SUMMARY

Selling of LTC Beds – Other CON States

SUMMARY
Selling of LTC Beds: Other CON States

FLORIDA

1. Currently, there is a moratorium. However, if the moratorium was not in place, a CON permit would be required for the relocation of existing LTC beds from one facility to another existing LTC facility.
2. The proposed relocation must involve facilities within the same planning area.
3. The selling facility must certify that the license for the beds will be removed and the buyer of the beds must certify that the purchased beds will be accepted and licensed.
4. Healthcare systems can relocate beds from one facility within the system to another within the system. If a chain proposes to relocate beds from one existing LTC facility to another within the chain and within the planning area, the application qualifies for an exemption.
5. An expedited review is available to applicants proposing to relocate existing beds within a 30-mile radius within the same planning area.

ASSESSMENT:

No reply.

SUMMARY

Selling of LTC Beds: Other CON States

MARYLAND

The seller must de-license the unused beds being sold. Has 1 year to re-license these beds. If not re-licensed within this time period (because the beds cannot be filled to occupancy target levels), the beds are permanently de-licensed by the Dept..

The buyer must submit a CON application for permit for an expansion of the buyer's facility, when purchasing beds from another facility.

The transaction must occur between two existing licensed facilities within the same jurisdiction (planning area).

< SEE APPENDIX A – MARYLAND LTC STATUTES for overall plan for all LTC services under the jurisdiction of CON regulation >

ASSESSMENT:

No assessment…provided a summary of subject rules.

SUMMARY

Selling of LTC Beds: Other CON States

MICHIGAN-1

1. Michigan does **not** allow the **sale** of licensed beds. Rather, LTC facilities are allowed to **transfer** beds from one facility to another.
2. Michigan uses a **bed pool** with a pre-determined number of beds needed for each planning area (county).
3. Nursing home/Hospital LTC beds may be relocated or transferred from one **existing** LTC facility to another **existing** LTC facility within the **same planning area**.
4. The transfer of LTC beds is allowed ONLY to "right-size" beds from over-bedded facilities to under-bedded facilities. The receiving facility must document a consistently high occupancy rate.
5. The occupancy of the "giving" facility is examined…if all the excess beds are not transferred to facility needing beds, the remaining excess beds are surrendered to State Licensure.
6. An applicant proposing to transfer nursing home/hospital LTC beds to another existing facility must comply with the CON-determined bed need **unless a number of certain requirements are ALL met**. (See the applicable rules below for a complete list of these requirements.)
7. An applicant proposing to add new nursing home/HLTCU beds, as the receiving existing nursing home/H LTCU must comply with the CON-determined bed need **unless a number of certain requirements are ALL met**. (see the applicable rules below for a complete list of these requirements.)
8. The approval of the proposed new nursing home/H LTCU beds shall not result in an increase in the number of nursing home beds in the planning area.
9. No new facilities are allowed to be established through the relocation of beds.

CON Review Standards for Nursing Home and HLTCU Beds **CON-21 7**
Approved December 15, 2010

Section 7. Requirements for approval to relocate existing nursing home/HLTCU beds

Sec. 7. **(1) An applicant proposing to relocate existing nursing home/H LTCU beds** shall not be required to be in compliance with the needed nursing home bed supply set forth in Appendix B, **if the applicant demonstrates <u>all</u> of the following:**

(a) An existing nursing home may relocate no more than 50% of its beds to another existing nursing home, and an existing HLTCU may relocate all or a portion of its beds to another existing nursing home/H LTCU.

(b) The nursing home/HLTCU from which the beds are being relocated and the nursing home/H LTCU receiving the beds shall not require any ownership relationship.

(c) The nursing home/HLTCU from which the beds are being relocated and the nursing home/HLTCU receiving the beds must be located in the same planning area.

(d) The nursing home/HLTCU from which the beds are being relocated has not relocated any beds within the last seven (7) years.

(e) The relocated beds shall be licensed to the receiving nursing home/HLTCU and will be counted in the inventory for the applicable planning area.

MICHIGAN-2

(f) At the time of transfer to the receiving facility, patients in beds to be relocated must be given the choice of remaining in another bed in the nursing home/HLTCU from which the beds are being transferred or to the receiving nursing home/H LTCU. Patients shall not be involuntary discharged to create a vacant bed.

(2) An applicant proposing to add new nursing home/HLTCU beds, as the receiving existing nursing home/H LTCU under subsection (1), shall not be required to be in compliance with the needed nursing home bed supply set forth in Appendix B, **if the applicant demonstrates <u>all</u> of the following**:

(a) At the time of application, the applicant, as identified in the table, shall provide a report demonstrating that it does not meet any of the following conditions in 14%, but not more than five, of its nursing homes/H LTCUs:

(i) A state enforcement action resulting in a license revocation, reduced license capacity, or receivership within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(ii) A filing for bankruptcy within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iii) Termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the Department or licensing and certification agency in another state, within the last three years, or from the change of ownership date if the facility has come under common ownership or control within 24 months of the date of the application.

(iv) A number of citations at Level D or above, excluding life safety code citations, on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average, calculated from the quarter in which the standard survey was completed, in the state in which the nursing home/H LTCU is located. For licensed only facilities, a number of citations at two times the average of all licensed only facilities on the last two licensing surveys. However, if the facility has come under common ownership or control within 24 months of the date of the application, the first two licensing surveys as of the change of ownership date, shall be excluded.

(v) Currently listed as a special focus nursing home by the Center for Medicare and Medicaid Services.

(vi) Outstanding debt obligation to the State of Michigan for Quality Assurance Assessment Program (QAAP) or Civil Monetary Penalties (CMP).

(b) The approval of the proposed new nursing home/H LTCU beds shall not result in an increase in the number of nursing home beds in the planning area.

(c) A Plan of Correction for cited state or federal code deficiencies at the health facility, if any, has been submitted and approved by the Bureau of Health Systems within the Department. Code deficiencies include any unresolved deficiencies still outstanding with the Department.

ASSESSMENT:

The relocation of LTC beds has been helpful in reducing the number of “phantom” or paper beds in the State and there are no unstaffed beds. Not too many problems in Michigan with their program, since the beds are not allowed to be sold, but are transferred from a facility

that needs to downsize to facilities in the same district that have a documented need for more beds.

SUMMARY
Selling of LTC Beds: Other CON States

MISSOURI-1

1. LTC bed expansions involving a Chapter 198 facility may qualify for an exemption to the LTC bed minimum occupancy requirements. In addition to the shortened information requirements and review times, apliants shall also submit:
   a. If an effort to purchase has been successful pursuant to section 197.318.8(1), RSMo, a Purchase Agreement Form (Form MO 580-2352), incorporate by reference) between the selling and purchasing facilities, and a copy of the selling facility's reissued licensed verifying the surrender of the beds; or
   b. If an effort to purchase has been unsuccessful, a Purchase Agreement Form between selling and purchasing facilities which documents the "efforts to purchase" LTC beds.

Section 197.318. Certification ineligibility not to apply, when-department certification of no need final-ethnic and religious composition of residents may be considered-no expenditure minimum, expiration date-licensed and available, defined-review of letters of intent-application of law in pending court cases-expansion procedures.–

1. The provisions of section 197.317 shall not apply to a residential care facility I, residential care facility II, intermediate care facility or skilled nursing facility only where the department of social services has first determined that there presently exists a need for additional beds of that classification because the average occupancy of all licensed and available residential care facility I, residential care facility II, intermediate care facility and skilled nursing facility beds exceeds 90% for at least four consecutive calendar quarters, in a particular county, and within a fifteen-mile radius of the proposed facility, and the facility otherwise appears to qualify for a certificate of need. The department's certification that there is no need for additional beds shall serve as the final determination and decision of the committee. In determining 90% occupancy, residential care facility I and II shall be one separate classification and intermediate care and skilled nursing facilities are another separate classification.

2. The Missouri health facilities review committee may, for any facility certified to it by the department, consider the predominant ethnic or religious composition of the residents to be served by that facility in considering whether to grant a certificate of need.

*3. There shall be no expenditure minimum for facilities, beds, or services referred to in subdivisions (1), (2) and (3) of section 197.317. The provisions of this subsection shall expire January 1, 2003.

4. As used in this section, the term "licensed and available" means beds which are actually in place and for which a license has been issued.

5. The provisions of section 197.317 shall not apply to any facility where at least 95% of the patients require diets meeting the dietary standards defined by section 196.165, RSMo.

6. The committee shall review all letters of intent and applications for long-term care hospital beds meeting the requirements described in 42 C.F.R., section 412.23(e) under its criteria and standards for long-term care beds.
Sections 197.300 to 197.366 shall not be construed to apply to litigation pending in state court on or before April 1, 1996, in which the Missouri health facilities review committee is a defendant in an action concerning the application of sections 197.300 to 197.366 to LTC hospital beds meeting the requirements described in 42 C.F.R., section 412.23(e).

7. **Notwithstanding any other provisions of this chapter to the contrary:**
(1) A facility licensed pursuant to chapter 198, RSMo, may increase its licensed bed capacity by:
(a) Submitting a letter of intent to expand to the division of aging and the health facilities review committee;
(b) Certification from the division of aging that the facility:
a. Has no patient care class I deficiencies within the last 18 months; and
b. Has maintained a 90% average occupancy rate for the previous six quarters;
(c) Has made an effort to purchase beds for 18 months following the date the letter of intent to expand is submitted pursuant to paragraph (a) of this subdivision. For purposes of this paragraph, an "effort to purchase" means a copy certified by the offeror as an offer to purchase beds from another licensed facility in the same licensure category; and
(d) If an agreement is reached by the selling and purchasing entities, the health facilities Review committee shall issue a certificate of need for the expansion of the purchaser facility upon surrender of the seller's license; or
(e) If no agreement is reached by the selling and purchasing entities, the health facilities Review committee shall permit an expansion for:
a. A facility with more than forty beds may expand its licensed bed capacity within the same licensure category by 25% or 30 beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of 93% or greater over the previous six quarters;
b. A facility with fewer than forty beds may expand its licensed bed capacity within the same licensure category by 25% or 10 beds, whichever is greater, if that same licensure category in such facility has experienced an average occupancy of 92% or greater over the previous six quarters;
c. A facility adding beds pursuant to subparagraphs a. or b. of this paragraph shall not expand by more than 50% of its then licensed bed capacity in the qualifying licensure category;

(2) Any beds sold shall, for five years from the date of relicensure by the purchaser, remain unlicensed and unused for any LTC service in the selling facility, whether they do or do not require a license;

(3) The beds purchased shall, for two years from the date of purchase, remain in the bed inventory attributed to the selling facility and be considered by the department of social services as licensed and available for purposes of this section;

(4) Any residential care facility licensed pursuant to chapter 198, RSMo, may relocate any portion of such facility's current licensed beds to any other facility to be licensed within the same licensure category if both facilities are under the same licensure ownership or control, and are located within six miles of each other;

(5) A facility licensed pursuant to chapter 198, RSMo, may transfer or sell individual long-term licensed beds to facilities qualifying pursuant to paragraphs (a) and (b) of subdivision (1) of this subsection. Any facility which transfers or sells licensed beds shall not expand its licensed bed capacity in that licensure category for a period of five years from the date the licensure is relinquished.

ASSESSMENT:

As an overall statement, the relocation of LTC beds in Missouri is helpful in that the excess beds are usually relocated to a facility that has high occupancy. This activity allows high occupancy facilities to acquire needed beds without adding to the existing State's LTC bed capacity.

SUMMARY
Selling of LTC Beds: Other CON States

NEW JERSEY-2

1. The buyer must submit an application for CON permit.

2. Rules related to relocation/sale of LTC beds:

(a) The following criteria apply to changes in licensed beds and/or services:

1. Any increase in the number of licensed beds by licensure and/or health planning category requires a certificate of need unless the bed type is specifically exempted from the certificate of need requirement pursuant to P.L. 1992, c. 160, as amended by P.L. 1998, c. 43, section 19 (N.J.S.A. 26:2H-7a), or otherwise exempted pursuant to this chapter. The certificate of need application shall be subject to the full review process, except as provided for at N.J.A.C. 8:33-5.1(a).

2. Any decrease in the number of licensed beds by licensure and/or health planning category shall not require a certificate of need. Conversions of licensed beds to other uses shall be treated as increases in the number of beds by licensure or health planning category and the provisions of (a)1 above shall apply.

3. For services for which there is no specific licensed bed complement, relocation is not permitted, unless the service is otherwise exempt from the certificate of need requirement in accordance with those rules. For services for which there is a specific licensed bed complement, the relocation of a portion of a facility's licensed beds or the entire service from one licensed facility (sending facility) to another (receiving facility) located within the same planning region requires a certificate of need and shall follow the expedited review process, unless the beds or service at issue are otherwise exempt from the certificate of need requirement in accordance with these rules. The application shall be considered pursuant to the following criteria:

i. The relocation shall take place within the same planning region where the sending facility is located;

ii. The receiving facility shall already hold a license for the category of beds proposed for relocation. The Commissioner may, in the case of proposed bed relocations, waive this requirement when the receiving facility is the site of a general hospital proposed or approved for closure in the previous 12 months, if the Commissioner makes a finding that such approval will not reduce quality of care associated with the beds;

iii. The relocation shall not have an adverse impact on the ability of the population currently being served in the sending facility's service area to access the same types of service or bed complement as those proposed for relocation;

iv. The relocation shall not reduce access by the medically underserved and shall address the criteria set forth at N.J.A.C. 8:33- 4.10(a);

v. The relocation shall not have an adverse impact on quality of care at either the sending or receiving facility;

vi. All minimum and maximum bed/unit size requirements (for example, six bed pediatric units, 10 bed obstetrics units, 240 bed long-term care facilities) shall be maintained at both the sending and receiving facilities; and

vii. The relocation shall not violate a condition of a prior certificate of need approved for the establishment of the beds or services, unless the applicant presents evidence of substantial changes since imposition of the condition and the Commissioner makes a finding that the evidence warrants removal or modification of the condition.

4. The relocation of a portion of a health care facility's licensed beds or an entire service, whether it has a bed-related component or not, from one licensed facility to another outside the same planning region shall not be permitted.

ASSESSMENT:

- No improvement in the distribution of beds.
- In New Jersey, transfer of ownership for a LTC facility does not require a CON permit. The CON agency is not always notified…difficult to keep track of the LTC bed count in the State.
- The requirements for relocation need to be tightened to correct these problems. Suggests that the beds being sold should be de-licensed immediately. The relocation of beds should take into consideration the impact on the availability and access to Medicare/Medicaid beds.

SUMMARY

Selling of LTC Beds: Other CON States

OHIO

3701-12-23.2 Replacement of LTC Beds and Relocation of LTC Beds

(B) 1. The applicant or person proposed to own or operate the facility to which the beds will be relocated:

a. Owns the operating rights to the facility from which the beds are being relocated and is the licensed operator of that facility;

b. Has entered into a contract to acquire the beds being relocated; or

c. In the case of an application to relocate approved beds, is the holder of the CON for the beds or is proposed in the application to enter into a contract to acquire the CON permit.

(C) The applicant provides documentation of a feasible plan to care for the residents served in the beds being relocated. The application shall state whether those residents will be offered admission to the new beds and the procedure for facilitating availability of the beds to the residents.

