Certificate of Need NH/HLTCU Workgroup

Summary of January 16, 2014 Meeting

I.	**Call to order** **Quick introductions of any new attendees** **Approval of the December 18, 2013 Meeting Summary** **Review and approval of the agenda**
	Chair, Karen Messick, called the meeting to order at 9:38 am. Attendees, including Department staff, provided brief introductions. See separate attendance sheet for participants. Ms. Messick briefly re-stated the "Ground Rules" for the Workgroup as outlined in the summary of the December 18, 2013 meeting and added the following: • An additional Workgroup meeting has been scheduled for February 13, 2014 • Sub-groups may be formed to study specific issues that arise with respect to the five charges. • Although the CON Commission will have its next regular meeting in March 2014, if additional time is needed for the Workgroup to conclude its discussions and to finalize its recommendations, Ms. Messick will provide an interim report to the CON Commission at that time. There was consensus that it is more important for the Workgroup to suggest good policy in proposed revisions than to try to conclude all of its work by the March Commission meeting. Ms. Messick reviewed the agenda and it was approved by consensus, subject to the following revision. With respect to Charge #4 (hospice), it was reported that there are ongoing discussions between AHPCM and MDCH so that further discussion of this Charge could be delayed. Accordingly, the agenda was revised to defer further discussion of Charge #4 until the next Workgroup meeting.
II.	**Presentation and discussion of comparative review criteria grid and policies supporting the criteria**
	• Ms. Bhattacharya, CON Section reviewed the analysis of comparative review criteria and scoring by applicants on a historical basis. The purpose of the analysis was to try to determine which criteria/points have typically been satisfied/earned by all or most

applicants and which criteria have differentiated comparative review applications.

- Ms. Bhattacharya noted that, with respect to the quality criteria in Section 10, similar criteria are also included in Section 6 (increase beds in planning area), although the "look-back" period in Section 10 (with deduction of 15 points) is 3 years vs. two years in Section 6. No application included in the analysis had points deducted under Section 10 given that, if the threshold for substandard quality as triggered there, it was likely that the applicant was ineligible to submit an application under Section 6.
- Per the MDCH grid, 100% of the CON applications reviewed scored points under Section 10(7) (existing or proposed nursing home is fully equipped with sprinklers). Accordingly, this criterion (although an important safety requirement) is not currently useful in differentiating applications during comparative review.
- There was discussion that all Medicare/Medicaid nursing homes are required by federal regulations to be fully sprinkled as of August 2013. Ms. Messick will obtain confirmation from HFES/Bureau of Fire Services that all Michigan nursing homes are in compliance with this requirement. It was noted that it would be more appropriate for this requirement to be in Section 6 so that it applies to any project proposing to increase beds instead of including it in the comparative review section.
- In response to questions about current enforcement practices, Ms. Bhattacharya noted that Section 11 (project delivery requirements) should be amended to add the requirement that, if approved, an applicant shall operate the project in compliance with the commitments made in their comparative review responses/Section 10. Currently, failure to operate an approved project in compliance with commitments made under Section 10 does not constitute grounds for CON enforcement given such compliance is not a project delivery requirement. Other enforcement mechanisms were discussed including using the LARA, Health Facilities Engineering Section staff to confirm during plan review and physical plant surveys for completion of a project that any physical elements promised in the comparative review section were actually completed. It was noted that other states use companion agencies (such as licensing and physical plant inspectors) to assist with CON compliance. Ms. Bhattacharya confirmed that type of cooperation is already occurring in Michigan on physical plant issues and culture change implementation but that it is more difficult to monitor Medicare/Medicaid performance, e.g., percentage of Medicaid patient days.
- There was further discussion that compliance with state CON requirements is a condition for Medicaid payment in Michigan and that Part 201 of the Public Health Code makes CON compliance a condition for health facility licensure. Some provider representatives confirmed that they are aware of the need to maintain CON compliance in order to avoid noncompliance with conditions for payment by various payors.

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III.	**Discussion and recommendations related to Comparative review. NOTE: Section 6 and 10 as it relates to recommendations will be considered in this discussion. Delegation to a subgroup will also be considered as an option to expedite this charge.**
	A. Section 10(2) (percentage of Medicaid patient days and percentage of Medicaid certified beds) and 10(3) Medicare certification
	• There was a robust discussion of the Medicaid and Medicare criteria in Section 10(2) and (3). Some participants observed that these Medicaid criteria are too heavily weighted so that facilities focusing on the need for additional short-term stay (Medicare Part A, post-hospital rehabilitative discharges) ("Short-Stay Focus") are unable to compete for new beds, even though the national trend is toward more Short-Stay Focus programs with rehabilitation of hospital/surgical patients and then discharge to home. There was discussion that Short-Stay Focus facilities operate very differently than those facilities focusing on more traditional, geriatric long-term stay or dementia residents ("Residential Focus"). Comments were offered that some facilities have both types of programs. Mr. Weir, from the LTC Ombudsman Office, noted that they still see situations where individuals cannot access Medicaid beds in nursing home facilities. It was unclear how widespread that problem may be or what exact factors may be contributing to that problem. • There was discussion that, the bigger view, is that the total reimbursement and post-acute care delivery system is changing and that the CON standards should be forward-looking to promote where care delivery is going – not where it has been historically. It was noted that, for many providers, they must subsidize their Medicaid admissions with Medicare and private pay admissions given the differential in reimbursement by their different payment sources. • It was suggested that it may be possible to bifurcate the criteria in Section 10(2) and (3) so that Short-Stay Focus facilities would earn points under one track and Residential Focus facilities would earn points under a different track with the total points under either track being equal. There was further discussion regarding that concept including changes in the population served by nursing homes (more short-stay), Short-Stay and Residential Focus providers truly operate differently, and that there will always be a need for access to Medicaid beds for residents in Michigan. Ms. Rogers, MDCH, noted that Part 222 addresses participation in Medicaid as a distinct and important criterion in awarding CON approval. • The question was raised as to whether there is data as to difficulty in accessing Medicaid beds, including the percentage of nursing home beds in Michigan that are currently certified for participation in Medicaid, total Medicaid patient days relative to all nursing home patient days and percentage of Medicaid occupancy. It was noted that, given the CON Standards should be evidence-based,

