02 - .04, which can be accessed at:
http:// www.dsd.state.md.us/comar/Subtitle5earch.aspx?search=10.24.01.*

5. Should the scope of CON regulation be changed?
   A. Are there general hospice projects that require approval by the Maryland Health Care Commission that should be deregulated?

The modern interpretation of the regulation, calls for a separate Certificate of Need for Inpatient Beds to be developed, in all settings. If any change is to be considered given that a CON is required for a general hospice license, as well as for hospitals and skilled nursing facilities, we would simply suggest that an already licensed general hospice provider (with a CON), should be able to develop inpatient beds within its existing CON geography using the structure which Medicare regulation considers "direct/shared". Direct/shared is where the hospice and an already licensed hospital or skilled nursing facility may enter into an arrangement, where the

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hospice provides some services direct (staffing most common) and some services are purchased (shared), including the use of the facilities licensed beds. This is a structure that allows the hospice to repurpose existing capacity (that is already overseen by the state regulatory agencies on each side of the arrangement, as both the hospice and facility are licensed and surveyed) and adjust more quickly to changes in need both up./down with limited capital risk, and is very different than developing a freestanding inpatient facility (which Medicare refers to as "direct"). At present, there is an equal CON requirement for both structures.

B. Are there general hospice projects that do not require approval by the Maryland Health Care Commission that should be added to the scope of CON regulation?

Current regulated scope is inclusive

The Project Review Process

6. What aspects of the project review process are most in need of reform? What are the primary choke-points in the process?

The process at present has been fine for our needs

7. Should the ability of competing general hospice programs or other types of providers to formally oppose and appeal decisions on projects be more limited? Are there existing categories of exemption review (see COMAR 10.24.01.04) that should be eliminated? Should further consolidation of health care facilities[2] be encouraged by maintaining exemption review for merged asset systems?

A formal process to oppose and appeal is needed and should not be limited. Interested parties should have a venue and a platform to challenge and discuss competing hospice CON filings.

8. Are project completion timelines, i.e., performance requirements for implementing and completing projects, realistic and appropriate? (See COMAR 10.24.01.12.)

Yes, from our experience, they have not posed any problems

The State Health Plan for Facilities and Services

9. In general, do State Health Plan regulations for general hospice services provide adequate and appropriate guidance for the Commission's decision-making? What

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are the chief strengths of these regulations and what do you perceive to be the chief weaknesses?

Chief weakness is primarily the formula in which need is determined. A demographic weighting related to the underserved communities should be considered. As an example African American hospice utilization is low nationally, as reported by the National Hospice and Palliative Care Organization (NHPCO). On a national level, the African American community, as a percentage of total population, is about 14% and in Maryland is 29.4%. Overall hospice utilization in the state of Maryland is slightly lower than the national average, but this does not mean there is unmet need, because Maryland's demographic makeup isn't a pure compliment to the national demographic makeup. The existing need calculation does not factor in the impact of cultural diversity and their utilization of hospice. Our recommendation would be to compare "demographically" weighted utilization against those same demographically weighted national utilization rates.

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2 Under Maryland CON law, home health agencies are classified as "health care facilities."

10. Do State Health Plan regulations focus attention on the most important aspects of general hospice projects? Please provide specific recommendations if you believe that the regulations miss the mark.

The State Health Plan would benefit by adding quality markers related to hospice length of stay. Hospice is most effective when the interdisciplinary team (IDG) has time to work with the patient and family. This takes time to build the trust and have the crucial conversations that provide the outcome of a high-quality hospice experience. Today our length of stay is approximately 60 days but more than a third of our admissions die within 7 days. Considering the baseline for hospice eligibility is a prognosis of 6 months or less, there is significant variance in the hospice benefit design and actual outcome. The quality markers should be physician education focused. Increased physician knowledge and comfort with prognostic indicators will provide enhanced end of life experiences in Maryland.

11. Are the typical ways in which MHCC obtains and uses industry and public input in State Health Plan development adequate and appropriate? If you believe that changes should be made in the development process for State Health Plan regulations, please provide specific recommendations.

The process is generally a good one, the issue we highlight in our response to #9, relates to the demographic issue that impacts the comparative data used to evaluate provider performance captured through successful industry and public input.

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General Review Criteria for all Project Reviews

COMAR 10.24.01.08G(3)(b)-(f)) contains five general criteria for review of all CON projects, in addition to the specific standards established in the State Health Plan: (1) Need; (2) Availability of More Cost-Effective Alternatives; (3) Viability; (4) Impact; and (5) the Applicant's Compliance with Terms and Conditions of Previously Awarded Certificates of Need.