(E) The facility from which the beds are being relocated is a LTC facility and an existing LTC facility. If the application proposes relocation of approved beds, the CON for the beds shall not have been withdrawn before the decision is made on the application proposing the relocation.

(F) The relocation of the existing or approved beds will not impair the access of the population served or proposed to be served by the existing facility or the existing or approved beds to quality LTC, particularly in the case of medically-under-served populations, including consideration of:

a. Geographic access; and

b. Availability of Medicaid-certified LTC beds.

(G) The applicant documents, and the Director of Health shall consider the impact of the relocation project on costs and charges on both a per diem and an aggregate basis. This documentation shall include portrayal of all costs, including any costs of acquiring the existing beds, and of how the costs will be recovered and a demonstration that the costs are reasonable when compared to the benefits of relocation.

Average price per bed is $16,000.

No assessment received.

SUMMARY
Selling of LTC Beds: Other CON States

VIRGINIA

1. The establishment of a nursing home, intermediate care facility, or extended care facility of a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.
2. The establishment of a nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds within a planning district.
3. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility of a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.
4. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds within a planning district.
5. The relocation at the same site of 10 nursing home, intermediate care facility, or extended care facility beds or 10% of the nursing home, intermediate care facility, or extended care facility beds of a medical care facility, whichever is less, from one physical facility to another in any two- year period, if such relocation involves a capital expenditure of $17,095,823 or more (see 12VAC5-220-280).
6. Any capital expenditure of $17,095,823 or more, not defined as a project category in Batch Groups A through D/F, by or in behalf of a nursing home, intermediate care facility, or extended care facility, which does not increase the total number of beds of the facility.
7. Any capital expenditure of $17,095,823 or more, not defined as a project category in Batch Groups A through D/F, by or in behalf of a medical care facility, that is primarily related to the provision of nursing home, intermediate care, or extended care services, and does not increase the number of beds of the facility.

NOTE: The two facilities (buyer and seller) can be under the same ownership or not. Any bed relocation requires a CON permit.

ASSESSMENT:

For a long time, at least a dozen years and probably longer, Virginia has allowed nursing homes to relocate beds *within the same one of Virginia's 22 planning districts* by agreement between them and subject to COPN approval. The nursing homes involved can be under the same ownership or not under the same ownership. That makes no fundamental difference, although it might affect the COPN review in some way.

When the NH to give up the beds and the NH to receive the beds are *not* under the same ownership, they typically enter into a formal "forbearance agreement", as it's usually called, whereby the NH to

give up the beds "forbears" from maintaining licensure of them *if* the other party is successful in obtaining a COPN to establish the beds in a new location.

The party desiring to receive the beds then files a COPN application, and we review it in the normal way. Since our primary interest in the COPN program with respect to controlling the supply of NH beds is to control the supply *within the planning district*, and since these relocation proposals so far are to relocate beds within the planning district, we have never denied or even recommended denial of a NH bed relocation proposal, as far as I can recall, going back at least a dozen years.

The primary reason for this is that the relocation proposals have made good sense. They've proposed to move beds from an over-bedded area of a planning district or from an underutilized (perhaps out of date, perhaps poorly located, perhaps poorly managed) nursing home to a more rapidly growing part of the planning district or to a nursing home experiencing greater occupancy and greater likely future demand.

Occasionally a NH provider who feels threatened in some way by a proposed relocation of nursing home beds asserts that these "forbearance" agreements are just a sale of a COPN, which Virginia law does not allow. We contend these arrangements are not a sale of a COPN, and so far no one has taken the matter to court or even requested a formal opinion from the Office of the Attorney General, as far as I know.

It would certainly be conceptually better for planning if there was competition for bed relocations, i.e., if a NH willing to give up some or all of its beds agreed to "forbear" from maintaining their licensure, if *any* party obtained a COPN to establish them in another location. However, no NH provider is willing just to give up beds into a common pool, as long as there's some prospect of ever being able to improve their occupancy or ever being able to give them up to a particular party in exchange for a forbearance fee. This forbearance or bed-transfer fee typically runs from $5,000 to $10,000 per beds.

In general, I think that as a practical matter, our present situation with respect to relocation of nursing home beds is as good an arrangement as can be expected. It does lead to improvement or rationalization of the supply and locational distribution of nursing home beds *within a planning district*.

SUMMARY
Selling of LTC Beds: Other CON States

WASHINGTON

1. Court case determined that bed rights belong to licensee.
2. CON review of "Increase in Licensed Beds" is used for relocation of bed projects - includes review for "Need" and "Financial Viability".
3. In the CON review of the relocation, the **distribution** of beds (a key factor to avoid over-bedding and under-bedding) is assessed.
4. Price per beds can be very high. Suggests setting a "cap" on pricing.

ASSESSMENT:

1. What were the key factors that lead your State to develop a bed relocation/sales program?

   Answer: In WA, the bed rights are considered the personal property of the licensee (1992 Appellate court ruling). As a result licensees may sell the bed rights to another nursing home. A CoN review is required for the facility adding the beds. Since this ruling, the CoN law has changed several times in an effort to reduce the number of licensed nursing homes in the state. These changes include bed banking for the purpose of providing an alternative service (i.e., assisted living, boarding home, home health), and full facility closure bed banking. Facilities that reduce the number of licensed beds may be eligible for an increase in there Medicaid rate.

2. What other issues became important to consider?

   Answer: 1) Did the relocation result in increased access to services for residents of the planning area. For example, were the beds being relocated to an under-bedded planning area or just to another facility within the same planning area? 2) If the beds were moving between planning areas, what would there be on the existing planning area if the beds were to move?

3. What are the best results your State has experienced due to the bed relocation program?

   Answer: Existing bed capacity is used to address distribution issues rather than creating new system-wide bed capacity. It also generally resulted in a marginal quality provider either getting out of the business or at least reducing its bed capacity.

4. What are the worst features or unintended consequences of the bed relocation/sales program?

   Answer: Cost per bed went very high. At one point applicant facilities were paying as much as $15,000 per bed.

5. How would you rate your overall satisfaction with the bed relocation/sales program?

   Answer: I would say overall it's about 60% out of 100.

6. If you could start the relocation program all over again, what would you do differently?

Answer: If there are particular policy positions the state wants to happen, make it clear in any rules developed. Prepping for any rule development, I would try to identify as many different what if scenarios as possible and think how they would fit into the proposed rule scheme. That way you can think about level of variation that would be acce

Marilyn Moon, Ph.D.
CHAIR

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OR

APPENDIX A

MARYLAND HEALTH CARE COMMISSION
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STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

NURSING HOME, HOME HEALTH AGENCY AND HOSPICE SERVICES

COMAR 10.24.08

Effective March 12, 2007

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State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services

.01 Incorporation by Reference. This Chapter is incorporated by reference in the Code of Maryland Regulations.

.02 Introduction.

A. Purposes of the State Health Plan.

The Maryland Health Care Commission has prepared this Chapter of the State Health Plan for Facilities and Services ("State Health Plan" or "Plan") in order to further the mission of health planning, which is to plan to meet the current and future health care system needs of all Maryland residents by assuring access, quality, and cost-effectiveness. The Commission views the State Health Plan, of which this Chapter is a part, as a policy blueprint for shaping and reshaping the health care system toward these ends, through the action of public agencies and the cooperation of private actors. Through the State Health Plan, the Commission undertakes an active role in proposing needed changes in the system, including the reallocation of resources to achieve a health care system that is cost-effective, and that balances considerations of affordability, access, and quality. In every aspect of the Plan, and in its individual Certificate of Need decisions, the Commission carefully weighs issues of quality of care and access to long term care services with considerations of quality and cost.

The State Health Plan serves two purposes:

(1) It establishes health care policy to guide the Commission's actions and those of other health-related public agencies, and to foster specific actions in the private sector. Activities of State agencies must, by law, be consistent with the Plan.

(2) It is the legal foundation for the Commission's decisions in its regulatory programs. These programs ensure that appropriate changes in service capacity are encouraged, and that all major expenditures for health care facilities are needed and consistent with the Commission's policies. The State Health Plan, therefore, contains policies, standards, and service-specific need projection methodologies that the Commission uses in making Certificate of Need decisions.

B. Legal Authority for the State Health Plan for Facilities and Services.

The Maryland Health Care Commission is given legal authority under Maryland Code Annotated, Health-General Article, §19-118 to develop and adopt the State Health Plan. Subsection §19-118(a)(2) states that the State Health Plan shall include:

1. The methodologies, standards, and criteria for Certificate of Need review; and
2. Priority for conversion of acute care capacity to alternative uses where appropriate.

C Organizational Setting of the Commission.

The Maryland Health Care Commission is an independent agency located within the Department of Health and Mental Hygiene for budgetary purposes. The purposes of the Commission, as provided under §19-103(c) are to:

1. Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;
2. Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by advocating policies and systems to promote the efficient delivery of and improved access to health care services, and enhancing the strengths of the current health care service delivery and regulatory system;
3. Facilitate the public disclosure of medical claims data for the development of public policy;
4. Establish and develop a medical care data base on health care services rendered by health care practitioners;
5. Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services.
6. In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan, and a uniform set of effective benefits to be included in the Limited Health Benefit Plan;
7. Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;
8. Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;
9. Establish standards for the operation and licensing of medical electronic claims clearinghouses in Maryland;

10. Reduce the costs of claims submissions and the administration of claims for health care practitioners and payors;
11. Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article;
12. Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; and
13. Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Health Services Cost Review Commission.

The Commission has sole authority to prepare and adopt the State Health Plan and to issue Certificate of Need decisions and exemptions therefrom.

Subsection §19-118(e) requires the Secretary of Health and Mental Hygiene to make annual recommendations to the Commission on the State Health Plan and permits the Secretary to review and comment on the specifications used in its development. However, §19-110(a) prohibits the Secretary from disapproving or modifying any determinations the Commission makes regarding the State Health Plan or other matters. The Commission pursues effective coordination with the Secretary and State health-related agencies in the course of developing its plans and plan amendments**.** As required by statute, the Commission coordinates its activities with the hospital rate-setting program of the Health Services Cost Review Commission to assure access to care at a reasonable cost. The Commission also coordinates its activities with the Maryland Insurance Administration. Subsection §19-117(c) empowers the Governor to notify the Commission of any intent to modify or revise the State Health Plan, or changes the Plan within 45 days of its receipt. Otherwise, the Plan becomes effective.

D. Plan Content.

This Nursing Home, Home Health Agency, and Hospice Services Chapter comprises one component of the overall State Health Plan for Maryland, which also addresses acute care, ambulatory surgery, obstetric, comprehensive rehabilitation, acute psychiatric, addictions, and other services.

Under §19-120 (j)(2)(iii)(4) of the Health-General Article, Annotated Code of Maryland and COMAR 10.24.01.02, a Certificate of Need is required for the establishment, or certain expansions, of a comprehensive care (nursing home) facility, chronic hospital, home health agency or subunit, and a hospice program. Commission statute, at §19-123, excludes certain comprehensive care beds in continuing care retirement communities from Certificate of Need review.

This regulation fulfills the Commission's responsibility to adopt a State Health Plan at least every five years and to review and amend the plan annually, or as necessary, by superseding the current COMAR 10.24.08 and replacing it with this regulation.

.03 Issues and Policies: Nursing Homes.

A. Introduction.

Long term care refers to the array of medical, social, and support services needed by individuals who, because of chronic illness or disability, need help in caring for themselves over an extended period of time. Long term care services can include both institutional and community-based services for persons of all ages. This section of the Chapter focuses on nursing homes, including facilities licensed as comprehensive care facilities (CCF). It also includes policies and standards for short-stay hospital-based skilled nursing facilities with beds licensed as comprehensive care or extended care, as well as special hospital-chronic facilities.

In Maryland, nursing homes are licensed as either comprehensive care or extended care facilities. Under regulations of the Office of Health Care Quality, a nursing home or "comprehensive care facility" is defined as "a facility which admits patients suffering from disease or disabilities or advanced age requiring medical service and nursing service rendered by or under the supervision of a registered nurse."[1] An extended care facility license is required for "a facility which offers subacute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous hospital services."[2]

This section of the Chapter addresses major issues underlying the policies developed for nursing home services in Maryland. These issues are organized into four major categories: nursing homes in the continuum of care; quality of care; consumer choice; and innovation. Supporting data on nursing homes may be found in the ***Supplement to COMAR 10.24.08: Statistical Data Tables***.

B. Statement of Issues and Policies.

(1) Nursing Homes in the Continuum of Care

The aging of the baby boom generation, those born between 1946 and 1964, will increase the size of the future elderly population. This might not, however, translate into increased nursing home utilization. The use of nursing homes has declined with the development of other types of long term care services. Although the overall supply of nursing homes may be adequate, the physical stock of nursing homes is aging. Many nursing homes in Maryland are now 20 years old or older, and are in need of renovation or replacement. Data supplied by one corporate office for 28 nursing homes showed that the age of facilities ranged from 3 to 63 years with a mean facility age of 26 years.

[1] COMAR 10.07.02.01B(6)
[2] COMAR 10.07.02.01B (12)

Another corporate group with 14 Maryland facilities has nursing homes ranging in age from 2 to 46 years with a mean of 30 years.

The role of nursing homes is changing and evolving in response to changes in the larger health care system. Due to earlier discharges from acute care hospitals, residents of nursing homes are more acutely ill than they were ten to fifteen years ago. An analysis of data from the MDS (Minimum Data Set) shows an increase in short-stay residents and a decrease in overall lengths of stay with a concomitant increase in admissions per bed. There is now a bimodal distribution of residents, with nursing homes serving two distinct roles. One is a post-acute setting for those who need some short-term rehabilitation before they are discharged home. The other is the more traditional nursing home role of long-term residential care for persons who are increasingly frail and may be in the last months of their life. As will be discussed in the hospice section of this Chapter, nursing homes are also a setting for hospice care.

Consumers, however, see nursing homes as one of many options for care, and are often seeking residential care in other settings. There is increasing use of assisted living, adult day care, and enhanced services at home. This has been encouraged by *Olmstead v. L. C.,* ("Olmstead") the 1999 Supreme Court decision which requires states to administer services, programs, and activities in the least restrictive setting appropriate to the needs of individuals with disabilities. Moreover, the Maryland Medicaid Program is seeking a waiver from the Centers for Medicare and Medicaid Services (CMS) to provide funding for more persons in community-based settings.[3] All of these factors will require nursing homes to look outside of their own boundaries and form linkages to other parts of the health care system.

Policy 1.0 **The Commission will assess the impact of nursing home physical plant age and design on quality of care, and encourage facilities to develop replacement facilities where needed.**

Policy 1.1 **The Commission will encourage nursing homes to establish transfer agreements and partner with other types of settings in order to integrate their services into the larger continuum of care.**

(2) Quality of Care.

Along with the changes in the delivery of long term care, there is also increasing oversight from various local, state, and federal agencies responsible for assuring the quality of care provided in nursing homes. On the federal level, as Medicare is responsible for an increasing share of the cost of care provided in nursing homes, it is undertaking efforts to make sure that the dollars are spent in the most efficient and effective manner. Similarly, states, burdened by increasing costs to the Medicaid

[3] Health General §15-141, effective 1/11/05.

program, are looking for ways to reduce Medicaid's share of long term care costs by the promotion of home and community-based services.

