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MEMORANDUM

TO: Commissioners

FROM: Eileen Fleck
Chief, Acute Care Policy and Planning E.F.

DATE: November 21, 2013

RE: Staff Recommendation for Final Regulations: State Health Plan for Acute Inpatient Rehabilitation Services (COMAR 10.24.09); Analysis of Comments Received

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Maryland Health Care Commission staff is requesting that the Commission adopt as final regulations a replacement COMAR 10.24.09: State Health Plan Chapter for Acute Inpatient Rehabilitation Services ("Chapter"). The Commission adopted the Chapter as proposed permanent regulations at its July 18, 2013 meeting. Only one organization, MedStar Health ("MedStar"), filed comments (attached) on the proposed Chapter. MedStar's comments (appendix 2) essentially repeat its informal comments on the draft Chapter, which were considered by the Commission prior to adopting the Chapter as proposed permanent regulations. Staff notes that, in response to MedStar's informal comments, it recommended and the Commission adopted, changes to the draft regulations. Staff recommends that the Commission adopt the revised Chapter (appendix 1) as final regulations, with the following non-substantive changes.

1. Deletion of the definition of "hospital" found at .06B(9). This definition simply makes reference to Maryland statute and is unnecessary for that reason. In addition, the definition of hospital as a facility located in Maryland is inconsistent with the intention and wording of .04B(3), which considers whether a proposed project will have an "unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services." This review standard is not limited to the impact on providers or hospitals located in Maryland. Furthermore, the need methodology references hospitals in the District of Columbia, so the term hospital is not being used to exclusively refer to Maryland hospitals.

2. The addition of the following words (underlined) to data sources regarding acute rehabilitation discharges fount at .05E(1)(a) and (b): Notice of changes in the DRG codes used to count acute rehabilitation discharges will be published on the Maryland Health Care Commission web site and in the *Maryland Register.* This added language will provide notice of any necessary updates to the list of DRG codes counted as acute rehabilitation discharges as a result of updates in the version of DRG codes used by hospitals. As noted in the regulation, DRG codes are different for 2007-09 than from 2010 to the present. Since the codes are periodically updated, the ability to make changes without amendment of the regulations will be helpful.

Summary of Comments and Staff Recommendation regarding COMAR 10.24.09, Adopted by the Commission as Proposed Permanent Regulations on July 18, 2013

MedStar Comments: Sections .03 and .04, Access to Care

MedStar Health commented that there is no data included in the draft Chapter to support the existence of an access problem and that the proposed Chapter, while retaining five health planning regions for acute inpatient rehabilitation services, retreats from regionalization concepts. MedStar Health also commented that according to data from the U.S. Health Indicators Data Warehouse, Medicare inpatient rehabilitation discharges in Maryland are among the highest in the country, when discharges from Maryland hospitals that do not report to Medicare are taken into account. MedStar Health also notes that consideration of access to providers outside Maryland, such as National Rehabilitation Hospital would demonstrate even greater access.

MedStar Health also commented that the draft Chapter expressly permits projects not supported by projected need that seek to address access barriers, even though the draft Chapter does not find or substantiate that a problem exists. It notes that the Medicare Payment Advisory Commission's March 2012 Annual Report concludes that access to acute rehabilitation is not a problem for the Medicare population. MedStar Health also notes that no Maryland studies regarding distance to providers being a problem are cited. Lastly, MedStar Health commented that even if variation could be shown to exist in Maryland, it could mean that education and outreach, rather than new capacity, are needed. MedStar requested that review standard .04B(1) be deleted and that .04B(2)(d) be revised to provide additional guidance regarding analysis of access problems that an applicant is required to make in the absence of identified need.

Staff Analysis and Recommendations Regarding Sections .03 and .04, Access to Care

As Staff noted in response to the informal comments, data to support the wide variation in use rates among Health Planning Regions (HPRs) by age groups was provided when the draft Chapter was posted for review. Staff previously reviewed data from the Centers for Medicare and Medicaid Services' Chronic Conditions Warehouse for 2008 and found that the rate of Maryland discharges per 1,000 Medicare beneficiaries was similar to the national average when data from the discharge abstracts of Maryland and the District of Columbia were reviewed; the days per 1,000 Maryland Medicare beneficiaries was lower than the national average. Staff regards a measurement of utilization based on Maryland residents as a more accurate

measurement of utilization rates than discharges from Maryland hospitals, which may include residents from other states.

Staff agrees that variation in the utilization of acute rehabilitation beds may not always be due to access barriers, and notes that the proposed Chapter does not assume that is the case. Applicants are only given an opportunity to provide evidence of access barriers, and then an applicant must demonstrate its ability to successfully address the identified access barriers. Staff notes that it previously recommended, and the Commission adopted, changes in response to MedStar's earlier comments on .04B(1) and (2).

