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STATE HEALTH PLAN FOR

FACILITIES AND SERVICES:

HOSPICE SERVICES

COMAR 10.24.13

Effective
October 14, 2013

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.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 for Facilities and Services.

The Maryland Health Care Commission has prepared this Chapter of the State Health Plan for Facilities and Services ("State Health Plan") to meet the current and future health system needs of Maryland residents.

The State Health Plan serves two purposes:

(1) It establishes health care policy to guide the Commission's actions. Maryland law requires that all State agencies and departments involved in regulating, funding, or planning for the health care industry carry out their responsibilities in a manner consistent with the State Health Plan and available fiscal resources.

(2) It is the foundation for the Commission's decisions in its regulatory programs. These programs ensure that changes in health care facilities and services are appropriate and consistent with the Commission's policies. The State Health Plan contains policies, methodologies, standards, and criteria that the Commission uses in making Certificate of Need ("CON") decisions.

The Commission views the State Health Plan as an incentive for positive change in health care delivery that provides guidance on resource allocation decisions based on considerations of the appropriate balance among availability, accessibility, cost, and quality of health care.

B. Legal Authority for the State Health Plan.

The State Health Plan is adopted under Maryland's health planning law, found in the Health-General Article of Maryland Code Annotated ("Health-General"), at §19-118. This Chapter partially fulfills the Commission's responsibility to adopt a State Health Plan at least every five years and to review and amend the Plan as necessary. Health-General §19-118(a)(2) provides 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 Commission is an independent agency, which is located within the Department of Health and Mental Hygiene for budgetary purposes. The purposes of the Commission, as enumerated at Health-General §19-103(c), include responsibilities 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; and
>
> (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.

Health-General §19-110(a) provides that the Secretary does not have power to disapprove or modify any regulation, decision, or determination that the Commission makes regarding or based upon the State Health Plan. The Commission has sole authority to prepare and adopt the State Health Plan and to issue Certificate of Need decisions and exemptions based on the State Health Plan. Health-General §19-118(e) provides that the Secretary of Health and Mental Hygiene shall 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. The Commission pursues effective coordination with the Secretary and State health-related agencies in the course of developing the State Health Plan and Plan amendments.

D. Plan Content

Under Health-General §19-120(j) (2) (iii) 3, a Certificate of Need (CON) is required prior to the "establishment of a …hospice program…." Also, under Heath-General §19-120(f), a Certificate of Need is required before a new health care facility is built, developed, or established. Under Health-General §19-114(d) (vii), the definition of health care facility includes a hospice program. Health-General §19-120 (h) (1) provides that a change in the bed capacity of a health care facility requires CON review and approval. Finally, under Health-General §19-120(k) (2), a capital expenditure by a health care facility that exceeds an applicable capital expenditure threshold requires a CON.

The establishment of a residential hospice ("hospice house") does not require a CON because a hospice house does not meet the definition of a health care facility under the Commission's statute. The Office of Health Care Quality (OHCQ) will begin licensing and regulating hospice houses on January 1, 2014.

Regarding the applicability of CON to hospice, the following rules apply:

A CON is required for: (1) the establishment of a new licensed general hospice program; (2) the development of an inpatient hospice facility; (3) any other change in the inpatient bed capacity of a hospice; and (4) a capital expenditure by a licensed general hospice that exceeds the applicable capital expenditure for this category of health care facility.

A CON is NOT required for: (1) the establishment of a limited license hospice; (2) the establishment of a hospice house (as defined by OHCQ in regulation) that does not contain any facilities for, or bill for, the provision of general inpatient hospice services; and (3) any other change in bed capacity in a hospice house, provided that the expenditures are below the capital threshold.

.03 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.[1] 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 locations for the provision of hospice services, such as residential hospices 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 §19-901 through §19-913. A *General Hospice Care Program* means "a coordinated, interdisciplinary program of hospice care services for meeting 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 the illness or bereavement: (1) to individuals who have no reasonable prospect of cure as estimated by a physician; and (2) to the families of those individuals. "[2]

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[1] National Hospice and Palliative Care Organization (website: http://nhpco.org).

[2] Health-General §19-903(d).