Quality oversight can be encouraged at several levels. In April 2002, CMS launched a six state test of its quality initiative; Maryland was one of the pilot states. The National Nursing Home Quality Initiative (NHQI) includes a web-based public report of quality measures called "Nursing Home Compare." Maryland has been among the leaders in this initiative, launching its own public report, a Nursing Home Performance Evaluation Guide in August 2001, including facility and resident characteristics, quality measures, and deficiency reports. During 2006, the Commission conducted a Nursing Home Family Satisfaction Survey, and is working on the adoption of a Resident Satisfaction Survey as well.

In addition, the Delmarva Foundation, the Quality Improvement Organization (QIO) for Maryland, has focused initiatives on four major quality measures: high-risk pressure ulcers; physical restraints; depression; and chronic pain. Delmarva works with nursing facilities to achieve improved outcomes for the initiatives and recognizes those facilities ranking in the top 5% of all nursing homes nationwide with quality excellence awards. In addition, the Office of Health Care Quality of the Maryland Department of Health and Mental Hygiene (DHMH) established a Health Care Quality Account for nursing homes in 2000. The account is funded through civil money penalties assessed to nursing homes for violation of standards. Monies in the account can then be awarded to facilities for use in training, grant awards, demonstration projects, and other projects designed to improve the quality of care in nursing homes.

Policy 2.0 **The Commission will support the Department of Health and Mental Hygiene, including Medicaid and the Office of Health Care Quality, in efforts to improve and monitor the quality of care in nursing homes.**

Policy 2.1 **The Commission, through its Nursing Home Performance Evaluation Guide, will report current data on nursing home services and quality of care in order to assist consumers in decision-making regarding long term care services.**

(3) Consumer Choice.

With the aging of the baby boom generation, there are increasingly more initiatives involving consumer choice. Aging baby boomers will not be content to be directed to a health care facility by their physician; they will want to have more choice in determining where they receive care. Supplying up-to-date information, as described in the Commission's Nursing Home Performance Evaluation Guide, will be essential. The Commission recently sought consumer input about the performance guides in order to be more responsive to consumer needs, and will continue to evaluate the guide on an ongoing basis.

Another component of consumer choice is access to care. Although each jurisdiction in Maryland has at least one nursing home, there are a small number of jurisdictions that have only one or two facilities. The Commission should encourage the development of services and programs to serve the residents of these jurisdictions. In addition to geographic access, there is also the issue of financial access. The State Health Plan has required that nursing homes that receive a Certificate of Need (CON) participate in the Medicaid program and provide a level of Medicaid participation that is commensurate with other providers in their area[4]. This continues to ensure access for all to needed quality long term care facilities and services.

Having access to a full continuum of care is a benefit to consumers, but also raises the issue of the need to link various data from one setting to another. When a patient moves from one part of the continuum to another, data collection is often redundant and often begins again. There is a need to develop linkages, not only within the long term care system, but also between the acute and long term care systems. With almost 60% of nursing home admissions coming from acute care general hospitals, it would be a benefit to both consumers and providers to be able to share the data collected in the hospital with the nursing home.

There is a need for more consumer education about community alternatives and the ability to limit the length of stay in institutional settings. Although nursing homes will continue to provide an essential component of long term care services, the Commission encourages the development of an infrastructure in local communities to support services that can delay institutionalization.

Policy 3.0 The Commission will work with the Department of Health and Mental Hygiene, the Health Facilities Association of Maryland (HFAM), Lifespan, the Maryland Department of Aging, and other interested groups to develop, streamline, and coordinate the necessary data and informational programs to assist consumers in selecting long term care services that include a full continuum of care, including institutional and community-based services.

[4] The required level of Medicaid participation is calculated as follows. For the four years 2000-2003: (1) Calculate the weighted mean of the proportion of Medicaid participation (defined as Medicaid patient days divided by total patient days) for each jurisdiction and region; (2) Calculate the 25th percentile value for Medicaid participation in each jurisdiction; (3) Subtract the 25th percentile value from the weighted mean value of Medicaid participation for each jurisdiction; (4) Calculate the average difference for step 3 across all jurisdictions for each year; (5) Calculate the average across all four years. The resulting proportion, 15.5%, is subtracted from the weighted mean for each jurisdiction.

Policy 3.1 **The Commission will work with long term care providers to assist in the development of standards for the exchange of health information among different health care sectors in order to enhance the care of individuals in long term care settings.**

Policy 3.2 **The Commission will project the need for nursing home beds on a jurisdictional basis, making adjustments for the use of community-based services.**

Policy 3.3 **The Commission will require that an applicant seeking a Certificate of Need to establish, expand, renovate, or replace a nursing home serve an equitable proportion of Medicaid-eligible individuals in the jurisdiction or region. The Commission will work with Medicaid to develop a process by which providers holding a current Medicaid Memorandum of Understanding (MOU) can renegotiate their MOU, if requested, at the most recently published participation rates.**

(4) Innovation.

Just as consumers are seeking alternatives in the types of settings where care is provided, they are also demanding more options within the nursing home setting. Both in an effort to improve the quality of care, as well as to provide innovative programs for educated consumers, new models of care are emerging. There are several new models of care, such as, the Eden Alternative[5], Wellspring [6] and the Green House Project,[7] that seek to restructure the way long term care services are provided. The Eden Alternative seeks to create "habitats for human beings" with an emphasis on animals, plants, and an enlivened environment. The Green House Project, an offshoot of the Eden Alternative, focuses on altering facility size, modifying interior design, and changing methods of delivering skilled professional services. This model focuses on self-contained dwellings for seven to ten people, with a large open kitchen, dining rooms, and central hearth and with each person having a private bedroom and bathroom. Wellspring integrates the concepts of resident-directed care, federal quality indicators, nationally-defined best practices, and a new leadership paradigm. These are but a few examples of types of models that have been developed both nationally and locally.

[5] www.edenalternative.com/about

[6] www.wellspringis.org/ourstory[7]

www.thegreenhouseproject.com

While these models of care might not be able to be developed in all nursing homes, they suggest different ways of approaching nursing home care. Features such as designing a facility to meet the clinical needs of its residents must be addressed in all nursing homes projects, and access to private bathrooms should be considered.

Policy 4.0 The Commission will work with applicants for Certificate of Need to encourage the development of innovative programs, both within nursing homes and between nursing homes and other health care providers.

.04 Certificate of Need Procedural Rules: Nursing Homes.

A. Certificate of Need Nursing Home Merger Exemption Rules. Exemptions are permitted under this section, consistent with COMAR 10.24.01.04, to assure that merger and consolidation projects involving nursing home(s) meet statutory requirements, are not inconsistent with this or other Chapters of the State Health Plan, will result in the delivery of more efficient and effective health care services, and are in the public interest. A merged system or two or more entities proposing a merger, must satisfy the following requirements.

(1) The project shall:

(a) Replace at least one obsolete physical plant, as defined in .16B(32) of this Chapter, or renovate that physical plant such that existing life safety code waivers granted by the Office of Health Care Quality and the State Fire Marshall's Office are no longer required; or

(b) Afford residents in each involved facility demonstrated advantages of existing or proposed special programs and services offered by one party to the merger or consolidation.

(2) Each involved facility must attain or maintain the proportion of Medicaid participation applicable for its jurisdiction or region as required by .05A (2) of this Chapter.

(3) The proposed merger or consolidation must be cost-effective.

(4) Each involved facility shall provide details on the improvements to the quality of care for all affected residents that result from the proposed project.

(5) Each involved facility must have Medicare-certified beds.

(6) Each involved facility shall provide an appropriate living environment including, but not limited to:

(a) In a new construction project:

i. No more than two beds for each patient room;
ii. Individual temperature controls for each patient room; and
iii. No more than two residents sharing a toilet.

(b) In a renovation project:

i. Reduce the number of patient rooms with more than two residents per room;

ii. Provide individual temperature controls in renovated rooms; and

iii. Reduce the number of patient rooms where more than two residents share a toilet;

(c) An applicant may show evidence as to why this rule should not be applied to the applicant.

(7) Each involved facility has met all conditions of each previous Certificate of Need.

(8) The applicant shall disclose whether any of the principals of each involved facility have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

(9) The applicant shall report the number and percentage of nursing home beds in the jurisdiction and planning region controlled by the applicant before and after the proposed merger.

(10) If a facility that is included in the merger or consolidation is not a nursing home, portions of other Chapters of the State Health Plan applicable to the project shall also be met.

(11) If the merger results in only one facility, the merged entity must meet .04A(1)-(9) of this Chapter.

B. Nursing Home Waiver Bed Rules. The Commission will apply the following rules to a facility seeking to increase or decrease its bed capacity pursuant to Health-General Article §19-120 (h)(2)(i), Annotated Code of Maryland.

(1) Calculation of Waiver Beds.

(a) The determination of the right to obtain waiver beds is based on increases or decreases in bed capacity deriving from changes in licensed beds, Certificate of Need-approved beds, waiver beds, and temporarily delicensed beds obtained pursuant to COMAR 10.24.01.03E.

(b) The Commission will calculate the number of allowable waiver beds based on the following:

(i) Total licensed capacity of the facility; and

(ii) Documentation that the facility has the licensable, physical space to accommodate the waiver beds consistent with the requirements of COMAR 10.24.08.05A(5).

(c) A facility cannot have more than 10 unlicensed waiver beds at any given time.

(2) *Time Period.*

(a) The Commission will only authorize waiver beds if all of a facility's beds have been licensed and operational at the same site for at least two years.

(b) The Commission will not authorize waiver beds if a facility has increased or decreased its licensed capacity during the last two years.

(i) The Commission will not authorize waiver beds if the facility has loaned, leased, transferred, or sold beds during the last two years.

(ii) The Commission will only authorize waiver beds two years after any temporarily delicensed beds are relicensed or relinquished.

(iii) The Commission will only authorize waiver beds two years after all previously authorized waiver beds have been licensed.

(3) *Use and Implementation.*

(a) Waiver beds authorized may be implemented only at the facility that applied to add the beds and may not be loaned, leased, transferred, or sold.

(b) The Commission will not approve a Certificate of Need that includes the sale, loan, lease, or transfer of licensed beds, if the applicant has, or will receive, beds from an entity that has replaced or will replace the loaned, leased, transferred, or sold beds with waiver beds.

C. Purchase of Nursing Home. The Commission will apply the following rules to persons seeking to purchase a facility pursuant to Health General Article §19-120.

(1) ***Notice of Purchase.*** A person seeking to purchase a facility licensed entirely, or in part, as comprehensive care, must provide the Commission with the notice required by COMAR 10.24.01.03A.

(2) ***Information Required.*** A person subject to .04C of this Chapter must affirm that the services provided will not change as a result of the proposed acquisition, and must provide information on corporate structure and affiliations of the purchaser, purchase price, source of funds, and other relevant data as requested.

(3) ***Disclosure.***

(a) A person subject to .04C of this Chapter shall report the number and percentage of nursing home beds in the jurisdiction and planning region controlled by the person before and after the proposed purchase.

(b) A person subject to .04C of this Chapter shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

D. Relocation of Never Licensed, CON-Approved Beds. An application for a Certificate of Need to relocate a nursing home or a portion of a facility that includes never licensed, Certificate of Need-approved beds will be reviewed for continuing need in accordance with the published bed need projections in effect at the time of the letter of intent for the application.

E. Effective Date. These regulations are effective for a Commission action and staff determination requested after the effective date of the regulations, regardless of the date on which the requesting facility received initial Commission approval or action.

.05 Nursing Home Standards.

A. **General Standards.** The Commission will use the following standards for review of all nursing home projects.

(1) ***Bed Need.*** The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review.

(2) ***Medical Assistance Participation.***

(a) Except for short-stay, hospital-based skilled nursing facilities required to meet .06B of this Chapter, the Commission may approve a Certificate of Need for a nursing home only for an applicant that participates, or proposes to participate, in the Medical Assistance Program, and only if the applicant documents a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A 2(b) of this Chapter.

(b) Each applicant shall agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus 15.5%[8] based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the ***Supplement to COMAR 10.24.08: Statistical Data Tables***, or in subsequent updates published in the *Maryland Register*.

(c) An applicant shall agree to continue to admit Medicaid residents to maintain its required level of participation when attained and have a written policy to this effect.

(d) Prior to licensure, an applicant shall execute a written Memorandum of Understanding with the Medical Assistance Program of the Department of Health and Mental Hygiene to:

(i) Achieve or maintain the level of participation required by .05A 2(b) of this Chapter; and

[8] For explanation of the derivation of this percentage, see Statement of Issues and Policies, 3. Consumer Choice above.

(ii) Admit residents whose primary source of payment on admission is Medicaid.

(iii) An applicant may show evidence why this rule should not apply.

(3) ***Community -Based Services.*** An applicant shall demonstrate commitment to providing community-based services and to minimizing the length of stay as appropriate for each resident by:

(a) Providing information to every prospective resident about the existence of alternative community-based services, including, but not limited to, Medicaid home and community-based waiver programs and other initiatives to promote care in the most appropriate settings;

(b) Initiating discharge planning on admission; and

(c) Permitting access to the facility for all "Olmstead" efforts approved by the Department of Health and Mental Hygiene and the Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.

(4) ***Nonelderly Residents.*** An applicant shall address the needs of its nonelderly (<65 year old) residents by:

(a) Training in the psychosocial problems facing nonelderly disabled residents; and

(b) Initiating discharge planning immediately following admission with the goal of limiting each nonelderly resident's stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.

(5) ***Appropriate Living Environment***. An applicant shall provide to each resident an appropriate living environment, including, but not limited to:

(a) In a new construction project:

(i) Develop rooms with no more than two beds for each patient room;

(ii) Provide individual temperature controls for each patient room; and

(iii) Assure that no more than two residents share a toilet.

(b) In a renovation project:

(i) Reduce the number of patient rooms with more than two residents per room;

(ii) Provide individual temperature controls in renovated rooms; and

(iii) Reduce the number of patient rooms where more than two residents share a toilet.

(c) An applicant may show evidence as to why this standard should not be applied to the applicant

(6) ***Public Water***. Unless otherwise approved by the Commission and the Office of Health Care Quality in accordance with COMAR 10.07.02.26, an applicant for a nursing home shall demonstrate that its facility is, or will be, served by a public water system.

(7) ***Facility and Unit Design***. An applicant must identify the special care needs of the resident population it serves or intends to serve and demonstrate that its proposed facility and unit design features will best meet the needs of that population. This includes, but is not limited to:

(a) Identification of the types of residents it proposes to serve and their diagnostic groups;

(b) Citation from the long term care literature, if available, on what types of design features have been shown to best serve those types of residents;

(c) An applicant may show evidence as to how its proposed model, which is not otherwise documented in the literature, will best serve the needs of the proposed resident population.

(8) ***Disclosure.*** An applicant shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

(9) ***Collaborative Relationships.*** An applicant shall demonstrate that it has established collaborative relationships with other types of long term care providers to assure that each resident has access to the entire long term care continuum.