	it would be helpful to have this information. There was discussion that medical necessity is the trigger that requires care to be provided in a nursing home. It was also noted that participation in Medicaid is not mandatory and that placement of Medicaid patients may be more difficult in certain areas, e.g., rural areas. Further discussion of Medicaid access issues ensued and whether access to Medicaid beds should be assessed on a planning area basis, with additional points awarded if the area had an access issue, the impact of dual eligible and new dual eligible payment methodology, and the impact of operational policies where Medicaid-certified facilities decline to accept additional Medicaid patients. • There was additional discussion regarding Medicare. The question was raised as to whether there are other measurable Medicare criteria that would get at quality and innovation and help to distinguish applicants. Should any of these elements be included in Section 10(15) (technology)? • There was consensus that it would be helpful to have a subgroup look at the Medicare/Medicaid criteria and to propose recommendations back to the Workgroup. Volunteers for the subgroup included: Lisa Rosenthal, Walt Wheeler, Susan Steinke, John Weir, David Stobb, Pat Anderson and Phyllis Adams, with a report back to the Workgroup at the next meeting (2/13/14). There was further commentary that the Workgroup needs input from the subcommittee as to what makes sense in the context of today's SNF environment/climate.
	B. Section 10(4) (quality criteria with a 3-year look-back)
	• The discussion turned to the quality criteria in Section 10(4) of the Standards and the 3-year look-back period vs. the 2-year look-back in Section 6. Under Section 10(4), 15 points are deducted if an applicant is eligible to file under Section 6 (2-year look-back) but triggers any of the quality criteria under the 3-year look-back under Section 10(4). • There was a comment as to whether the look-back period in Section 6 should also be 3 years. Other comments included that the CON comparative review criteria should select the most optimal applicant; these are not criteria that apply to existing or all applicants. • With respect to the obligation to have no "outstanding debt obligation to the state of Michigan for quality assurance assessment . . . " the question was raised as to whether the Standards needed to address situations where a quality assurance assessment was outstanding because it was being contested in a legitimate manner. • A comment was made that it would improve the Standards if all of the quality requirements appeared in one Section instead of being repeated in all of the Sections, e.g., add beds, relocate beds, replace beds, etc.

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	C. Section 10(5) Culture Change
	• Given most applicants score all or the majority of points allowed for culture change programs under Section 10(5), there was discussion about the current culture change criteria. Ms. Laseur, CON Section, explained both the criteria and the culture change worksheet (CON 217B Form). Ms. Bhattacharya indicated that the Workgroup can propose changes to the approved culture change programs currently being used to award points in comparative review. • There was discussion as to whether there should be a 5 point differential under Section 10(5) for an existing facility vs. a proposed facility. It is unclear what public policy supports the current differential. Comments were also offered as to how "home grown" culture programs can qualify under the current language if the elements of culture change on the CON-217B form are demonstrated. • As a technical correction, one commentator noted that the current Standards do not specify when the culture change program needs to be in place so that enforcement initiatives could be initiated before a new facility has time to put its culture change program in place. It was also observed by several participants that the culture change criteria are too heavily weighted under the Section 10. Other commentators raised concerns about whether the definition of "culture change model" was too nebulous. Participants in prior workgroups indicated that the criteria listed were developed to match the MDCH initiative "Advancing Excellence." Ms. Laseur noted that "person-centered care" was a significant objective of MDCH so that it was important to include that in the culture change requirements. • The participants discussed a separate subcommittee to address culture change. Ms. Beniak and Ms. Laseur volunteered to check with Ms. Middleton, MDCH and to obtain input as to any proposed recommendations/changes to the culture change criteria. • The substantive discussion of the comparative review criteria in Section 10 ended with subsection (5).
IV.	**Discussion and preliminary recommendations regarding the other 3 CON charges (#2, #3, #4 (deferred) and #5)**
	Because of the time spent on the comparative review criteria, this agenda item was deferred to the next meeting on February 13, 2014.
V.	Summary of next steps and any homework or subgroup assignments
	• Ms. Messick reviewed the subcommittee assignments and participants noted above on (i) Medicare/Medicaid criteria (Section 10(2); and (ii) culture change (Section 10(5).

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V.	Adjourn
	The meeting was adjourned at 12:04 pm.

Prepared and respectfully submitted by Phyllis Adams, Dykema Gossett