A *Limited Hospice Care Program* means "a coordinated, interdisciplinary program of hospice care services for meeting 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: (1) to individuals who have no reasonable prospect of cure as estimated by a physician; and (2) to the families of those individuals." [3]

This 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; quality measures; and data collection. Utilization trends and analysis of factors influencing future hospice need may be found in the ***Supplement to COMAR 10.24.13: 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. The number of patients served by hospice nationally has grown from 25,000 in 1982 to 1,650,000 in 2011.[4] In Maryland, between 2003 and 2011, the number of hospice patients has increased by 75% from 12,427 to 21,834, and the number of hospice patient days increased by 281% from 310,714 to 1,185,089. [5] Although the current supply of hospice programs may be adequate, the availability of hospice services needs to be assessed periodically, particularly where jurisdictions are served by only one hospice.

To assure availability of hospice services if a sole provider in a jurisdiction ceases operation, docketing rules are in place to permit another provider to enter that jurisdiction. In addition, there is need for further study of consumer choice where there is a single hospice provider.

The use of hospice services nationally and within Maryland varies by population groups. It has been shown that some individuals and groups are reluctant to access hospice services based on religious, ethnic, cultural and other factors. The Commission has discussed the issues of outreach and education with the Hospice and Palliative Care Network of Maryland and will continue to work with them to determine to what extent these efforts can effectively address this issue.

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[3] Health-General §19-903(f).

[4] National Hospice and Palliative Care Organization, "Graph of Hospice Patients Served, 1982-2010", (website: http://nhpco.org

[5] Data from annual MHCC Maryland Hospice Surveys.

Policy 1.0 The Commission, in conjunction with the Hospice and Palliative Care Network of Maryland, needs to monitor the availability and accessibility of hospice programs on an ongoing basis.

(2) Quality Measurement.

Hospices have been required to have Quality Assessment and Performance Improvement (QAPI) programs in place since December 2008 in order to comply with Medicare Conditions of Participation. Section 3004 of the Affordable Care Act (ACA) of 2010 requires the establishment of a quality reporting program for hospice. Measures of quality as well as patient and family satisfaction are increasingly becoming the focus of health care assessment, both nationally and in Maryland. In addition to the federal (CMS) and National Quality Forum (NQF) measures, the Commission will select and publish measures for assessing the quality of hospice programs. The success of hospices in meeting these quality measures will also be reported in the Commission's Consumer Guide to Long Term Care.

Policy 2.0: As measures are developed, the level of quality achieved by hospices, as indicated by measurement and reporting of performance on the quality measures, will be incorporated into the review criteria and standards used in Certificate of Need reviews.

(3) Data Collection and Need Projection.

Starting 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 SB 732 in 2003, the Commission began collecting its own hospice data. The first annual Maryland Hospice Survey conducted by the Commission was for fiscal year 2003. The hospice surveys conducted in Maryland have 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 permits comparisons of Maryland and national data.

Several factors affect future hospice utilization. Differing views of health care, illness, and dying impact the use of end-of-life services by various ethnic and religious groups. Currently, the Maryland Hospice Survey collects aggregate data on race and ethnicity. The Commission will revise its annual survey to collect this data by provider and by jurisdiction.

Another major factor 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 10.24.13: 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 whose conditions improve, without the loss of future benefits. Although the growth in live discharges is reflected in the growth of both hospice patients and hospice patient days, the methodology, for consistency with the literature, internal consistency, and ease of understanding, uses hospice deaths for its forecast. 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.

In 2008, the Medicare Conditions of Participation were updated for hospice providers to address: a plan of care; personnel requirements; physician contracting requirements; core services; and non-core services. Effective October 2009, the Medicare Payment Advisory Commission (Med PAC) stated that certification and recertification for hospice requires a demonstrated clinical basis for the patient's prognosis. The Affordable Care Act (ACA) of 2010 required physicians or nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180 day recertification as well as each subsequent recertification.

In addition, the ACA requires the collection of data and information to revise a payment methodology for hospice care. No earlier than October 1, 2013, the Centers for Medicare and Medicaid Services (CMS) is required to begin implementation of revisions to the methodology for determining payment rates for routine home care and other services included in hospices.

Prediction of future utilization patterns is affected by many factors, including cancer vs. non-cancer utilization, use by various age groups, and settings where care is provided. Utilization of hospice services has undergone many changes in recent years. Utilization of hospice in nursing homes, residential and inpatient hospice units, and other non-home based settings has increased, and the percentage of hospice patients with a diagnosis of cancer has decreased. 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. These factors require the Commission to continue to monitor trends in utilization.