B. New Construction or Expansion of Beds or Services. The Commission will review proposals involving new construction or expansion of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed, using the following standards in addition to .05A(1)-(9):

(1) Bed Need.

(a) An applicant for a facility involving new construction or expansion of beds or services, using beds currently in the Commission's inventory, must address in detail the need for the beds to be developed in the proposed project by submitting data including, but not limited to: demographic changes in the target population; utilization trends for the past five years; and demonstrated unmet needs of the target population.

(b) For a relocation of existing comprehensive care facility beds, an applicant must demonstrate need for the beds at the new site, including, but not limited to: demonstrated unmet needs; utilization trends for the past five years; and how access to, and/or quality of, needed services will be improved.

(2) Facility Occupancy.

(a) The Commission may approve a nursing home for expansion only if all of its beds are licensed and available for use, and it has been operating at 90 percent or higher, average occupancy for the most recent consecutive 24 months.

(b) An applicant may show evidence why this rule should not apply.

(3) Jurisdictional Occupancy.

(a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.

(b) An applicant may show evidence why this rule should not apply.

(4) *Medical Assistance Program Participation.*

(a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A 2(b) of this Chapter.

(b) An applicant for new comprehensive care facility beds has three years during which to achieve the applicable proportion of Medicaid participation from the time the facility is licensed, and must show a good faith effort and reasonable progress toward achieving this goal in years one and two of its operation.

(c) An applicant for nursing home expansion must demonstrate either that it has a current Memorandum of Understanding (MOU) with the Medical Assistance Program or that it will sign an MOU as a condition of its Certificate of Need.

(d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to include a Medicaid percentage that reflects the most recent Medicaid participation rate.

(e) An applicant may show evidence as to why this standard should not be applied to the applicant.

(5) ***Quality.*** An applicant for expansion of an existing facility must demonstrate that it has no outstanding Level G or higher deficiencies, and that it maintains a demonstrated program of quality assurance.

(6) ***Location.*** An applicant for the relocation of a facility shall quantitatively demonstrate how the new site will allow the applicant to better serve residents than its present location.

C **Renovation of Facility.** The Commission will review projects involving renovation of comprehensive care facilities using the following standards in addition to .05A(1)-(9).

(1) ***Bed Status*** The number of beds authorized to the facility is the current number of beds shown in the Commission's inventory as authorized to the facility, provided:

(a) That the right to operate the facility, or the beds authorized to the facility, remains in good standing; and

(b) That the facility provides documentation that it has no outstanding Level G or higher deficiency reported by the Office of Health Care Quality.

(2) ***Medical Assistance Program Participation.*** An applicant for a Certificate of Need for renovation of an existing facility:

(a) Shall participate in the Medicaid Program;

(b) May show evidence as to why its level of participation should be lower than that required in .05A2(b) of this Chapter because the facility has programs that focus on discharging residents to community-based programs or an innovative nursing home model of care;

(c) Shall present a plan that details how the facility will increase it its level of participation if its current and proposed levels of participation are below those required in .05A2(b) of this Chapter; and

(d) Shall agree to accept residents who are Medicaid-eligible upon admission

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(3) Physical Plant An applicant must demonstrate how the renovation of the facility will improve the quality of care for residents in the renovated facility, and, if applicable will eliminate or reduce life safety code waivers from the Office of Health Care Quality and the State Fire Marshall's Office.

.06 Chronic Hospitals and Hospital-Based Skilled Nursing Facility Standards.

A. Chronic Hospitals. The Commission will use the standards in this section to review applications for special hospital-chronic beds:

(1) ***Need.*** An applicant shall quantitatively demonstrate the specific unmet needs it proposes to meet in its service area, by number of patients, principal and additional diagnoses, and expected length of stay.

(2) ***Financial Access.*** An applicant shall agree to accept patients whose primary payer source is Medicare and Medicaid.

(3) ***Facility Occupancy.*** An applicant shall propose to serve and maintain at least an 85 percent average annual occupancy level.

(4) ***Jurisdictional Occupancy.***

a. The Commission may approve a Certificate of Need application for a new chronic hospital or a new chronic hospital service at an existing health care facility only if every chronic hospital in the jurisdiction has maintained, on average, an 85 percent or higher occupancy level, for the latest 12-month period, as shown in the Health Services Cost Review Commission's Current Rates Report for the latest fiscal year. Each December, the Commission will issue a report on chronic hospital occupancy.

b. The applicant may show evidence why this standard should not apply.

(5) ***Financial Viability***. Any applicant proposing to develop a new chronic hospital or a new chronic hospital service at an existing health care facility must demonstrate that it can meet the Medicare Conditions of Participation as a Long Term Care Hospital consistent with 42 CFR Part 412.

(6) ***Expansion.***

a. The Commission may approve a chronic hospital for expansion only if all of its beds are available for use and it has been operating at 85 percent or higher average occupancy for the most recent consecutive 24 months, as shown in the Health Services Cost Review Commission's Current Rates Report for the latest fiscal year.

b. An applicant may show evidence why of this standard should not apply.

B. Short-Stay, Hospital-Based Skilled Nursing Facilities. The Commission will use the standards in this section to review applications for short-stay hospital-based skilled nursing facilities.

(1) ***Applicable Standards.*** The Commission shall use Subsections .05 A(1),(3-9) and the following standards, to review proposals for post-acute, hospital-based facilities that are licensed either as comprehensive care or extended care, that are Medicare-certified as hospital-based skilled nursing facilities, and that have an average length of stay of less than 30 days.

(2) ***Financial Access.***

a. An applicant shall document in its Certificate of Need application that it admits or will admit patients whose primary source of payment on admission is Medicaid.

b. Subsection .05A (2) of this Chapter does not apply to short-stay, hospital-based skilled nursing facilities.

(3) ***Facility Occupancy.*** An applicant shall propose to serve and maintain at least an 85 percent average annual occupancy level

(4) ***Certification.*** An applicant shall be licensed and meet all of the requirements under COMAR 10.07.02.14-1 (Special Care Units-General) or 10.07.02.14-2 (Special Care Units-Respiratory Care Unit).

.07 Methodology for Projecting Need for Nursing Home Beds.

A Methodology Assumptions. Need projections for nursing home beds will use the following assumptions:

(1) Jurisdictional Need.

(a) Nursing home bed need includes need for both comprehensive care facilities and extended care facilities.

(b) Except as provided in Paragraph .07A (1)(c), nursing home bed need is projected on a jurisdictional basis.

(c) In jurisdictions for which this methodology does not project net need of 90 beds or more by the target year, the Commission may combine the projected bed need for two or more jurisdictions in the planning region, as defined in Regulation .16.

(2) Age Adjustment. Nursing home bed need is projected using an adjusted age-specific use rate, based on the base year use rate minus 5 percent, applied by jurisdiction, in order to account for the correlation between age and utilization.

(3) Migration Adjustment.

(a) The need projection for nursing home beds reduces net out-migration from jurisdictions with retention rates less than 80 percent and use rates for the 65+ population greater than the 33rd percentile by half and allocates the reduction back to the jurisdiction.

(b) Migration into Maryland from the adjacent states of Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia is taken into account in estimating bed need, by assuming that the current pattern of migration from these adjacent states into Maryland will increase in the future at their projected rate of population growth.

(c) Migration into Maryland from other than adjacent states is not taken into account in estimating need.

(d) Out-migration from Maryland to adjacent and other states is assumed to remain constant.

(4) ***Community -Based Services Adjustment.*** The utilization of community-based services, measured as patient days for those who, on admission, are light care, continent, and not cognitively impaired, is a viable substitute for a proportion of nursing home utilization, and projected nursing home bed need is reduced accordingly.

B. Period of Time Covered.

(1) The base year from which projections are calculated is the most recent calendar year for which all utilization and population data used in the projections are available.

(2) The target year to which projections are calculated is seven years after the base year.

C. Services. Projections are made for the following services:

(1) Except as provided in Subsection .07C(3), need is projected for all nursing home beds licensed as either comprehensive care or extended care in Maryland.

(2) The need for extended care beds is included with comprehensive care beds in the nursing home bed need projections.

(3) The nursing home bed need projections exclude utilization at Charlotte Hall Veterans Home.

D. Age Groups. The following age groups are used: Under 65, 65-74, 75-84, and 85 years and over.

E. Geographic Area. Need for nursing home beds is projected by jurisdiction.

F. Inventory Rules. The following rules identify beds counted in the inventory used for nursing home bed need projections:

(1) Nursing home beds are counted in the jurisdiction where they are located, regardless of the jurisdiction of origin of patients using the beds.

(2) Except as provided in Subsection .07 F(4)-(5), all licensed comprehensive care and extended care beds are counted.

(3) Comprehensive care and extended care beds which have Certificate of Need approval from the Commission are counted.

(4) Multiply-licensed beds, including swing beds in acute care hospitals, are not counted.

(5) Beds in Charlotte Hall Veterans Home are not counted.

(6) Waiver beds authorized under COMAR 10.24.01.03E(2) are counted.

(7) Existing licensed beds, removed on a temporary basis from a facility's license, pursuant to COMAR 10.24.01.03C, are counted.

(8) When a Certificate of Need is withdrawn or relinquished, the affected beds will be eliminated from the inventory of comprehensive care beds.

G. Data Sources.

(1) The need for nursing home beds is based on the total noninstitutionalized civilian population, broken down by age groups, as indicated in §.07 D of this Regulation.

(2) Maryland population estimates and projections by age group and jurisdiction are obtained from the most recent population projections available from the Maryland Department of Planning. Population estimates and projections by age group for adjacent states are obtained from the relevant planning agencies in those states and from the United States Census Bureau.

(3) Nursing home utilization data are obtained from the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set (MDS) for Maryland.

H. Nursing Home Beds.

(1) The number of licensed comprehensive care and extended care beds is obtained from program records of the Office of Health Care Quality.

(2) The number of Certificate of Need-approved beds, waiver beds, and temporarily delicensed comprehensive care and extended care beds are obtained from the Commission's records.

I Method of Calculation The Commission uses the following procedure to project need for nursing home beds in the target year:

(1) Calculate the base year patient days by age group, area of origin, and jurisdiction of care.

(2) Calculate the base year use rate by age group by applying the following rules:

(a) Calculate the use rate for the most recent year, by age group and jurisdiction of origin, by dividing the base year patient days, by age group and Maryland jurisdiction of origin, by the base year population, by age group and jurisdiction of origin, and multiplying the result by 1,000.

(b) Calculate an adjusted base year use rate by reducing the base year use rate calculated in Paragraph (a) above by 5 percent.

(3) Calculate the target year patient days for each age group for each

Maryland jurisdiction of residence by multiplying the adjusted base year use rate for a given age group in the jurisdiction of residence by the target year projected population for the same age group in the jurisdiction, and dividing the result by 1,000.

(4) Calculate the migration-adjusted target year patient days for each jurisdiction of care by using the following rules:

(a) When the jurisdiction of residence is the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, add the base year patient days for a given age group, receiving care in the same jurisdiction of residence, to one half of the base year patient days for a given age group receiving care outside the jurisdiction of residence; divide the result by the base year patient days for the age group and jurisdiction of residence; multiply by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence in Maryland;

(b) When the jurisdiction of residence in Maryland is not the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, divide the

base year patient days for a given age group, a given jurisdiction of residence, and a given jurisdiction of care by twice the base year patient days for the age group and the jurisdiction of residence; multiply the result by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence;

(c) When the retention rate is greater than 80 percent, or the base year use rate for the 65+ population is less than the 33rd percentile, the target year patient days are equal to the patient days for each jurisdiction of residence as calculated in step 4(a); sum the result over all jurisdictions of residence;

(d) When the jurisdiction of residence is an adjacent state, sum the base year patient days for each age group and jurisdiction of residence for a given jurisdiction of care, multiply the base year patient days for each age group by the population growth rate in that age group, and sum the result over all jurisdictions of residence for a given jurisdiction of care.

(5) Calculate the total target year patient days for each jurisdiction of care by summing the target year patient days for each age group in the jurisdiction of care over all age groups.

(6) Calculate the gross bed need for each jurisdiction of care by dividing the target year patient days for the jurisdiction by the product of 365 and 0.95.

(7) Calculate the net bed need for each jurisdiction of care by subtracting the inventory of beds obtained using the rules in .07 H (1) and (2) of this Chapter from the gross bed need for the jurisdiction.

(8) Calculate the number of nursing home beds for which community based services (CBS) will substitute in each jurisdiction of care.

(a) Calculate the proportion of total nursing home patient days represented by the patients appropriate for CBS by dividing the CBS days by the total patient days for each jurisdiction of care in the base year.

(b) Calculate the number of target year patient days appropriate for CBS by multiplying the target year patient days by the

proportion of total nursing home patient days calculated in Step 8(a).

(c) Calculate the number of nursing home beds for which CBS will substitute for nursing home beds in each jurisdiction of care by dividing the target year patient days appropriate for CBS by the result of the product of 365 and 0.95.

(9) Calculate the adjusted net bed need for each jurisdiction of care by subtracting the number of nursing home beds for which CBS will substitute from the net bed need for each jurisdiction of care.

J **Mathematical Formula.** The need projection methodology described in .07I of this Chapter is shown here in mathematical form.

(1) ***Definitions of Terms.*** Terms used in .07J(2) of this Chapter are defined as follows:

Term	**Definition**
i	area of origin, where 1, ..., 24 = 24 Maryland jurisdictions and 25, ..., 29 = specified adjacent states
j	jurisdiction of care, where 1, ..., 24 = 24 Maryland jurisdictions
k	age group
PDAYS	base year total patient days
TPD	target year patient days
BPOP	base year estimated population
TPOP	target year estimated population by age group
JRATE	base year jurisdictional use rate
ADRATE	JRATE multiplied by .95
ASPOP	adjacent state population growth rate
RRATE	base year jurisdictional retention rate
65JRATE	jurisdictional use rate for the 65+ population in the base year
TPERCENT	the 33rd percentile of the jurisdictional use rates for the 65+ population in the base year
GNEED	gross bed need
INV	inventory beds
NNEED	net bed need
NHCBAP	number of base year nursing home days appropriate for community based services
SDAYS	projected number of target year nursing home days for which community based services will substitute
CBSBEDS	number of nursing home beds for which community based services will substitute
ANEED	net bed need adjusted for community based services

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(2) ***Formula***. Need for nursing home beds in each jurisdiction is calculated as shown in the following table:

(a) When i = 1, ..., 24, the Base Year $JRATE_{ki} = (1000)\ ((PDAYS_{ki})\ /(BPOP_{ki}))$

(b) When i=1,....24, then $ADRATE_{ki}=(JRATE_{ki}*.95)$

(c) When i = 1, ..., 24, then $TPD_{ki} = [ADRATE_{ki})\ (TPOP_{ki})\ )]/1000$

(d) When i = j, and $RRATE_i < .8$ and $65JRATE_i > TPERCENT_i$, then

$$TPD_{kj} = \sum_{i-1}^{24} \{BPD_{kij} + [0.5 (BPD_{ki} - BPD_{kij}) (TPD_{ki})] / BPD_{ki}\}$$

When i # j and i = 1,..., 24 and $RRATE_i < .8$ and $65JRATE_i > TPERCENT_i$, then

$$TPD_{kj} = \sum_{i=1}^{24} \{[(0.5) (BPD_{kij}) (TPD_{ki})] / BPD_{ki}\}$$

When $RRATE_i >= .8$ or $65JRATE_i < TPERCENT_i$, then $TPD_{kj} = TPD_{ki}$

When i = 25, ..., 29, then

$$TPD_{kj} = \sum_{i=25}^{29} (BPD_{kij}) (ASPOP_{kj})$$

(e) $TPD_j = \sum TPD_{kj}$

(f) $GNEED_j = TPD_j / [(365) (.95)]$

(g) $NNEED_j = GNEED_j - INV_j$

(h) $SDAYS_j = (NHCBAP_j / PDAYS_j) * TPD_{kj}$

(i) $CBSBEDS_j = SDAYS_j / (365 * 0.95)$

(j) $ANEED_j = NNEED_j - CBSBEDS_j$

K Update, Correction, Publication, and Notification Rules.

