March 30, 2023

The Honorable Peña-Melnyk
Chair, Health and Government Operations Committee
241 Taylor House Office Building
6 Bladen Street
Annapolis, MD 21401

Re: Letter of Information – Senate Bill 509: Health Care Facilities - Nursing Homes - Acquisitions and Licensure

Dear Chair Peña-Melnyk and Members of the Health and Government Operations Committee:

First, genuine thanks for the dedication you are putting into conducting the people's business in this 445th Session of the Maryland General Assembly. We are writing to offer context and background regarding Senate Bill 509: Health Care Facilities - Nursing Homes - Acquisitions and Licensure.

Providing quality care to Marylanders in need is the steadfast focus of the vast majority of long-term and post-acute care providers in the State, as well as the Health Facilities Association of Maryland (HFAM).

There are 225 skilled nursing and rehabilitation centers in Maryland. We estimate that from 2019 to January 1, 2022, 103 skilled nursing centers were sold, with a few being sold more than once. Such extreme turnover in ownership can present challenges to consistent quality care.

However, it is important to note that in healthcare – and specifically in skilled nursing facilities – sales are not inherently negative and not all new operators are of poor quality. Often, a sale can be a positive step toward new capital improvements and investments in quality care.

Before getting into the details of acquisitions in the sector, I'd like to highlight and offer insight regarding the amendment of this legislation to create a task force to study the use of rooms with two or more beds in Maryland nursing homes.

First, it is important to note that the sector is not dominated by such rooms. Of the estimated 27,854 nursing home beds in Maryland, it is estimated that about 1,354 of those beds are distributed in triple or quad rooms. We would note that we do not have an estimate of triple and quad rooms in Maryland hospitals.

There was a time in the evolution from community convalescent centers to skilled nursing and rehabilitation centers when triple and quad rooms were highly valued. In some settings, they continue to meet community needs. Triple and quad rooms are still federally permitted in existing centers and allowable in existing centers in Maryland.

From a communicable disease standpoint, a room with more than two beds can present challenges. From a socialization and community standpoint, and to fight isolation, rooms with more than two beds can provide benefits.

Generally speaking, and almost without exception, triple and quad bed rooms exist in Maryland nursing homes that were built decades ago. Physically modifying those buildings is very difficult. The financial viability of the entire center and therefore the quality care for all residents in the center – even those not in triple or quad rooms— must be considered when potentially modifying rooms with more than two beds.

In addition, financial viability is important such as when mortgages and loans for those centers are underwritten by lenders based on the total number of beds in the center or a historical revenue flow, which includes triple and quad bed rooms.

As we move forward to study the use of rooms with more than two beds in nursing homes, and hopefully in other parts of healthcare, we would stress that:

- Owners and operators of Maryland skilled nursing and rehabilitation centers with triple and quad rooms be allowed to convert those rooms to double rooms and be allowed to maintain ownership of the beds initially taken out of service for future use in that center or another new or existing center in the same county.

- As owners and operators of Maryland skilled nursing and rehabilitation centers take triple and quad rooms out of service, they may be permitted to operate 25% of their previous triple and quad bed capacity. This will ensure beds are available, will help keep the center financially viable, and will allow for remodeling or new construction plans.

- Owners and operators of Maryland skilled nursing and rehabilitation centers who initially take those beds out of service be allowed, subject to local and state building requirements, but not subject to a new certificate of need or additional state healthcare requirements, to use those beds for a newly constructed center or addition in the same county within 7 years of voluntarily taking those beds out of service.

Now, relative to acquisitions and licensure, most nursing home sales that have taken place in Maryland have been financially backed by private equity, family businesses, or Real Estate Investment Trust (REIT) financing. Not all REITs operate under the same parameters and one would have to go back to the Great Recession of 2008 to understand the entry of REITs into various enterprises, including skilled nursing facilities.

The increase in transactions in our sector began about six years ago and sales have recently slowed. These sales have been driven primarily by personal family business wealth and only somewhat by REITs. Nationally, there has been much media coverage about hedge-fund ownership of skilled nursing facilities but I know of just one such owner in Maryland that perhaps fits that definition – The Portopiccolo Group.

In my experience, healthcare operational challenges after a sale are less about the funding source and more about an organization becoming over-leveraged while not adequality investing in quality care. This can be true across traditional and non-traditional funding sources.

There are current statutory and regulatory requirements for the change of ownership of skilled nursing facilities and other healthcare entities in Maryland with oversight from the Maryland Health Care

Commission (MHCC), the Office of Health Care Quality (OHCQ), and the Maryland Department of Health (MDH).

Senate Bill 509 requires the Maryland Health Care Commission to provide certain information regarding the acquisition of a nursing home to the Office of Health Care Quality and requires the Secretary of Health to consider the information before acting regarding licensure to operate a nursing home.

While well-intentioned, there are several technical flaws in this legislation. For example, owner-operators of skilled nursing facilities do not have personal Medicare and Medicaid numbers – those numbers are assigned to facilities.

HFAM has never advocated that the Centers for Medicare and Medicaid Services (CMS) Five-Star Rating System should be the sole measure of quality care. While the CMS rating system can be a helpful tool, it should not be relied on exclusively to make care decisions. That is especially true coming out of the COVID-19 pandemic at a time when the State has a backlog in annual inspections and when inspections often take weeks to complete at a single center when they are conducted.

In addition, some provisions are similar or redundant to the current change of ownership requirements.

A few final points:

- In advocating and advising on regulatory issues, HFAM's traditional stance is that regulations should uniformly apply across settings. This would mean that if the ownership of skilled nursing facilities is to be more heavily scrutinized, then the same should be true of other settings, just as an example, Med Surge centers.
- Skilled nursing facilities are amongst the most regulated healthcare entities in Maryland and across the nation.
- MDH, MHCC, and OHCQ already have regulatory tools in place to require more transparency regarding transactions in healthcare generally and skilled nursing facilities specifically.
- Lastly, I worry about a time in the future when these well-intentioned steps could make it difficult for new and better operators to assume ownership of underperforming centers.

All of this said we agree that the recent sales history of healthcare entities does warrant a closer look. In partnership with the long-term care sector, the State government will review aspects of financing and, most importantly, direct measures of quality and care delivery. Quality care and people must remain our steadfast focus.

Respectfully submitted,

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