These changes among hospice providers and patients motivated changes in the need methodology. Major changes in the proposed methodology include:

- A change from a demand based approach for projecting need to setting target use rates based on reported national use rates.
- A change from no accounting of the capacity of existing hospice services to grow and meet future demand to an explicit inclusion of the capacity of existing providers to grow based on their recent trends in the number of deaths served.
- A change in focus from cancer alone to the inclusion of all diagnoses to account for the shift in the diagnostic mix of patients served by hospice programs.

- A change from using all age groups to just using the 35 and over age group in the forecast model because less than 1% of hospice patients are less than 35 years of age.
- A change from a use rate of hospice cancer deaths relative to population cancer deaths to a use rate of all hospice deaths relative to total population deaths.
- A change from a fixed-volume threshold to a variable-volume threshold based on the median number of deaths served by providers.

Policy 3.0: 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 3.1: The Commission will examine how need for hospice services is calculated, and continually assess 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.

.04 Certificate of Need Docketing and Exception Rules: Hospice

The Commission will use rules in this section to determine whether an application to establish a new general hospice program or to expand the services of an existing general hospice to a jurisdiction not previously authorized for service by the existing hospice applicant meets the necessary criteria to allow initiation of Certificate of Need (CON) review by docketing.

A. General Docketing: Establishment of a General Hospice or Expansion into a New Jurisdiction

(1) Except as noted in .04B(1) and (2) below, the Commission will only consider an application for docketing to establish a new general hospice in the jurisdiction or to expand the general hospice services of an existing hospice to that jurisdiction if the net need in that jurisdiction exceeds the volume threshold of that jurisdiction, as determined by the need calculation methodology outlined in .06H of this chapter; and

(2) An application to establish a new general hospice in Maryland or to expand the services of an existing general Maryland hospice to a new jurisdiction will only be docketed if the applicant:

(i) Has experience in providing licensed and Medicare-certified general hospice services in Maryland or in another state; or

(ii) Has experience as a licensed provider of hospital, comprehensive care facility, home health agency, or limited license hospice services in Maryland or in another state.

B. Docketing: Sole Provider Jurisdictions.

(1) If a hospice agency that is the sole authorized 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 jurisdiction has only one authorized general hospice provider, the Commission may docket an application by an existing limited license hospice provider operating in the jurisdiction to become a general hospice in that jurisdiction.

C. Docketing: Inpatient Capacity. A Certificate of Need application by an existing general hospice to establish inpatient capacity or change the inpatient bed capacity operated by the hospice under its general hospice license may be docketed without regard to need projections generated through application of the methodology found in .06H of this chapter.

D. Service Exception. The Executive Director of the Commission may grant an exception to a general hospice to provide specified services to a specified resident of a jurisdiction where the hospice has not been authorized to provide hospice services, under the following circumstances:

(1) If a general hospice is unable to serve a patient in a jurisdiction for which it is authorized, it may request an exception from the Executive Director that permits a Maryland licensed general hospice in a contiguous Maryland jurisdiction to serve that patient.

(2) If a general hospice requests an exception so that it may serve a specific patient in a jurisdiction for which it is not authorized to provide services, it must demonstrate that:

(a) It has specific service capabilities or attributes that would benefit the patient, or that there are unique circumstances regarding the patient and/or the patient's family that make it uniquely qualified to serve the patient;

(b) It has contacted each hospice authorized to serve the jurisdiction; and

(c) Each hospice it contacted either agreed with the requesting hospice as to the validity of the statements made in (a) above or, if an authorized hospice disagreed, the requesting hospice provided the details of any objections to the request.

(3) An exception granted by the Executive Director is limited to the specific patient and does not permit the hospice to serve any other patient in the jurisdiction.

.05 Hospice Standards. The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new general hospice program, expand an existing hospice program to one or more additional jurisdictions, or to change the inpatient bed capacity operated by a general hospice.