(1) The Commission will update nursing home bed need projections at least every three years and publish them in the *Maryland Register*, including:

(a) Utilization data from the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set for Maryland**;** and

(b) The most recent inventory prepared by the Commission.

(2) Updated projections published in the *Maryland Register* supersede any previously published projections in either the *Maryland Registe*r or any Plan approved by the Commission.

(3) Published projections remain in effect until the Commission publishes updated nursing home bed need projections, and will not be revised during the interim other than to incorporate inventory changes or to correct errors in the data or computation.

(4) Published projections and Commission inventories in effect at the time of submission of a letter of intent will control projections of need used for that Certificate of Need review.

.08 Issues and Policies: Home Health Agency Services.

A. Introduction.

In Maryland, there are various types of home care services provided to sick or disabled persons in their own place of residence. The continuum of home care services includes, but is not limited to, home health agencies (HHAs), residential service agencies (RSAs), and nurse referral staffing agencies (NRSAs). The Maryland Health Care Commission regulates only one of these entities, home health agencies. Therefore, the focus of this section of the Chapter is on home health agencies.

Maryland's licensing statute defines a "home health agency" as "a health-related institution, organization, or part of an institution that: (1) is owned or operated by one or more persons, whether or not for profit and whether as a public or private enterprise; and (2) directly or through a contractual arrangement, provides to a sick or disabled individual in the residence of that individual, skilled nursing services, home health aide services, and at least one other home health care service that are centrally administered."[9] Only a home health agency that meets Maryland licensure requirements, COMAR 10.07.10.02, may be certified to receive Medicare reimbursement.

This section of the Chapter addresses major issues underlying the policies developed for home health agencies in Maryland. These issues are organized into four major categories: availability and accessibility of home health agency services; staffing shortages; quality of care; and data collection. Utilization trends and analysis of factors influencing future home health agency need may be found in the ***Supplement to COMAR 10.24.08: Statistical Data Tables.***

B. Statement of Issues and Policies.

(1) Availability and Accessibility of Home Health Agency Services.

One of the most significant factors influencing access to home health agency services has been the change in the supply and distribution of home health agencies due to the closures/mergers/acquisitions of agencies throughout Maryland following the implementation of Medicare's Prospective Payment System. [10]

Closures of home health agencies do not always result in lack of availability of services. Merging of existing agencies allowed for continued access to home health agency services in many jurisdictions. Since home health is a client-based rather than a facility-based service, there is more flexibility with remaining agencies being able to absorb additional clients. The Commission's Certificate of Need docketing rules have historically recognized this assumption by stipulating that projected net need at or below

[9] Health-General Article § 19-491, Annotated Code of Maryland.

[10] The first full complete 12-month period when all home health agencies in Maryland were reimbursed under Medicare's Prospective Payment System (PPS) was fiscal year 2002.

400 clients within a jurisdiction is assumed to be able to be absorbed by existing home health agencies.

In some cases, closure of a home health agency may result in reduced access for certain clients. Many of Maryland's local county health departments serve the indigent population in rural geographic areas. There is concern that closure of county agencies may limit financial and geographic access to needed home health agency services by this at-risk population.

Home health agency closures are not unique to Maryland. Implications of the wide variation in the number of Medicare-certified agencies across the states may simply be a reflection of the various closures and merger activities. Moreover, in Maryland, there are other types of home care providers, including residential service agencies and nurse referral staffing agencies. Such alternative types of home care providers may skew the data that compares Maryland with other states, where other types of home care providers may not be available.

Another way of estimating home health agency capacity is based on the number of clients one agency can serve. However, not all home health agencies in Maryland have the ability to serve the same number of clients. Moreover, there is no standard national measure for determining a minimum or maximum number of home health clients per agency. Variations across Maryland's five planning regions may indicate differences in referral patterns to home health agencies from physicians, hospitals, and nursing homes. Furthermore, the availability of alternative delivery sites of care, as well as the presence of a caregiver at home, may be other factors contributing to the regional variations.

Whatever the reasons for the variations in the geographic distribution of home health agencies, as measured by the number of home health agencies per jurisdiction across Maryland, it is important to provide greater consumer choice for clients, especially in those jurisdictions where there is a limited number of home health agencies. To extend greater consumer choice in every Maryland jurisdiction where need has been identified, there should be at least three home health agencies serving its residents.

Policy 5.0 The Commission will continue to monitor the availability of, and access to, needed home health agency services in coordination with the Maryland Department of Health and Mental Hygiene and its Office of Health Care Quality, and the home health industry.

Policy 5.1 The Commission will encourage existing home health agencies currently serving clients in a jurisdiction contiguous to another jurisdiction with fewer than three home health agencies to become an additional provider in the jurisdiction with fewer than three home health agencies, in order to extend greater consumer choice.

In forecasting future home health agency need, it is important to consider what factors contribute to changes in utilization patterns. The federal reimbursement system and its underlying incentives will continue to be a significant factor in predicting future home health utilization trends, since the largest portion of home health agency care in Maryland is financed by Medicare. Other factors contributing to the way home health agencies have been utilized in the past, and which will most likely continue to impact the need and demand for home health agency use in the future, include: changing demographics; advances in medical technology; and increased consumer demand for community-based alternatives.

Regarding access to home health agency services by clients not typically or readily served by general home health agencies, the Commission will continue to consider applicants seeking to serve special populations, including the following: services exclusively to a pediatric population; to a population group limited by the nature of its diagnosis or medical condition, such as high-risk maternity patients, or limited by its need for a highly specialized set of services; or to the residents of a specific continuing care retirement community provided by that community. The applicant will be required to provide a quantitative analysis to support the need for the specialty home health agency, since such agencies are not included in the need methodology for general home health agencies, and will need to meet State Health Plan standards for both general and specialty home health agencies.

Policy 5.2 The Commission will continue to monitor and analyze changes in home health agency utilization patterns, and make a determination whether to revise underlying assumptions relating to the current need projection methodology.

Policy 5.3 The Commission will consider an application to establish a specialty home health agency, as defined at Regulation .16B of this Chapter, based on the applicant's demonstrated need for the service, and its compliance with applicable Certificate of Need review criteria and State Health Plan standards.

(2) Staffing Shortages.

In recognition of the growing concern about the nursing shortage in Maryland, the Maryland General Assembly, during its 2000 Legislative Session, created the Statewide Commission on the Crisis in Nursing, composed of representatives from across the State, to determine the current extent and long-term implications of the shortage in nursing personnel. The Commission on the Crisis in Nursing was terminated by sunset on December 31, 2005. The new statewide Maryland Nursing Workforce Commission became effective February 1, 2006, and is tasked with extending the work initiated by the previous Commission. This new 36-member Maryland Nursing Workforce Commission is funded and supported by the Maryland Board of Nursing. Given the statewide, as well

as nationwide, shortage of home care nurses and aides, many home health agencies may be unable to maintain a sufficient number of staff to serve a larger number of home health clients. The home health industry may be at a disadvantage when competing with hospitals and nursing homes for a limited pool of nursing resources. Many home health agencies cannot offer the relatively higher salaries and benefit packages offered by hospitals and nursing homes.

Moreover, with a finite number of available healthcare professionals, staffing shortages can be expected to become more serious as the population ages, patients' care needs become more medically complex, and the demand for a greater number of healthcare professionals increase. Since the home health industry relies greatly on skilled nurses and nurse's aides, as well as physical therapists, there is concern about the future supply of these workers on continued access to needed home health agency services. The impact of the Commission's projected need for home health agency services on future home health workforce supply should be evaluated.

Policy 6.0 The Commission will support efforts to evaluate the impact of nursing staff shortages on access to home health agency services, in coordination with the Maryland Nursing Workforce Commission, Office of Health Care Quality, and the home health industry.

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(3) Quality of Care.

Home health agencies are under much stricter quality oversight and compliance requirements than are other types of home care providers in Maryland. Moreover, there is a wide variation in the degree to which health care workers in the home are held accountable for their qualifications, performance, and behavior. Such fragmented oversight in the delivery of home care services raises concern for the patient and the patient's family, and make it difficult for one in need of home care services to navigate through the maze of alternative types of home care providers.

Although home care providers other than licensed home health agencies cannot be Medicare-certified, they may give some of the same services as those provided by home health agencies. Although required to obtain a license from the Office of Health Care Quality (OHCQ), RSAs and NRSAs are not subject to Certificate of Need. According to the OHCQ, there has been an explosive growth in the number of licensed RSAs. In response, OHCQ has begun surveying RSAs, and granting an RSA a temporary license until the agency has met specific RSA licensing requirements.

From a consumer/client perspective, obtaining home-based health care services in Maryland may be quite confusing. Given the fragmented and uneven regulatory oversight of alternative home based providers available in Maryland, it is important to develop the

necessary infrastructure to assure consistent regulation and oversight of all providers of home based health care services.[11]

Policy 7.0 The Commission will support efforts to reorganize the current statutory framework for licensure of home-based health care services to provide consistent and improved oversight for home health agencies, residential service agencies, nurse referral staffing agencies, and any other entity operating in Maryland that provides health care services in the home.

Policy 7.1 The Commission will monitor the effectiveness of Certificate of Need oversight for home health agencies in light of the changing environment, and periodically assess whether or not Certificate of Need regulation for home health agencies is still warranted.

(4) Data Collection.

Accurate, complete, and timely data are essential for planning for home health agency services. Under COMAR 10.07.11, licensed home health agencies in Maryland are required to submit an annual report in the format prescribed by the Secretary of the Department of Health and Mental Hygiene. The Maryland Home Health Agency Annual Report survey, conducted by the Commission, constitutes the format prescribed by the Secretary. The Annual Report is organized in two parts. Part I requests information pertaining to the overall operation of the agency, and Part II requests information on the demographic characteristics and provision of home health agency services to the clients served in each Maryland jurisdiction where the agency is licensed to provide home health agency services. The online availability of the data collection instrument has contributed to a more efficient way in which to disseminate the survey instrument. However, Maryland home health agencies continue to submit the data manually. An upgrade to online submission of the completed survey would further enhance a more timely and accurate data reporting process.

The Maryland Home Health Agency Annual Report is the primary source used in analyzing data and monitoring changes in referral source and utilization patterns. Trend data on Maryland resident discharges from acute care hospitals and nursing homes are important data elements obtained from the Maryland Hospital Discharge Abstract Data Base and the Long Term Care Resident Assessment's Minimum Data Set (MDS),

[11] The Office of Health Care Quality (OHCQ), Maryland Department of Health and Mental Hygiene, established the In-Home Health Services Forum (the "Forum") in August 2005. The focus of the Forum is to develop a series of recommendations for a more appropriate regulatory structure centered on quality, taking into account what is in the best interests of the citizens of Maryland who receive in-home health care services, as well as establishing consistent standards, based on the scope of services provided by in-home health care providers (OHCQ, August 23, 2005 meeting notes).

respectively. These data elements are key to forecasting need for home health agency clients in Maryland. Moreover, other data collected, such as the monetary value and number of charity care clients a home health agency provides is part of the information needed to monitor whether certain Certificate of Need standards are being adequately addressed.

All Medicare-certified home health agencies complete the federally required Outcome and Assessment Information Set (OASIS), which is electronically submitted to DHMH's Office of Health Care Quality. The amount of Medicare reimbursement under the Prospective Payment System (PPS) for home health agencies is determined based on the OASIS data submitted. Information collected on the OASIS data set includes, but is not limited to, the following: clinical record items, demographics and patient history, living arrangements, supportive assistance, activities of daily living, medications, equipment management, and any data collected at inpatient facility admission or discharge.

While this is a comprehensive data base for home health agencies, there is no data uniformly collected on the other types of home care providers in Maryland. As noted above, in order to have a complete understanding of Maryland's home health care delivery system, and to be able to compare Maryland's home health agencies with those of other states in a consistent manner, it is imperative that aggregate data be collected from all licensed Residential Service Agencies in Maryland. The most efficient and effective way to collect data on the number and utilization of RSAs may be through the current licensure process conducted by the Office of Health Care Quality. The accelerated growth of RSAs further supports the need to obtain such information in order to determine their impact on access to home health care services.

Policy 8.0 The Commission, in cooperation with the home health industry, will collect data through its Maryland Home Health Agency Annual Report using an upgrade to online submission of the completed survey in order to obtain timely, Maryland-specific information necessary to support the planning and regulation of home health agencies.

Policy 8.1 The Commission will support efforts of the Office of Health Care Quality to obtain basic, aggregate information, which will be made publicly available, on the number and utilization of Residential Service Agencies.

.09 Certificate of Need Docketing Rules: Home Health Agencies.

The Commission will use rules in this section to determine whether an application for a home health agency meets the necessary criteria to allow initiation of a Certificate of Need (CON) review by docketing.

A. Agency Type. If an applicant is required to be licensed as a home health agency in Maryland, it must apply as either a general home health agency under .10A of this Chapter or as a specialty home health agency under .1 0B of this Chapter.

B. Jurisdictional Volume Threshold. Except as noted in .09C below, the Commission will not docket an application for a new general home health agency, unless the projected net client need in a jurisdiction in the target year, calculated in accordance with the methodology in .11 of this Chapter, exceeds 400 clients.

C. Jurisdictions with Fewer than Three General Home Health Agencies. For a jurisdiction with fewer than three authorized general home health agencies serving residents in that jurisdiction, the Commission will not impose the jurisdictional volume threshold in .09B above, and will docket applications by existing Maryland licensed general home health agencies having served at least 25% of the total clients within a contiguous jurisdiction, provided that net need is identified for the jurisdiction in which there are fewer than three general home health agencies.

.10 Home Health Agency Standards.

A. **General and Specialty Home Health Agencies.** The Commission will use the following standards to review proposals for general and specialty home health agencies, as defined in §.16B of this Regulation.

(1) ***Service Area.*** An applicant shall:

(a) Designate the jurisdiction in which it proposes to provide services; and

(b) When applying to provide services in more than one jurisdiction, provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, each subunit, and each branch, as defined in this Regulation, or other major administrative offices recognized by Medicare.

(2) ***Financial Accessibility.***

(a) An applicant shall be, or propose to be, Medicare- and Medicaid-certified, and accept clients whose expected primary source of payment is one or both of these programs.