12. Are these general criteria adequate and appropriate? Should other criteria be used? Should any of these criteria be eliminated or modified in some way?

Very appropriate, we wouldn't suggest modifications in any way.

CHANGES/SOLUTIONS

Alternatives to CON Regulation

13. If you believe that CON regulation of general hospices should be eliminated, what, if any, regulatory framework should govern establishment and service area expansion of home health agencies?

We do not believe CON regulation should be eliminated.

14. Are there important benefits served by CON regulation that could be fully or adequately met with alternative regulatory mechanisms? For example, could expansion of the scope and specificity of general hospice licensure requirements administered by the Maryland Department of Health serve as an alternative approach to assuring that these services are well-utilized and provide an acceptable level of care quality, with appropriate sanctions to address under-utilization or poor quality of care?

We do not believe any alternative would provide the governance necessary for continued sustained quality and service, which has kept pace with need.

The Impact of CON Regulation on General Hospice Program Competition and Innovation

15. Do you recommend changes in CON regulation to increase innovation in service delivery by existing general hospice programs and new market entrants? If so, please provide detailed recommendations.

No. As an experienced provider in the state, we are having NO challenges in deploying innovation and unique service models, and developing collaborative relationships with the health care continuum. The only item as mentioned under #5, which is a bit stricter than in most other environments and recognized by Medicare, would be the "direct/shared" structure for inpatient services, to be considered permitted without a separate CON.

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16. Should Maryland shift its regulatory focus to regulation of the consolidation of general hospice programs to preserve and strengthen competition for home health agency services?

Hospice is extremely different than home health care. The goals of care, coverage from a capitation perspective (24/7, etc…), and locations of service are not always overlapping (i.e. SNF's, hospitals, etc…). The largest and most successful hospice organizations, nationally, are not integrated with home health care. Even, the few that do have both service lines, do not operationally integrate them. The cultures, due to the reimbursement model and care goals, have proven to compete within integrated agencies. Hospice focus, being the harder conversation and harder to operate (given scope and capitation) usually is diminished and therefore so are the outcomes which hospice delivers.

The Impact of CON Regulation on General Hospice Access to Care and Quality

17. At what stage (prior to docketing or during project review) should MHCC take into consideration an applicant's quality of care performance? How should applicants be evaluated if they are new applicants to Maryland or to the industry?
Note: docketing is the determination by the MHCC when an application is judged complete and ready for review.

MHCC should use actual complaint and survey data of the existing providers. New applicants should be evaluated on like data from the state or states in which they operate. Applicants with active DOJ investigations related to potential fraudulent practice should be disqualified. Industry tools like Hospice Compare and the Pepper report, which are indicators of quality, satisfaction and regulatory adherence should also be reviewed and compared.

Scope of CON Regulation

18. Should MHCC be given more flexibility in choosing which general hospice projects require approval and those that can go forward without approval, based on adopted regulations for making these decisions? For example, all projects of a certain type could require notice to the Commission that includes information related to each project's impact on spending, on the pattern of service delivery, and that is based on the proposals received in a given time period. The Commission could consider staff's recommendation not to require CON approval or, based on significant project impact, to require the general hospice project to undergo CON review.

No. The only change we would propose is the response we provided under #5.

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19. Should a whole new process of expedited review for certain projects be created? If so, what should be the attributes of the process?

If "direct/shared" would continue to require the same CON process as a freestanding ("direct") inpatient unit, then an expedited process for hospital or skilled nursing facility based hospice inpatient beds/units, would be an area for expedited review. General criteria could be established regarding the size of the hospital/community, LOS, Mortality, and financial impact. As the global budget model expands and hospital utilization decreases space will become available in which hospitals may want to consider hospice inpatient units.

The Project Review Process

20. Are there specific steps that can be eliminated?

None at this time.

21. Should post-CON approval processes be changed to accommodate easier project modifications?

None at this time.

22. Should the regulatory process be overhauled to permit more types of projects to undergo a more abbreviated form of review? If so, please identify the exemptions and describe alternative approaches that could be considered.

Nothing beyond our response to #19.

23. Would greater use of technology, including the submission of automated and form-based applications, improve the application submission process?

Yes.

Duplication of Responsibilities by MHCC and MDH

24. Are there areas of regulatory duplication in general hospice regulation that can be streamlined between MHCC and MDH?

None that we have identified at this time.

Thank you for your responses.

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