STATE OF MARYLAND

Craig Tanio, M.D.
CHAIR

Ben Steffen
ACTING EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MEMORANDUM

TO: Commissioners

FROM: Paul E. Parker, Director PEP
Center for Hospital Services

DATE: September 20, 2012

SUBJECT: Hospice of the Chesapeake
Establishment of a 14-bed General Inpatient Hospice Facility in Anne Arundel County
Docket No. 12-02-2333

Hospice of the Chesapeake, Inc. ("HOC") seeks Certificate of Need authorization to build a new 14-bed general inpatient facility, and to operate it under its general hospice license on a 6.2-acre campus in Pasadena (Anne Arundel County). The proposed facility would be the second inpatient facility operated by HOC in this jurisdiction. The 14,000 square foot facility will be built as the second of two phases, with the first phase involving the completion of renovations to an existing 26,000 square foot office building that will house HOC's Hospice Service Center, Life Center, Conference Center and administrative offices. All patient rooms will be single-occupancy with private bathrooms. Preliminary capital cost estimates for the project total $5,232,072, with the renovations to the offices totaling $1,642,072, and the cost for constructing the new GIP estimated at $3.59 million, including $2.59 million for new construction and $1.0 million for furniture and fixtures. It is not anticipated that any debt will be incurred in development of this project, with most funding coming from philanthropic donations.

It is anticipated that this facility will be licensed as a "Hospice House" under anticipated DHMH licensure rules and be able to serve "routine residential" and respite care needs below the acuity level of general inpatient care as well. Staff recommends approval of the proposed project.

IN THE MATTER OF	*	**BEFORE THE**
	*	
HOSPICE OF THE	*	**MARYLAND HEALTH**
	*	
CHESAPEAKE, INC.	*	**CARE COMMISSION**
	*	
DOCKET NO. 12-02-2333	*	

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Staff Report and Recommendation

September 20, 2012

I. INTRODUCTION

Background and Project Description

Hospice of the Chesapeake, Inc. ("HOC") is a general hospice serving residents of Anne Arundel County and Prince George's County. A "general hospice program" is, under Maryland regulations, 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."

HOC is the largest provider of hospice services in Anne Arundel County, serving 85% of the patients in this jurisdiction. It is the second-largest provider in Prince George's County, serving 26% of the hospice demand in this jurisdiction in 2010 as reported in MHCC's Hospice Survey. Founded in 1979 as "Arundel Hospice," it has operated as "Hospice of the Chesapeake" for the past eleven years. It has provided hospice care in patients' homes, nursing homes, assisted living facilities, and area hospitals and, in recent years, has operated residential hospice facilities, one of which is authorized to provide general inpatient hospice services; the Creston G. & Betty Jane Tate Foundation Chesapeake Hospice House (Tate Hospice House) in Linthicum (8 residential beds) and the John & Arloine Mandrin Inpatient Care Center ("MICC") in Harwood. The 8-bed MICC was opened in September 2011, and is staffed and equipped to provide general inpatient ("GIP") care to patients who would otherwise require hospitalization for symptom management. MICC is the only GIP hospice facility in the two-county service area. Neither facility is currently licensed as a health care facility under Maryland regulations, although the Maryland Department of Health and Mental Hygiene is currently developing licensure regulations for facilities of this type.

HOC seeks Certificate of Need ("CON") authorization to build a new 14-bed GIP facility, and to operate it under its general hospice license on a 6.2-acre campus in Pasadena.[1] As with MICC, this will allow HOC to bill Medicare and other third party payors for inpatient hospice care. "Inpatient care services" are defined in State regulation as "services provided by a general hospice care program for the purpose of pain control, symptom management, or respite." This is generally consistent with Medicare criteria for GIP but federal regulations stipulate that the pain control and symptom management must be such that it cannot be provided outside of an inpatient setting. Also similar to MICC, HOC intends to dedicate the new beds primarily to GIP care, with the understanding that it may occasionally use the beds for residential or respite care as demands dictate.