(b) An applicant seeking Certificate of Need approval as a specialty home health agency may show evidence why this rule should not apply.

(3) ***Information to Providers and the General Public.***

(a) An applicant shall inform the following entities about the agency's services, service area, reimbursement policy, office locations, and telephone numbers:

(i) Except as provided in .10B(5) of this Chapter, all hospitals, nursing homes, assisted living facilities, and hospice programs within its proposed service area;

(ii) At least five physicians who practice in its proposed service area;

(iii) At least one appropriately age-focused Medicaid home and community-based waiver program;

(iv) Except as provided in .10B(5) of this Chapter, the Senior Information and Assistance offices located in its proposed service area; and

(iv) The general public in its proposed service area.

(b) An applicant shall make its fees known to clients and their families before services are begun.

(4) ***Time Payment Plan*** An applicant shall:

(a) Establish special time payment plans for an individual who is unable to make full payment at the time services are rendered; and

(b) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

(5) ***Charity Care and Sliding Fee Scale.*** Each applicant for home health agency services shall have a written policy for the provision of charity care for uninsured and underinsured patients to promote access to home health agency services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) Establishing estimates of the amount of charity care the agency intends to provide annually;

(ii) A sliding fee scale for clients unable to bear the full cost of services;

(iii) Individual notice of its charity care and sliding fee scale policies to each client before services are begun; and

(iv) Making a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.

(b) An applicant for a specialty home health agency exclusively serving continuing care retirement community residents may present evidence why .10A (5) (a) of this Regulation should not apply.

(6) ***Quality.*** An applicant shall develop an ongoing quality assurance program that includes compliance with all applicable federal and state quality of care standards, and provide a copy of its program protocols when it requests first time approval as required by COMAR 10.24.01.18.

(7) ***Cost.*** An applicant shall assure that its costs and charges are not excessive in relation to those of other agencies that operate in the same and nearby jurisdictions.

(8) ***Linkages with Other Service Providers.*** Except as provided in .10B(5) of this Chapter, an applicant shall document its established links with hospitals, nursing homes, hospice programs, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home-delivered meal programs located within its proposed service area.

(a) A new home health agency shall provide this documentation when it requests first use approval.

(b) A home health agency already licensed and operating in Maryland shall provide documentation of these linkages before beginning operation in the new jurisdiction.

(9) ***Discharge Planning.*** An applicant shall provide documentation of a formal discharge planning process.

(10) ***Financial Solvency***. An applicant shall document that it can comply with the capital reserve and other solvency requirements specified by the Centers for Medicare and Medicaid Services (CMS) for a Medicare-certified home health agency.

(11) ***Data Collection and Submission.*** An applicant shall demonstrate the ability to comply with all applicable federal and State data collection requirements including, but not limited to, the Commission's Home Health Agency Annual Report and the CMS's Outcome and Assessment Information Set (OASIS).

B. Specialty Home Health Agencies. The Commission will use the Standards at .10A(1) – (11) of this Chapter, as well as the following standards to review proposals for specialty home health agencies, as defined in . 16B of this Regulation:

(1) Need. An applicant shall demonstrate quantitatively that there exists an unmet need that it intends to address. This demonstration shall include but not be limited to:

(c) Identification of the characteristics and/or special needs of the client group to be served;

(b) A detailed description of the types and quantities of specialty home health care services that the client group needs or is projected to need; and

(c) An assessment of the extent to which the home health needs of the client group are or are not being met by existing home health service providers.

(2) ***Quality.***

(a) An applicant shall demonstrate that its program will be more effective in meeting its clients' needs than those programs provided by existing home health agencies in its proposed service area.

(b) An applicant shall demonstrate that it will be able to provide appropriate referrals to maintain continuity of care.

(3) ***System Cost.*** An applicant shall demonstrate how its program will reduce health care costs in other parts of the health care system.

(4) ***Adding Populations or Services.*** An existing specialty home health agency that wishes to serve an additional population, or to provide services other than those described in its existing Certificate of Need, shall apply for another Certificate of Need.

(5) ***Information to Providers and the General Public.*** Specialty home health agencies that do not serve persons over the age of 65 are not required to address .10A (3) (a) (iv) or those applicable portions of .10A (3) (a) (i), and .10A (8) of this Chapter that apply to populations of older adults.

(6) ***Continuing Care Retirement Communities.***

(a) A continuing care retirement community (CCRC) proposing to establish a specialty home health agency to provide home health agency services to a specified CCRC shall:

(i) Serve exclusively the subscribers of the specified CCRC, who have executed continuing care agreements for the purpose of utilizing independent living units or assisted living beds within the continuing care facility, except as provided in COMAR 10.24.01.03K;

(ii) Permit subscribers of the CCRC to receive these services from other home health agencies authorized by the Commission to provide services in the same jurisdiction; and

(iii) Provide to the subscribers of the CCRC a list of home health agencies authorized by the Commission to provide services in the same jurisdiction, and provide a copy of this list when it requests first-use approval.

(b) If a CCRC served by a Certificate of Need-approved specialty home health agency with which it has an exclusive contractual agreement chooses to terminate that contract:

(i) The specialty home health agency's authority to provide these services to subscribers of the CCRC is also terminated; and

(ii) Any entity with which the CCRC may subsequently seek an exclusive contractual agreement to provide home health agency services to its subscribers must obtain a Certificate of Need as a specialty home health agency in its own right.

.11 Methodology for Projecting Need for Home Health Agency Services.

A Methodology Assumptions.

(1) The number of clients from each jurisdiction served by existing agencies, expressed as a percentage of clients served by jurisdiction of residence, is assumed to remain stable between the base and target years.

(2) The percent of hospital discharges referred to home health agencies is assumed to be seven percent.

(3) The percent of nursing home discharges with 30 days or less length of stay referred to home health agencies is assumed to be 60 percent.

(4) The percent of referrals referred to home health agencies from sources other than hospitals and nursing homes is assumed to be 50 percent of the combined hospital and nursing home referrals.

(5) Of the total number of clients served by a general home health agency, the percent of referrals from hospitals and nursing homes (with a length of stay of 30 days or less) is assumed to be 50 percent and 17 percent, respectively, while referrals from sources other than hospitals and nursing homes is assumed to be 33 percent.

B. Period of Time Covered

(1) The base year from which projections are calculated is the most recent calendar or fiscal year for which hospital discharge abstract data, nursing home discharge data, and home health agency survey data are available.

(2) The target year to which subsequent projections are calculated is six years after the base year.

C. Services. Expected number of clients served in the target year is projected only for licensed general home health agencies.

D. Age Groups Projections are calculated for the entire population, rather than for specific age groups.

E Geographic Areas Need is projected by jurisdiction of client residence.

F. Inventory Rules.

(1) The number and location of licensed general home health agencies in Maryland in the base year are obtained from the Office of Health Care Quality, Maryland Department of Health and Mental Hygiene.

(2) The number and location of Certificate of Need-approved general home health agencies in Maryland, and the jurisdictions in which licensed and Certificate of Need-approved agencies may provide services, are obtained from Commission program records.

(3) A general home health agency with a Certificate of Need approved by the Commission is counted in the Commission inventory.

G. Data Sources

(1) ***Population.*** Base year estimates and target year projections of Maryland population, by jurisdiction, are obtained from the most recent population projections available from the Maryland Department of Planning.

(2) ***Utilization.***

(a) The statewide number of Maryland resident hospital discharges (excluding deaths) in the base year is obtained from the most recent complete year of the Commission's acute hospital discharge abstract data, obtained under COMAR 10.24.02.

(b) The statewide number of Maryland resident nursing home discharges (excluding deaths), with a length of stay of 30 days or less, in the base year, is obtained from the most recent complete year of the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set (MDS).

(c) The unduplicated number of clients served in the base year by each home health agency, by jurisdiction of client residence, is obtained from the Commission's most recent home health agency survey obtained under licensing regulations at COMAR 10.07.10, supplemented as necessary by special data collection.

H Method of Calculation The Commission uses the following procedure to project need for additional general home health agency service capacity in the target year:

(1) Calculate the number of home health agency clients referred from hospitals by multiplying the total statewide number of Maryland resident hospital discharges (excluding deaths) by seven percent.

(2) Calculate the number of home health agency clients referred from nursing homes by multiplying the total statewide number of Maryland resident nursing home discharges with a length of stay of 30 days or less (excluding deaths) by 60 percent.

(3) Calculate the number of home health agency clients referred from sources other than hospitals and nursing homes by multiplying the combined number of hospital and nursing home referrals determined in (1) and (2), above by 50 percent.

(4) Calculate the total statewide number of clients referred to home health agencies by adding together (1), (2) and (3), above.

(5) Calculate the percentage of clients served in each jurisdiction in the base year, by dividing the total number of clients in a particular jurisdiction in the base year by the total number of clients statewide in the base year, using data from the home health agency annual survey, and apply these jurisdictional percentages to the total statewide number of home health agency referrals determined in (4) above, to calculate the number of home health agency clients by jurisdiction of residence.

(6) Calculate the population change, by jurisdiction of residence from the base year to the target year, by dividing the target year population estimate by jurisdiction, by the base year population estimate by jurisdiction.

(7) Calculate the gross home health agency need, by jurisdiction of residence in the target year, by applying the change in population by jurisdiction from base year to target year determined in (6) above, to the number of home health agency clients in each jurisdiction in the base year determined in (5) above.

(8) Calculate the inventory by summing the number of residents in each jurisdiction who received general home health agency services in the base year, as submitted to the Commission in its home health agency annual report, together with the projected number of clients proposed to be served by CON-approved agencies still under development.

(9) Calculate the net need for additional general home health agency capacity in the target year by subtracting from the gross need for home health agency capacity, by jurisdiction of residence, as calculated in (7) above, the inventory of clients as calculated in (8) above, by jurisdiction of residence.

I **Mathematical Formula**. The need projection methodology described in .1 1H of this Chapter is shown here in mathematical form.

(2) ***Definitions of Terms.*** Terms used in .1 1I(2) of this Chapter are defined as follows:

Term	Definition
HOSPREF	statewide number of home health agency clients referred from hospitals
HOSPDIS	statewide number of Maryland resident hospital discharges (excluding deaths)
NHREF	statewide number of home health agency clients referred from nursing homes
NHDIS	statewide number of Maryland resident nursing home discharges with a length of stay of 30 days or less (excluding deaths)
OREF	statewide number of home health agency clients referred from sources other than hospitals and nursing homes
TREF	total statewide number of clients referred to home health agencies
j	jurisdiction of residence, where 1, . . .24 = Maryland jurisdictions
JURPER	percentage of statewide home health agency clients served in a jurisdiction in the base year
BCARE	number of home health agency clients residing in a given jurisdiction in the base year
TBCARE	total statewide number of home health agency clients served in base year
CLIENTS	total number of home health agency clients in a given jurisdiction
BPOP	base year population
TPOP	target year population
POPCHG	change in population between base and target years
TYGNEED	number of home health agency clients expected to need care in the target year
TYNNEED	net additional number of home health agency clients expected to need care in the target year
PROCON	projected number of home health agency clients proposed to be served by CON approved agencies still under development

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(1) ***Formula.*** Need for additional general home health agency capacity in each jurisdiction is calculated as follows:

(a) HOSPREF = (HOSPDIS) (.07)

(b) NHREF = (NHDIS) (.60)

(c) OREF == (HOSPREF + NHREF) (.50)

(d) $TREF = HOSPREF + NHREF + OREF$

(e) $JURPER = BCARE_J / TBCARE$

(f) $CLIENTS_J = (TREF) (JURPER)$

(g) $POPCHG_j = TPOPj/BPOP_j$

(h) $TYGNEED_J = (CLIENTS_J) (POPCHG_J)$

(i) $TYNNEED_J = TYGNEED_J - BCARE_J - PROCON_J$

J. Update, Correction, Publication, and Notification Rules

(1) The Commission will update home health agency need projections at least every three years and publish them in the *Maryland Register,* including:

(a) The most recent utilization data available from the Commission's home health agency survey, hospital discharge abstract data set, and Long Term Care Facility Resident Assessment Instrument's Minimum Data Set (MDS);

(b) The most recently revised population estimates and projections from the Maryland Department of Planning; and

(c) The most recent inventory of licensed and CON-approved home health agencies and capacity prepared by the Commission.

(2) Updated projections published in the *Maryland Register* supersede any previous published projections.

(3) Published projections remain in effect until the Commission publishes updated home health agency need projections, and will not be revised during the interim, other than to incorporate inventory changes resulting from Commission Certificate of Need decisions, merger/consolidation decisions, or to correct errors in data or computation.

.12 Issues and Policies: Hospice Services.

A. Introduction.

Hospice involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. Physical, social, spiritual, and emotional care is provided during the last stages of illness, during the dying process, and during bereavement, by a medically directed, interdisciplinary team consisting of patients, families, professionals, and volunteers. [12] The focus is on caring, not curing and, in most cases, care is provided in the patient's home. However, in recent years, hospice utilization in locations other than the patient's home has increased. Patients living in nursing homes and assisted living facilities are increasingly using hospice services. Additional hospice facilities, such as residential facilities and inpatient units, have been developed for individuals needing hospice care.

Hospice care programs in Maryland are licensed as either general hospice programs or limited hospice programs under Health-General Article §19-901 through §19-913. A *General Hospice Care Program* means "a coordinated, interdisciplinary program of hospice care services designed to meet the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive medical, nursing, and other health-related services during illness and bereavement through home or inpatient care." A *Limited Hospice Care Program* means "a coordinated, interdisciplinary program of hospice care services designed to meet the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive non-skilled services during illness and bereavement through a home-based hospice care program."[13]

This section of the Chapter addresses major issues underlying the policies developed for hospice programs in Maryland. These issues are organized into three major categories: availability and accessibility of hospice services; pediatric hospice; and data collection. Utilization trends and analysis of factors influencing future hospice need may be found in the ***Supplement to COMAR 10.24.08: Statistical Data Tables.***

B. Statement of Issues and Policies.

(1) Availability and Accessibility of Hospice Services.

Hospice care is a growing service, both in Maryland and nationally. Although the current supply of hospice programs seems adequate, the availability of hospice services needs to be assessed over time, particularly where jurisdictions are served by only one hospice. Terminally ill patients, who are too sick to be discharged from the hospital, frequently receive palliative care in hospitals with outside consultations from a licensed

[12] National Hospice and Palliative Care Organization. Website: http://nhpco.org
[13] COMAR 10.07.21.02

hospice. This may not be the most cost effective setting for these individuals. Trends such as this, where hospice care is provided in a non-traditional setting for convenience sake, need to be monitored to insure access to, and availability of, an appropriate setting where individuals can receive the full spectrum of hospice services in a consistent way.

The availability of multiple providers for all types of health services in order to enhance consumer choice has become increasingly important for policymakers and consumers as well. Although some research has indicated that factors such as demographics, diagnosis, socioeconomic factors, as well as population density affect the utilization of hospice services, this is an area that requires further study.

In some rural areas, there may be a single hospice provider. Steps should be taken for the provision of hospice services if a sole provider ceases operation. In addition, it is more difficult for a small number of rural hospice providers to absorb additional clients.

Policy 9.0 The Commission, in conjunction with the Hospice Network of Maryland, needs to monitor the availability and accessibility of hospice programs on an ongoing basis.