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) Skilled nursing care;

(b) Medical social services;

(c) Counseling (including bereavement and nutrition counseling);

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

(a) Physician services and medical direction;

(b) Hospice aide and homemaker services;

(c) Spiritual services;

(d) On-call nursing response

(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management);

(f) Personal care;

(g) Volunteer services;

(h) Bereavement services;

(i) Pharmacy services;

(j) Laboratory, radiology, and chemotherapy services as needed for palliative care;

(k) Medical supplies and equipment; and

(l) 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. Impact. An applicant shall address the impact of its proposed hospice program, or change in inpatient bed capacity, on each existing general hospice authorized to serve each jurisdiction affected by the project. This shall include projections of the project's impact on future demand for the hospice services provided by the existing general hospices authorized to serve each jurisdiction affected by the proposed project.

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

I. Information to Providers and the General Public.

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

(a) Each hospital, nursing home, home health agency, local health department, and assisted living provider 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 prospective patients and their families before services are begun.

J. Charity Care and Sliding Fee Scale. Each applicant shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to hospice services regardless of an individual's ability to pay and shall provide hospice services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospice shall make a determination of probable eligibility.

(2) Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population. Notices regarding the hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, if such a site is maintained. Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families, and provide individual notice regarding the hospice's charity care policy to the patient and family.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each hospice's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income patients who do not qualify for full charity care, but are unable to bear the full cost of services.

(4) Policy Provisions. An applicant proposing to establish a general hospice, expand hospice services to a previously unauthorized jurisdiction, or change or establish inpatient bed capacity in a previously authorized jurisdiction shall make a commitment to provide charity care in its hospice to indigent patients. The applicant shall demonstrate that:

(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and

(b) It has a specific plan for achieving the level of charity care to which it is committed.

K. Quality.

(1) An applicant that is an existing Maryland licensed general hospice provider shall document compliance with all federal and State quality of care standards.

(2) An applicant that is not an existing Maryland licensed general hospice provider shall document compliance with federal and applicable state standards in all states in which it, or its subsidiaries or related entities, is licensed to provide hospice services or other applicable licensed health care services.

(3) An applicant that is not a current licensed hospice provider in any state shall demonstrate how it will comply with all federal and State quality of care standards.

(4) An applicant shall document the availability of a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09.

(5) An applicant shall demonstrate how it will comply with federal and State hospice quality measures that have been published and adopted by the Commission.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient hospice 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 Programs, 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 patients.

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 individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups that have used hospice services at a lower rate than the overall population in the proposed hospice's service area.

O. Patients' Rights. An applicant shall document its ability to comply with the patients' rights requirements as defined in COMAR 10.07.21.21.

P. Inpatient Unit: In addition to the applicable standards in .05A through O above, the Commission will use the following standards to review an application by a licensed general

hospice to establish inpatient hospice capacity or to increase the applicant's inpatient bed capacity.

(1) Need. An applicant shall quantitatively demonstrate the specific unmet need for inpatient hospice care that it proposes to meet in its service area, including but not limited to:

(a) The number of patients to be served and where they currently reside;

(b) The source of inpatient hospice care currently used by the patients identified in subsection (1) (a); and

(c) The projected average length of stay for the hospice inpatients identified in subsection (1) (a).

(2) Impact. An applicant shall quantitatively demonstrate the impact of the establishment or expansion of the inpatient hospice capacity on existing general hospices in each jurisdiction affected by the project, that provide either home-based or inpatient hospice care, and, in doing so, shall project the impact of its inpatient unit on future demand for hospice services provided by these existing general hospices.

(3) Cost Effectiveness. An applicant shall demonstrate that:

(a) It has evaluated other options for the provision of inpatient hospice care, including home-based hospice care, as well as contracts with existing hospices that operate inpatient facilities and other licensed facilities, including hospitals and comprehensive care facilities; and

(b) Based on the costs or the effectiveness of the available options, the applicant's proposal to establish or increase inpatient bed capacity is the most cost-effective alternative for providing care to hospice patients.

.06 Methodology for Projecting Need for General Hospice Services.

A. Methodology Assumptions.

(1) Historical hospice trends, including growth in hospice deaths, are reliable predictors of future capacity of existing providers.

(2) The most recent Medicare Payment Advisory Commission (MedPAC) reported national use rate is an appropriate target for Maryland.

(3) The Maryland death rate will remain constant in the planning window.

B. Period of Time Covered.

(1) Baseline data is calculated based on the five most recent years of available data.