The new 14,000 square foot inpatient treatment facility will be built as the second phase of the new campus development, following completion of renovations to an existing 26,000 square foot office building that will house its Hospice Service Center, Life Center, Conference Center and administrative offices later this year. HOC states that all necessary land use

[1] A "health care facility" regulated under the Maryland CON program is required to obtain CON approval to "change" its "bed capacity." [Health-General Article § 19-120(h)]

approvals and all required utilities are currently in place for the new GIP unit. The need for a second GIP facility on the campus is anticipated, and architectural drawings for a 14-bed addition, which would be connected to, and a mirror-image of, the proposed facility, have been provided. All patient rooms are single-occupancy with private bathrooms. Preliminary capital cost estimates for the project total $5,232,072, with the renovations to the offices totaling $1,642,072, and the cost for constructing the new GIP facility estimated at $3.59 million, including $2.59 million for new construction and $1.0 million for furniture and fixtures. The majority of funds for the project are projected to be raised through a capital campaign (approximately $4,132,072). The balance of project funding is anticipated to come through a state bond bill ($600,000) and through a dedicated donation ($500,000). HOC expects to obligate this capital expenditure within 18 months of CON approval, and anticipates an 8-month construction timetable.

Summary of Staff Recommendation

Staff's review of the proposed project's compliance with the applicable State Health Plan criteria and standards in COMAR 10.24.08.14, State Health Plan: Hospice Services, and the remaining criteria at COMAR 10.24.01.08G(3) supports a recommendation of **APPROVAL** of the project.

II. PROCEDURAL HISTORY

A. Review of the Record

Hospice of the Chesapeake submitted a letter of intent for this project on September 12, 2011. Staff acknowledged receipt of the letter of intent on September 21, 2011 (Docket Item ["D.I."] #1).

On February 29, 2012, the Honorable Pamela G. Beidle, the Delegate from Legislative District 32 representing Anne Arundel County and on March 6, 2012, Karen E. Olscamp, FACHE, President and Chief Executive Officer of Baltimore Washington Medical System, each submitted a letter of support for the Hospice of the Chesapeake's CON application (D.I. #2)

On March 13, 2012, Hospice of the Chesapeake filed a CON application (D.I. #3) and it was assigned Matter No. 12-02-2333.

On March 20, 2012, staff acknowledged receipt of the CON application. (D.I. # 4). On that same day, staff requested that *The Capital*, the *Maryland Gazette*, and the *Maryland Register* publish notice of receipt of the application. (D.I. #s 5-7).

On March 28, 2012, *The Capital* and the *Maryland Gazette* sent confirmation regarding publication of the notice of receipt for the application. (D.I. # 8).

On April 10, 2012, staff asked completeness questions (D.I. # 9).

On April 24, 2012, Hospice of the Chesapeake filed the response to completeness questions (D.I. #10).

On June 4, 2012, staff requested the *Maryland Register* publish notice of the docketing of the application. (D.I. #11) On June 18 2012, staff requested that the *Baltimore Sunpaper* (D.I. #12) and the *Maryland Gazette* (D.I. #13) publish notice of docketing of the application.

On June 8, 2012, staff submitted a request for review and comment, along with a copy of the application, to the Anne Arundel County Health Department (D.I. #14).

On June 26, 2012, the *Baltimore Sunpaper* submitted confirmation regarding the publication on the notice of docketing. (D.I. #15)

On June 27, 2012, the *Maryland Gazette* submitted proof of publication regarding notice of docketing on the notice of docketing for the CON application (D.I. #16).

B. Interested Parties

There are no interested parties in this review.

C. Letters of Support and Comments

The applicant provided letters of support for this project from the following persons:

1. Delegate Pamela G. Beidle, 32nd Legislative District representing Anne Arundel County
2. Victoria W. Bayless, President and CEO, Anne Arundel Medical Center
3. Karen E. Olscamp, FACHE, President and Chief Executive Officer, Baltimore Washington Medical System
4. Reverend Dr. James G. Kirk, Chairman of the Board, Hospice of the Chesapeake, Inc.
5. Mark Powell, Board Member, Hospice of the Chesapeake, Inc. and CEO, ARGO Systems, LLC
6. M. Kathleen Sulick, Board Member, Hospice of the Chesapeake, Inc.

III. DEMOGRAPHIC BACKGROUND

Service Area Population

The applicant defines the service area for this project as serving Anne Arundel and Prince George's Counties.