(2) Pediatric Hospice Services.

An issue that has arisen in the national hospice debate is the role of hospice in pediatric care. Although children should have the same access to hospice care and pain relief as older patients, to some, obtaining hospice services for children means "giving up." It is difficult for many parents to accept that nothing can be done for their children and to stop any aggressive, curative treatments. Physicians often delay seeking hospice benefits for children because so much progress has been made in fighting childhood cancers that were previously considered fatal. Furthermore, "physicians tended to realize that there was no chance of recovery nearly seven months before a child's death from cancer; parents, on the other hand, did not come to that realization until about 3 1/2 months before."[14] Often, physicians do not tell, and parents do not ask. Finally, the hospice benefit requires a prediction that the patient has six months or less to live. "Our ability to predict when a child may die is uncertain... children are not able to take advantage of hospice services because we can't say a child will die in six months."[15]

One national project addressing pediatric hospice is called the Program for All-Inclusive Care for Children and their families (PACC). Children's Hospice International, with funding from the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration), initiated a program to address the unmet need of hospice services for children. The program, which began as a demonstration project in

[14] Trafford, Abigail. "Children of Denial. Recent Advances in End-of Life Care Haven't Reached the Youngest Patients", *Washington Post* June 20, 2001.

[15] "Six Month Rule: Fatal Barrier". *Washington Post*, June 20, 2001.

five states, Florida, Kentucky, New York, Utah, and Virginia, during the first year is now available to any state that wishes to participate and apply for funding through CMS. Maryland has not applied for this program, but the results may have applications in all states.

Policy 10.0 The Commission should continue to monitor the results of national data to determine the need for pediatric hospice care.

(3) Data Collection.

With its formation in 1982, the Hospice Network of Maryland began collecting data from its member hospices across the State. This was done in collaboration with the Maryland Health Care Commission and its predecessor agency, the Maryland Health Resources Planning Commission. Subsequent to the passage of HB 732 in 2003, the Commission was directed to collect its own hospice data. The Maryland Hospice Survey, data collected by the Commission, replaced the data collection by the Hospice Network. The first annual Maryland Hospice Survey conducted by the Commission was for fiscal year 2003. This survey has been consistent with the national survey since 2000. This provides a valuable source of data not only on Maryland hospices and how they are used, but also it permits comparisons with national data.

Several factors affect the prediction of future hospice utilization. One is reimbursement of hospice services. Hospice has been a covered service under Medicare since 1982, and in many States, including Maryland, Medicaid and several private insurance plans also cover hospice services. As shown in the ***Supplement to COMAR 10.24.08: Statistical Data Tables***, most of hospice care is reimbursed by Medicare both in Maryland and nationally. Under the 1997 Balanced Budget Amendment, several modifications were made to hospice reimbursement. These modifications included allowing hospices to discharge patients, without the loss of future benefits, whose conditions improve. Therefore, planning for hospice services should now include live discharges as well as hospice deaths. Another change is that hospice reimbursement for home care recognizes where the patient lives, (i.e., assisted living, nursing home) not where the hospice is located. Furthermore, since some hospice care is provided by home health agencies, the impact of the prospective payment system on home health care may also have an impact on hospice services.

Prediction of future utilization patterns is affected by many factors, including cancer vs. non-cancer utilization, and competition for hospice patients. Utilization of hospice services has undergone many changes in recent years. Utilization of hospice in nursing homes and other non home-based settings has increased, the percentage of hospice patients with a diagnosis of cancer has decreased, and there has been an overall increase in hospice use as patients and physicians learn about hospice as an alternative to other types of end of life care. The hospice model of care has been recognized as a better quality care model for individuals with chronic conditions and may see increased utilization by these individuals who are nearing the end of life. The Medicare

Modernization Act of 2003 established the Chronic Care Improvement Program (CCIP) along with the Medicare Part D prescription drug program. This program focuses on better coordination of care for Medicare recipients with multiple chronic conditions. It calls for an initial pilot program, to be expanded at a later date, that will provide ongoing coordinated care across health care settings. It will include frequent contact with the recipient, patient education, centralized information about the patients' care, and continuous screening for better care options as disease progresses. This may increase the number of referrals to hospice as the CCIP expands across geographic areas.

Future trends in hospice utilization are also difficult to predict. The population is aging and awareness of hospice is growing. Yet, as discussed above, patients are still referred to hospice late in the course of their illness. In addition, the death rates in Maryland and nationwide are decreasing. The growth of for profit hospices may result in increased competition for limited clients. These factors require the Commission to continue to monitor trends in utilization.

Policy 11.0 The Commission will continue to collect data from all hospice providers in order to obtain timely, Maryland-specific data to support planning and regulation of hospice programs.

Policy 11.1 The Commission will examine how need for hospice services is calculated, and assess whether revisions should be made to the hospice need projection methodology in order to take into account future changes in the health care system, population, and other factors affecting hospice need.

.13 Certificate of Need Docketing Rules: Hospice

The Commission will use rules in this section to determine whether an application for hospice services meets the necessary criteria to allow initiation of Certificate of Need (CON) review by docketing.

A. General Docketing. Except as noted in .13(B)(1) below, if the maximum net number of additional hospice clients to be served in a jurisdiction, calculated in accordance with the methodology consistent with .15H of this Chapter, is below the calculated volume threshold in the target year, the Commission will not docket an application to provide additional hospice services in that jurisdiction.

B. Sole Provider.

(1) If a hospice agency that is the sole provider of hospice services to a jurisdiction should cease operations, the Commission may docket applications to serve that jurisdiction, even if the net need is less than the calculated volume threshold.

(2) If a hospice agency that is the sole provider of hospice services to a jurisdiction is unable to serve a patient, it may request authorization from the Commission to permit a licensed Maryland hospice in a contiguous Maryland jurisdiction to serve that patient. The Commission's authorization is limited to that specific patient and does not authorize the hospice agency in the contiguous jurisdiction to serve any other patients in that jurisdiction.

.14 **Hospice Standards**. The Commission will use the following standards to review Certificate of Need proposals to establish a new general hospice program, or expand an existing hospice program to one or more additional jurisdictions.

A. **Service Area**. An applicant shall designate the jurisdiction in which it proposes to provide services.

B. **Admission Criteria**. An applicant shall identify:

(1) Its admission criteria; and

(2) Proposed limits by age, disease, or caregiver.

C **Minimum Services**.

(1) An applicant shall provide the following services directly:

(a) Physician services and medical direction;
(b) Skilled nursing care;
(c) Counseling or social work;
(d) Spiritual services;
(e) Nutritional counseling; and
(f) On-call nursing response

(2) An applicant shall also provide the following services, either directly or through contractual arrangements:

(a) Personal care;
(b) Volunteer services;
(c) Bereavement services;
(d) Pharmacy services;
(e) Laboratory, radiology, and chemotherapy services as needed for palliative care;
(f) Medical supplies and equipment; and
(g) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

(3) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.

D. Setting. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.

E. Volunteers. An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.

F. Caregivers. An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.

G. Financial Accessibility. An applicant shall be licensed and Medicare-certified, and agree to accept clients whose expected primary source of payment is Medicare or Medicaid.

H. Information to Providers and the General Public.

(1) ***General Information.*** An applicant shall inform the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:

(a) All hospitals, nursing homes, and assisted living providers within its proposed service area;

(b) At least five physicians who practice in its proposed service area;

(c) The Senior Information and Assistance Offices located in its proposed service area; and

(d) The general public in its proposed service area.

(2) ***Fees.*** An applicant shall make its fees known to clients and their families before services are begun.

I Time Payment Plan. An applicant shall:

(1) Establish special time payment plans for individuals unable to make full payment at the time services are rendered; and

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

J. Charity Care and Sliding Fee Scale. Each applicant for hospice services shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to hospice services regardless of an individual's ability to pay. The policy shall include provisions for, at a minimum, the following:

(1) Provide documentation of financial estimates of the amount of charity care that it intends to provide annually;\

(2) Provide documentation of a written policy for the provision of complete and partial charity care for indigent and other persons unable to pay for services;

(3) Provide documentation of a written policy for the provision of sliding fee scales for clients unable to bear the full cost of services;

(4) Provide a written copy of its charity care and sliding fee scale policies to each client before services are begun;

(5) Provide documentation that an individual notice of charity care is provided to each person who seeks services in the hospice program; and

(6) Make a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.

K. Quality. An applicant shall document ongoing compliance with all federal and state quality of care standards.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of clients.

N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying people and their caregivers.

O. Patients' Rights. An applicant shall document its compliance with the patients' rights requirements of COMAR 10.07.21.2 1.

.15 Methodology for Projecting Need for Hospice Services.

A. Methodology Assumptions.

(1) All hospice utilization is appropriate.

(2) The number of non-cancer patients needing hospice care is 10 percent of the number of cancer patients needing hospice care.

(3) The number of clients from each jurisdiction served by existing agencies will remain stable between the base year and target years.

(4) The percentage of cancer patients who die while enrolled in a hospice program, referred to as the hospice utilization rate, is between 37.5 and 50 percent.

B. Period of Time Covered.

(1) The base year from which projections are calculated is the most recent calendar or fiscal year for which hospice survey data are available.

(2) The target year is five years after the base year.

C. Services.

(1) Expected minimum and maximum numbers of clients served in the target year are projected for general and limited hospice programs together.

(2) No separate projection is made for inpatient hospice programs.

D. Age Groups. The following age groups are used: under 18, 18-44, 45-54, 55-64, 65-74, 75-84, 85 years and over.

E. Geographic Areas. Need is projected by jurisdiction of client residence.

F. Inventory Rules.

(1) The number and location of licensed general and limited hospice programs in Maryland are obtained from the Office of Health Care Quality, Department of Health and Mental Hygiene.

(2) The number and location of Certificate of Need approved general hospices in Maryland are obtained from Commission program records.

G. Data Sources.

(1) ***Population.*** Base year estimates and target year projections of Maryland population by jurisdiction and age group are obtained from the most recent population projections available from the Maryland Office of Planning.

(2) ***Utilization.***

(a) Cancer death rate are based on three year average age adjusted death rates obtained from the most recent data available from the Department of Health and Mental Hygiene's Division of Vital Statistics.

(b) The number of patients served in Maryland hospices in the base year, by jurisdiction of residence, is obtained from data reported to the Hospice Network of Maryland, supplemented as necessary by special data collection.

(c) The number of patients who died in Maryland hospices in the base year, by jurisdiction of residence, is obtained from data reported to the Hospice Network of Maryland, supplemented as necessary by special data collection.

H Method of Calculation. The Commission uses the following procedure to project need for additional hospice capacity in the target year:

(1) Obtain cancer death rates by age group for the base year. Multiply projected population by age group to obtain the number of cancer deaths in the target year.

(2) Calculate the hospice death rate for each planning region, and use that rate to calculate the number of hospice deaths.

(3) Calculate the jurisdictional hospice use rate and adjust that rate by ranking all jurisdictional hospice use rates and determining the 37.5th and 50th percentile. Calculate the adjusted minimum hospice use rate by setting hospice use rates that fall below the 37.5th percentile at the rate of that percentile and setting hospice use rates that fall at or below the 37.5th percentile at its calculated rate.

(4) Calculate the adjusted maximum hospice use rate by setting all use

rates that fall below the 50th percentile at the rate of that percentile and setting use rates that fall at or above that percentile at its calculated rate.

(5) Use calculated use rates to determine expected hospice deaths in the target year, and use this to calculate minimum and maximum need for hospice capacity.

(a) Calculate the gross minimum and maximum need for hospice by multiplying the total need by 10 percent to account for growth in use by non-cancer patients who are expected to use hospice services.

(b) Calculate the adjusted number of residents of each jurisdiction who received care from hospices.

(c) Calculate the minimum and maximum need for additional hospice capacity by subtracting from the gross need for each jurisdiction the number of hospice patients cared for in that jurisdiction. Subtract out also the projected utilization by agencies approved by the Commission to deliver hospice services in that jurisdiction.

I Mathematical Formula The need projection methodology described in .15H of this Chapter is shown here in mathematical form.

(I) ***Definitions of Terms.*** Terms used in . 15I (2) of this Chapter are defined in the following table.

Term	**Definition**
i	jurisdiction residence, where 1,...,24 = Maryland jurisdictions and 25 equals out-of-state jurisdictions
j	jurisdiction of care, where 1,...,24 = Maryland jurisdictions and 25 = out-of-state jurisdictions
h	health planning region
k	age group
m	minimum and maximum jurisdictional hospice use rate, where 1 = minimum and 2 = maximum
p	hospice program
TPOP	target year population
CDRATE	average cancer death rate (most recent three years available)
TCDTH	total number of cancer deaths in the target year
THOSPAT	total number of hospice patients in the base year
HOSDR	hospice death rate in the base year
HOSDTH	number of hospice deaths in the base year
BCDTH	total number of cancer deaths in the base year
HOSUR	hospice use rate in the base year

AHOSUR	Adjusted hospice use rate
CHOSDTH	number of cancer patients who died in a hospice in the target year
CHOSLIV	number of cancer patients who do not die in a hospice in the target year
GNEED	number of hospice patient expected to need care in the target year
BCARE	number of hospice patients cared for in the base year
NSERV	number of clients served by an agency headquartered in a given jurisdiction regardless of the client's jurisdiction of residence
ORES	number of clients served by an agency headquartered in a given jurisdiction residing outside the jurisdiction
OJHQ	number of clients served in a given jurisdiction in the base year by an agency headquartered in another jurisdiction
OSHQ	number of clients served in a given jurisdiction in the base year by an agency headquartered out of state
NNEED	net additional number of hospice patients expected to need care in the target year

(2) ***Formula.*** Need for additional hospice service capacity in each jurisdiction is calculated as shown in the following table:

(a) $TCDTH_i = \sum_k [(CDRATE_{ki})(TPOP_{ki})]$

(b) $HOSDR_h = HOSDTH_h / HOSPAT_h$

(c) $THOSDTH_i = (HOSDR_h)(HOSPAT_i)$

(d) $HOSUR_i = THOSDTH_i / BCDTH_i$

(e) For m = 1, If $HOSUR_i < .375$, then $AHOSUR_{i_m} = .375$

If $HOSUR_i \geq .5$, then $AHOSUR_{i_m} = HOSUR_i$

(f) For m = 2, If $HOSUR_i < .5$, then $AHOSUR_{i_m} = .5$

If $HOSUR_i \geq .5$, then $AHOSUR_{i_m} = HOSUR_i$

(g) $CHOSDTH_{i_m} = (AHOSUR_{i_m})(TCDTH_i)$

(h) $CHOSLIV_{i_m} = (CHOSDTH_{i_m} / HOSDR_h) - CHOSDTH_{i_m}$

(i) $TCNEED_{im} = CHOSDTH_{i_m} + CHOSLIV_{im}$

(j) $GNEED_{im} = (1.1)(TCNEED_{i_m})$

(k) $BCARE_i = (NSERV_j - ORES_j) + OJHQ_i + OSHQ_i$

(l) $NNEED_{im} = GNEED_{im} - BCARE_i$

J. Update, Correction, Publication, and Notification.

(1) The Commission will update the hospice need projections at least every two years and publish them in the *Maryland Register*, including:

(a) The most recent utilization data available from the Hospice Network of Maryland;

(b) The most recent data on cancer death rates available from the Division of Vital Statistics, Department of Health and Mental Hygiene;

(c) The most recently revised population estimates and projections from the Maryland Office of Planning; and

(d) The most recent inventory of licensed and CON-approved hospice agencies and capacity prepared by the Commission.