(2) The target year is five years after the most recent baseline year.

C. Services.

(1) General and limited hospice programs are included in both the need projections and inventory.

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

D. Age Groups. Projections are calculated for the 35+ age group. No age adjustment is done.

E. Geographic Areas. Need is projected by jurisdiction.

F. Inventory Rules.

(1) The number, location, and authorized jurisdictions 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.

(3) Patient utilization and demographic data from Maryland hospice programs are obtained from the Commission's Maryland Hospice Survey.

G. Data Sources.

(1) **Population.**

(a) Five year baseline estimates and target year projections of Maryland population by jurisdiction and age group are obtained from the most recent

household population projections provided by the Maryland Department of Planning (DOP).

(b) Population mortality data is obtained from the most recent data provided by the Maryland Department of Health and Mental Hygiene's Vital Statistics Administration (VSA).

(2) **Utilization.**

(a) Hospice utilization and mortality data are obtained from the most recent five years of the Commission's Maryland Hospice Survey, 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) Definition of Terms:

Term	Definition
a	Age – range from 35 to m (max age)
byr	Baseline year – range from byr1 to byr5, with byr5 being the most recent of the five baseline years
$CAGR_i$	Compound Annual Growth Rate over the five baseline years for each jurisdiction
$capacity_{tyri}$	Target year capacity of existing providers for each jurisdiction
$gneed_{tyri}$	Target year gross need for each jurisdiction
hospdth	Total hospice deaths
$hospdth_{byr1}$	Total hospice deaths in the first baseline year
$hospdth_{byr5}$	Total hospice deaths in the most recent baseline year
h	Existing hospice providers – range 1 to n (number of existing hospice providers)
i	Each Maryland jurisdiction – range 1 to 24
j	Each of the five baseline years (byr); range 1-5
$nneed_{tyri}$	Target year net need for each jurisdiction
pop	Total household population
pop_{byr5i}	Baseline total household population (age 35+) in the most recent baseline year for each jurisdiction
pop_{tyri}	Target year total household population (age 35+) for each jurisdiction
totdth	Total population deaths
$totdth_{byr5i}$	Baseline total population deaths (age 35+) in the most recent baseline year for each jurisdiction
$totdth_{tyri}$	Target year total population deaths (age 35+) for each

	jurisdiction
tyr	Target year
$userate_{tyr}$	Target hospice use rate
volthresh	Volume threshold

(2) Steps of Calculation:

(a) Identify the most recent national hospice use rate reported by MedPAC. This will be the ***target hospice use rate*** (*$userate_{tyr}$*).

(b) Based on Maryland VSA data, calculate the ***baseline total population deaths*** for the 35+ age group for the most recent baseline year for each Maryland jurisdiction.

(i) Subset VSA data to include only the 35+ age group.

(ii) Sum total population deaths for the most recent baseline year (j=5) for each jurisdiction (i):

$$\sum_{a=35}^{m} totdth_{byr5ia} = totdth_{byr5i}$$

(c) Based on Maryland DOP data, calculate the ***total household population*** for the 35+ age group for each Maryland jurisdiction for the most recent baseline year and target year.

(i) Subset DOP data to only include the 35+ age group.

(ii) Sum total household population for the most recent baseline year (j=5) for each jurisdiction (i):

$$\sum_{a=35}^{m} pop_{byr5ia} = pop_{byr5i}$$

(iii) Sum total household population for the target year for each jurisdiction (i):

$$\sum_{a=35}^{m} pop_{tyria} = pop_{tyri}$$

(d) Calculate the ***target year total population deaths*** for each jurisdiction (i) by first dividing the *baseline total population deaths* by the *baseline total household*

population for the most recent baseline year for each jurisdiction (i). This proportion is then multiplied by the *target year total household population* for each jurisdiction (i).

$$\frac{totdth_{byr5i}}{pop_{byr5i}} \; x \; pop_{tyri} = totdth_{tyri}$$

(e) Calculate ***target year gross need*** for each jurisdiction (i) by multiplying the *target year use rate* by the *target year total population deaths* for each jurisdiction (i):

$$userate_{tyr} \; x \; totdth_{tyri} = gneed_{tyri}$$

(f) Based on the Commission's Annual Hospice Survey data, sum the ***total hospice deaths*** served by all existing hospice providers for the first and most recent baseline year (j=1,5) for each jurisdiction (i).