Staff recommends a non-substantive change that may, to some extent, address the concern raised by MedStar that the Chapter does not appropriately consider MedStar's National Rehabilitation Hospital, which is located in Washington, D.C. Staff recommends deletion of the definition of "hospital" found in the proposed Chapter at .06B(9), which refers to the definition of this term found in Maryland statute and is thus limited to facilities located in Maryland. Deletion of this term clarifies that the impact considered under project review standard .04B(3), includes impact on Maryland and non-Maryland hospitals.

MedStar Comments: Sections .03 and .04, Quality of Care

MedStar Health renewed its comments that the Chapter contains an inadequate analysis of skilled nursing facilities (SNFs) as an alternative to acute inpatient rehabilitation in terms of cost and quality. It noted that many patients cannot be managed by SNFs.

In its comments on .04A(2), MedStar stated that the Chapter should continue to explicitly require accreditation by the Commission on Accreditation of Rehabilitation Facilities ("CARF") for a special rehabilitation hospital license. MedStar also commented that the draft chapter fails to address CMS quality measures to which freestanding facilities are now subject. It noted that, depending on the outcomes of the Medicare waiver negotiations, Maryland hospitals may need to comply with those standards as well. MedStar recommended incorporating these standards in the draft Chapter, even if facilities are not currently required to report on them.

Staff Analysis and Recommendations Regarding Sections .03 and .04, Quality of Care

As previously noted, Staff agrees that some patients cannot be managed by SNFs and included as background material conclusions from published studies regarding the use of acute inpatient rehabilitation services as compared to SNFs. The information is not incorporated into the need methodology or standards for evaluating proposed projects.

CARF accreditation is required by statute in §19-318 of the Health-General Article. That requirement does not change in the proposed Chapter. Regarding quality measures, the proposed Chapter, at .04A(2)(iii)(b), requires a provider of acute rehabilitation services that is seeks to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies.

Staff recommends no changes to the proposed Chapter in response to these comments..

.05 Methodology for Projecting Adult Acute Rehabilitation Bed Need

MedStar again commented that the methodology results in an overstatement of need because it uses base year discharges and trend data prior to the full implementation of the Medicare rule on admission criteria for admitting patients to inpatient rehabilitation. It noted that, in 2010, SNF utilization increased for orthopedic patients especially and hospital admissions decreased and urged the Commission to use 2011 and 2012 base year data to eliminate the anomaly.

MedStar Health also commented that the need projections fail to account for the acute inpatient rehabilitation beds in the District of Columbia. As a result, there is positive bed need projection in Montgomery County. The draft Chapter states at .04B(2)(d)(iii) that it will consider cross-regional travel as a reason to ignore its own need projections, but fails to do so in calculating need.

MedStar Health also commented that the need projection is based on physical bed capacity rather than licensed capacity and it should be based on licensed capacity. Excluding beds not actually being used could result in another applicant filing a CON application to seek those beds.

Staff Analysis and Recommendations Regarding Methodology

Although MedStar Health stated that the methodology overstates need due to changes in Medicare payment policy that encourage a shift of certain patients to SNFs and should only use two years of recent data for the base utilization calculation, the methodology reflects what Commission staff regards as a reasonable period to review historic trend information, given the work group feedback received. Commission staff also notes that the methodology produces a range of need and should be a reasonable one from a long range perspective. Changes should not be made to address a potential short-term problem that may disappear in a couple of years.

Commission staff disagrees with MedStar Health's view that the need projection ignores cross-regional travel. Migration patterns across Maryland's health planning regions and the adjacent states is considered and reflected in the need projection. The inventory of beds available is only based on Maryland providers for the need projection, but by incorporating the current migration pattern into the need projection, the use of beds at hospitals in the District of Columbia is taken into account. In addition, an applicant that proposes to establish or expand new adult acute rehabilitation beds need must account for in-migration and out-migration patterns among Maryland health planning regions and bordering states. This information is intended for use in evaluating the reasonableness of the applicant's projection of need, when the applicant proposes to ignore the official need projection. Cross-regional travel alone is not a basis for ignoring the official need projection; access barriers must exist that the project will credibly address.

Although MedStar Health recommends using only licensed bed capacity to calculate the net need for acute rehabilitation beds, Staff's intent is to make sure that the available capacity is accurately reflected in the net bed need projected. A hospital may be licensed for more beds than it physically possesses and may have no intention of developing and staffing additional beds. In this circumstance, using the physical capacity rather than licensed capacity is the most accurate way to calculate the need for additional capacity.

Staff concludes that no change is necessary.

Other Comments

MedStar Comments re CON for Subcategories of Specialized Inpatient Rehabilitation Services

MedStar Health again commented that it is unclear if a CON must be obtained for each specialized program and what the applicable standards are.

Staff Analysis and Recommendations Regarding CON for Subcategories of Specialized Inpatient Rehabilitation Services

In response to MedStar's earlier comments on the draft Chapter, Staff added – and the Commission adopted – language under .04B to clarify that the standards apply to all inpatient rehabilitation projects.