(2) Updated projections published in the *Maryland Register* supersede any previously published projections in either the *Maryland Register* or any plan approved by the Commission.

(3) Published projections will remain in effect until the Commission publishes updated hospice need projections, and will not be revised during the interim other than to incorporate inventory changes resulting from Commission Certificate of Need decisions or merger/consolidation decisions, or to correct errors in the data or computation.

.16 Definitions.

A. In this Chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) *Activities of Daily Living (ADLs*) means a major and widely used measure of physical function developed by Sidney Katz et al. in 1963; the six ADLs measured are: bathing, dressing, toileting, transferring, continence, and eating.

(2) *Adult Day Care Center* means a place licensed by the Maryland Department of Health and Mental Hygiene (DHMH) that serves elderly or medically handicapped adults during part of the day in a protective group setting. An Adult Day Care Center provides, with or without charge, care for the elderly or medically handicapped individuals, and is either designated as group care for at least four individuals or as a family home that provides care for two to three individuals. Adult Day Care Centers may be funded by the DHMH under either of two programs:

(a) General Funds support financially eligible adults 55 years of age or older (Health General-Article, §14-201, Annotated Code of Maryland); or

(b) Medical Assistance supports financially and medically eligible adults aged 16 or older (Health-General-Article, § 14-301, Annotated Code of Maryland).

(3) *Adult Evaluation and Review Services (AERS*—formerly Geriatric Evaluation Services) means a program of the Maryland Department of Health and Mental Hygiene, operated by 24 local health departments, that uses a team of professionals to provide a comprehensive medical/nursing, environmental, and psychosocial assessment. The evaluation is conducted in the individual's home or current residence.

(4) *Assisted Living Program* means a residential or facility-based program licensed under COMAR 10.07.14 that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of those services to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the residents.

(5) *Branch* means an office of a parent home health agency or subunit that is located at a different site, but is sufficiently close to share administration, supervision and services with the parent agency or subunit on a daily basis. A branch is not autonomous from the parent home health agency or subunit. (This current "branch" definition refers to what was previously known as a "satellite" office.)

(6) *Case Management* means a coordinated package of services that includes, at a minimum:

(a) Assessment of individual client's strengths, weaknesses, needs, and resources;

(b) Planning of services in an effective and efficient package to enhance strengths, complement resources, and meet needs;

(c) Linkage of individual clients with resources in the community and insuring that clients and resources are effectively linked;

(d) Monitoring of services received by individual clients to determine whether or not they are effective, efficient, and needed on a continuing basis; and

(e) Advocacy on behalf of individual clients to ensure access to entitlement benefits and services, and to develop new resources when no service exists to meet a need.

(7) *Certificate of Need-Approved (CON-approved) beds* means those beds for which a Certificate of Need has been obtained from the Maryland Health Care Commission, consistent with COMAR 10.24.01, but which are not yet licensed.

(8) *Certificate of Need-Excluded Continuing Care Nursing Home Beds* means beds in a continuing care retirement community certifiable by the Maryland Department of Aging under Article 70B, that meet the provisions of Health-General Article, §19-114 (d)(2)(ii), Annotated Code of Maryland, which:

(a) Are for the exclusive use of the continuing care retirement community's subscribers who have executed continuing care agreements for the purpose of utilizing independent living units, or assisted living beds within the continuing care facility, except as provided in COMAR 10.24.01.03 K;

(b) Do not exceed 20 percent of the number of independent living units at a continuing care retirement community that has 300 or more independent living units, or 24 percent of the number of independent living units at a continuing care retirement community that has fewer than 300 independent living units; and

(c) Is located on the campus of the continuing care retirement community.

(9) *Charity Care*.

(a) Charity care means care for which there is no means of payment by the patient or any third-party payer.

(b) Charity care does not mean uninsured or partially insured days of care designated as deductibles or co-payments in patient insurance plans, nor that portion of charges not paid as a consequence of either a contract or agreement between a provider and an insurer, or a waiver of payment due to family relationship, friendship, or professional courtesy.

(10) *Chronic Hospital* means a facility licensed as special hospital-chronic disease in accordance with COMAR 10.07.01 that serves patients who do not need acute care or care in another kind of specialty hospital, whose needs for frequency of monitoring by a physician and for frequency and duration of nursing care exceeds the requirements of COMAR 10.07.02 for care in a comprehensive care or extended care facility, and whose expected length of stay, typically exceeds 25 days.

(11) *Community-Based Long Term Care Services* means services delivered to functionally disabled persons in their communities to help meet their needs for health care and social support, to enable them to achieve or maintain an optimal degree of independence, and to improve their quality of life.

(12) *Comprehensive Care Facility* means a facility licensed in accordance with COMAR 10.07.02 that admits patients suffering from disease or disabilities, or advanced age, requiring medical service and nursing service rendered by or under the supervision of a registered nurse.

(13) *Consolidation* means a merger, as defined in this section, that results in the elimination or centralization of long term care

services at one or more of the nursing homes in a merged organization.

(14) *Continuing Care* means furnishing shelter plus health services consistent with the requirements of Article 70B, Annotated Code of Maryland. Health services include: either medical or nursing services; a formal arrangement between the provider and a nursing home by which the nursing home grants priority to the subscriber for admission; or assistance with activities of daily living other than the provision of meals. Services may be paid for by the following methods: an entrance fee in advance of receipt of services; regular periodic charges which guarantee health services whenever needed; purchase of services at the option of the subscriber as services are needed; or any combination thereof. Services are offered to an individual 60 years of age or older, not related by blood or marriage to the provider, for the life of the subscriber, or for a period in excess of one year. Services are offered under a written agreement that may require periodic charges and shall require: a transfer of assets from the subscriber to the provider; an entrance fee, or both a transfer of assets and an entrance fee.

(15) *Continuing Care Retirement Community* means a legally organized entity to provide continuing care in a facility that has been certified by the Office on Aging consistent with Article 70B, Annotated Code of Maryland.

(16) *Existing Beds* means licensed or CON-approved beds, but does not mean waiver beds determined not to require a Certificate of Need under COMAR 10.24.01.03 or temporarily delicensed beds under COMAR 10.24.01.03 C.

(17) *Extended Care Facility (ECF)* means a facility licensed in accordance with COMAR 10.07.02 that offers sub-acute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous acute care services, and admitting patients who require convalescent or restorative services, or rehabilitative services, or patients with terminal disease requiring maximal nursing care.

(18) *General Home Health Agency* means a home health agency that provides a full range of home health services that are not restricted as a specialty home health agency.

(19) *Home Health Agency*.

(a) "Home health agency" means a health-related organization, institution, or part of an institution that directly, or through a contractual arrangement, provides to a sick or disabled individual in the residence of that individual skilled nursing and home health aide services, and at least one other home health care service that is centrally administered, as provided under Health-General Article, § 19-401, et seq., Annotated Code of Maryland.

(b) "Home health agency" includes both parent (previously known as branch) and subunit, as defined by the Centers for Medicare and Medicaid Services under 42 CFR §484.2.

(c) "Home health agency" does not mean a residential service agency as defined in Health-General Article, §19-4A, Annotated Code of Maryland.

(20) *Home Health Agency Service* means any or all of the following services that are provided in accordance with Health-General Article, §19-401, Annotated Code of Maryland, under the general direction of licensed health professionals practicing within the scope of their practice acts:

(a) Audiology and speech pathology;
(b) Dietary and nutritional services;
(c) Drug services;
(d) Home health aide;
(e) Laboratory services;
(f) Medical social services;
(g) Skilled nursing;
(h) Occupational therapy;
(i) Physical therapy; and
(j) Provision of medically necessary sick room equipment and supplies.

(21) *Hospice Care Program*

(a) *General Hospice Care Program* means a coordinated, interdisciplinary program provided in accordance with Health-General Article, §19-901, Annotated Code of Maryland, to meet the special physical, psychological, spiritual, and social needs of dying individuals and their families by providing palliative and supportive medical, nursing, and other health services through home or inpatient

care during illness and bereavement to individuals, and to the families of those individuals, who have no reasonable prospect of cure as estimated by a physician.

(b) *Limited Hospice Care Program* means a coordinated, interdisciplinary program of provided in accordance with Health-General Article, §19-901, Annotated Code of Maryland, to meet the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive non-skilled services through a home-based hospice care program during illness and bereavement to individuals who have no reasonable prospect of cure as estimated by a physician and to the families of those individuals.

(22) *Inpatient Hospice Care Services* means services provided by a general hospice care program for the purpose of pain control, symptom management, or respite, consistent with COMAR 10.07.21. Inpatient hospice care services include nursing services 24 hours a day in a manner sufficient to meet the total nursing needs identified in the patient's plan of care, with a registered nurse on duty during each shift.

(23) *Independent Living Unit* means a residential unit for the use of subscribers of a continuing care retirement community, but does not mean assisted living beds or comprehensive care beds.

(24) *Instrumental Activities of Daily Living (IADLs)* means the home management activities identified as a measure of function developed by Lawton and Brody in 1969: handling personal finances, shopping, traveling, doing housework, using the telephone, and taking medications.

(25) *Jurisdiction* means any of the 23 Maryland counties or Baltimore City.

(26) *Licensed* means a facility that has received approval to operate from the Office of Health Care Quality of the Maryland Department of Health and Mental Hygiene.

(27) *Long Term Care* means the array of medical, social, and support services needed by individuals who, because of chronic illness or disability, need another person's help in caring for themselves over an extended period of time.

(28) *Medicaid* means the Maryland Medical Assistance Program administered by the State under Title XIX of the Social Security Act to reimburse comprehensive medical and other health-related care for categorically eligible and medically needy persons.

(29) *Merger* means: The combining of existing beds or services of two or more independent health care facilities, including at least one nursing home, under a permanent arrangement of reorganization that is legally binding and that results in an entity that controls the business and programmatic functions of all the health care facilities involved.

(30) *Non-Excluded Continuing Care Nursing Home Beds* means those beds in a continuing care retirement community which do not meet all three of the provisions for exclusion from Certificate of Need found in §13 (7) of this regulation, which:

(a) Are located in a continuing care retirement community certifiable by the Department of Aging under Article 7013, Annotated Code of Maryland;

(b) Require a Certificate of Need; and (c) Must meet all

applicable rules and standards of this Chapter.

(31) *Nursing Home* means a health care facility licensed for comprehensive care beds under COMAR 10.07.02.

(32) *Obsolete Physical Plant* means a facility that:

(a) Has been granted two or more Life Safety Code waivers by the Office of Health Care Quality;

(b) Maintains 100 percent of its census in a building granted life safety code waivers by the Office of Health Care Quality;

(c) Has more than 30 percent of its beds in rooms with three or more beds; and

(d) If multi-storied, does not have an elevator.

(33) *Parent Home Health Agency* means the home health agency that develops and maintains administrative controls of subunits and/or branch offices.

(34) *Person* means an individual, receiver, trustee, guardian, executor, administrator, fiduciary, or representative of any kind and any partnership, firm, association, limited liability company, limited liability partnership, public or private corporation, or other entity.

(35) *Personal Care* means assistance with those functions and activities normally associated with body hygiene, nutrition, elimination, rest, and ambulation that enable an individual to be treated at home.

(36) *Planning Region* means one of the five areas of the State used in this Chapter for purposes of planning, bed need projections, and for Certificate of Need standards, including Medicaid percentage requirements. These areas include: Western Maryland; Montgomery County; Southern Maryland; Central Maryland; and the Eastern Shore.

(37) *Preadmission Screening and Resident Review (PASRR*) requires that nursing facilities cannot admit or retain an individual who has a serious mental illness, mental retardation, or a related condition unless the Developmental Disabilities Administration (DDA) or the Mental Hygiene Administration (MHA) has determined that a nursing facility placement is appropriate for the individual. PASRR applies to all new admissions to a nursing home that participates in the Medicaid program regardless of how the individual's stay is being paid.

(38) *Residential Service Agency* means any person that is engaged in a nongovernmental business of employing or contracting with individuals to provide home health care for compensation to an unrelated sick or disabled individual in the residence of that individual, as defined in Health-General Article, §19-4A-01, Annotated Code of Maryland.

(39) *Respite Care* means formal services provided in a home, at a day care center, or by temporary nursing home placement, to functionally disabled or frail individuals to give informal caregivers occasional or systematic relief.

(40) *Senior Care* means a statewide mechanism that coordinates aging services provided by major public and private agencies, in order to help persons 65 and older who are at risk of nursing home admission to remain independent in the community through assessment of needs, case management and, for low-income clients, gap filling funds.

(41) *Senior Center* means a program supervised by the Maryland Department of Aging that provides services to seniors including but not limited to: exercise programs, health and screening services, immunizations, and health education seminars. There are 112 senior centers in Maryland. In addition, *Senior Center Plus* is a program of structured group activities and enhanced socialization which is designed to have a positive impact on physically frail or cognitively impaired individuals. There are 41 Senior Center Plus sites in Maryland.

(42) *Senior Information and Assistance* means a statewide program designed to provide single point of entry centers for current information about programs, services, and, benefits for older persons and their caregivers by assisting in determining service need, processing requests, making referrals to appropriate agencies, and monitoring the outcome of requests for service or information. The information includes, but is not limited to: transportation, income and financial aid, senior centers, meals, pharmacy assistance, housing, and volunteer opportunities. There are 120 local Senior Information and Assistance offices in Maryland.

(43) *Specialty Home Health Agency* means a home health agency that provides:

(i) Services exclusively to the pediatric population;

(ii) An array of services exclusively to a population group limited by the nature of its diagnosis or medical condition;

(iii) To all population groups a highly limited set of services that can offer acceptable quality only through specialized training of staff and an adequate volume of experience to maintain specialized skills; or

(iv) Services exclusively to the residents of a specific continuing care retirement community.

(44) *Statewide Evaluation and Planning Service (STEPS)* means a statewide, comprehensive, multi-disciplinary long term care evaluation program for persons at risk of nursing home placement. The individual must be at risk of placement in a nursing home, and must be a Medicaid recipient or be eligible for Medicaid within 6 months of placement in a nursing home.

(45) *Subscriber* means a purchaser, or nominee, of a continuing care agreement.

(46) *Subunit* means a semi-autonomous independent entity of a parent home health agency that is located at such a distance from the parent agency that it is incapable of sharing administration, supervision, and services on a daily basis. A subunit serves home health clients in a different geographic area from the parent agency.

(47) *Temporarily Delicensed Beds* means beds authorized by the Maryland Health Care Commission, consistent with COMAR 10.24.0103C, permitting the facility to remove beds from its license on a temporary basis that are maintained on the Commission's inventory for a period not to exceed one year.

(48) *Waiver Beds* mean beds determined not to require a Certificate of Need under Health-General Article, §19-120, (h)(2)(i), Annotated Code of Maryland.

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