$$\sum_{h=1}^{n} hospdth_{jih} = \; hospdth_{byr1i}, hospdth_{byr5i}$$

(g) Calculate the ***Compound Annual Growth Rate*** (CAGR) based on hospice deaths over the five baseline years for each jurisdiction. Apply the formula for CAGR to calculate growth in deaths over the five baseline years

$$\left(\frac{hospdth_{byr5i}}{hospdth_{byr1i}}\right)^{\frac{1}{4}} - 1 = CAGR_i$$

(h) Calculate the ***target year capacity*** of existing hospice providers for each jurisdiction (i) by multiplying the *hospice deaths* in the most recent baseline year by the *CAGR* extrapolated over the five years to the target year for each jurisdiction (i).

$$hospdth_{byr5i} \; x \; (1+CAGR_i)^5 = capacity_{tyri}$$

(i) Calculate ***target year net need*** for each jurisdiction (i) by subtracting *target year capacity* of existing providers from the *target year gross need* for each jurisdiction (i).

$$gneed_{tyri} - capacity_{tyri} = nneed_{tyri}$$

(j) Calculate the ***volume threshold*** by calculating the median number of deaths served statewide by existing hospice providers (h) in the most recent baseline year (j=5).

$median[hospdth_{byr5h=1}$ *to* $hospdth_{byr5h=n}] = volthresh$

(k) If the *target year net need* for a jurisdiction ($nneed_{tyri}$) is greater than the *volume threshold (volthresh)*, then docketing may be considered for that jurisdiction, consistent with .04A(1) of this Chapter.

I. Update, Correction, Publication, and Notification. The Commission will update the hospice need projections periodically and publish them in the *Maryland Register.*

(1) Updated hospice need projections will be based on .06A-.06H:

(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. The Commission intends to update the hospice need projections every three years.

(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.

.07 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 and the costs of care subsidized by DHMH under either of two programs:

(a) General Funds appropriated for day care for eligible adults 55 years of age or older (Health-General §14-205); or

(b) Medical Assistance funds for financially and medically eligible adults aged 16 or older (Health-General §14-304).

(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 one of 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 individuals 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) *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.

(6) *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. Charity care does not include bad debt.

(7) *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.

(8) *Comprehensive Care Facility* means a facility (commonly referred to as a nursing home) 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.

(10) *Hospice Care Program.*

(a) *General Hospice Care Program* means a coordinated, interdisciplinary program of hospice care services, provided in accordance with Health-General §19-901, for meeting the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive medical, nursing, and other health care services through home or inpatient care during the illness and bereavement:

(i) To individuals, who have no reasonable prospect of cure as estimated by a physician; and

(ii) To the families of those individuals.

(b) *Limited Hospice Care Program* means a coordinated, interdisciplinary program of hospice care services, provided in accordance with Health-General §19-901, for meeting 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:

(i) To individuals, who have no reasonable prospect of cure as estimated by a physician; and

(ii) To the families of those individuals.

(11) *Hospice House* means a residence operated by a Maryland licensed general hospice care program that provides home-based hospice services to hospice patients in a home-like environment and the care provided is not billed as general inpatient care.

(12) *Indigent*: "An indigent person" is a person whose annual income, based on the number of persons in the family, falls within the most recently published poverty guidelines of the U.S. Department of Health and Human Services.

(13) *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 10.07.21.26. 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.

(14) *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.

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

(16) *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.

(17) *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.

(18) *Low Income*: "A low-income person" is a person whose annual income, based on the number of persons in the family, falls above the most recently published poverty

guidelines of the U.S. Department of Health and Human Services but below 200% of the poverty guideline.

(19) *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.

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

(21) *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.

(22) *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.

(23) *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.

(24) *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. As of February 2012, the Maryland Department of Aging lists on its website (http://www.aging.maryland.gov/index.html) 113 senior centers in Maryland. In addition, *Senior Center Plus* is a program of structured group activities and enhanced socialization that is designed to have a positive impact on physically frail or cognitively impaired individuals. There are 36 Senior Center Plus sites in Maryland listed on the Maryland Department of Aging website as of February 2012.

(25) *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.