The Maryland Department of Planning projects that the rate of total population growth in Anne Arundel and Prince George's Counties will be lower than the state average over the next 30 years. Both jurisdictions are expected to see substantial growth in their elderly populations. Hospice care is a service predicted to experience growth in demand, primarily originating in the elderly population, which will "boom" over the next 20 years.

Table 1: Trends in Population by Age Group,
Anne Arundel and Prince George's Counties, and State of Maryland, CY 2010 - 2040

Anne Arundel County								
	2010	2020	2030	2040	2010-2020	2020-2030	2030-2040	2010-2040
0-34	245,531	251,560	251,629	256,347	2.46%	0.03%	1.87%	4.41%
35-64	228,461	226,232	217,641	221,555	-0.98%	-3.80%	1.80%	-3.02%
65-74	36,853	54,336	65,093	56,141	47.44%	19.80%	-13.75%	52.34%
75-84	19,321	26,088	38,272	46,088	35.02%	46.70%	20.42%	138.54%
85+	7,490	9,534	12,816	18,418	27.29%	34.42%	43.71%	145.90%
Total	**537,656**	**567,750**	**585,451**	**598,549**	**5.60%**	**3.12%**	**2.24%**	**11.33%**
Prince George's County								
	2010	2020	2030	2040	2010-2020	2020-2030	2030-2040	2010-2040
0-34	432,792	421,212	409,627	408,480	-2.68%	-2.75%	-0.28%	-5.62%
35-64	349,115	352,089	349,955	349,732	0.85%	-0.61%	-0.06%	0.18%
65-74	50,100	81,919	100,610	96,153	63.51%	22.82%	-4.43%	91.92%
75-84	23,125	35,110	59,448	74,217	51.83%	69.32%	24.84%	220.94%
85+	8,288	12,170	19,910	34,269	46.84%	63.60%	72.12%	313.48%
Total	**863,420**	**902,500**	**939,550**	**962,851**	**4.53%**	**4.11%**	**2.48%**	**11.52%**
State of Maryland								
	2010	2020	2030	2040	2010-2020	2020-2030	2030-2040	2010-2040
0-34	2,672,366	2,787,099	2,865,884	2,936,868	4.29%	2.83%	2.48%	9.90%
35-64	2,393,544	2,428,230	2,417,583	2,506,391	1.45%	-0.44%	3.67%	4.71%
65-74	386,357	595,699	733,032	648,839	54.18%	23.05%	-11.49%	67.94%
75-84	223,159	282,260	436,609	537,932	26.48%	54.68%	23.21%	141.05%
85+	98,126	122,868	158,791	231,867	25.21%	29.24%	46.02%	136.30%
Total	**5,773,552**	**6,216,156**	**6,611,899**	**6,861,897**	**7.67%**	**6.37%**	**3.78%**	**18.85%**

Source: Maryland Department of Planning: Total Population Projections by Age, Sex and Race, March 2012

Hospice Programs in Anne Arundel and Prince George's Counties

Anne Arundel County is served by nine (9) general hospice providers. The programs operating in this county include: Community Hospice of Maryland; Evercare Hospice and Palliative Care; Gilchrist Hospice Care; Heartland Hospice Services (Baltimore); HOC; Joseph Richey House & Dr. Bob's Place; Professional Healthcare Resources of Baltimore; Seasons Hospice & Palliative Care of Maryland; and Stella Maris, Inc. HOC is the only hospice providing inpatient hospice service facilities operated under its own license that are located in Anne Arundel County.

Prince George's County is also served by nine (9) general hospice providers. The programs operating in this county include: Capital Hospice, Inc.; Community Hospice of Maryland; Evercare Hospice and Palliative Care; Gilchrist Hospice Care; Heartland Hospice –

Beltsville; Holy Cross Hospice; HOC; Joseph Richey House & Dr. Bob's Place; and Seasons Hospice & Palliative Care of Maryland.

The following table provides the total number of Anne Arundel and Prince George's County patients served by a hospice from 2008 to 2010. Both counties show an increase in the number of patients utilizing hospice services in 2010.

Table 2: Hospice Patients and Proportion of Maryland's Total Hospice Patients Anne Arundel County and Prince George's County, CY 2008 - 2010

Jurisdiction	2008		2009			2010		
	% Total Patients	Number	% Total Patients	Number	%Change 2008-2009	% Total Patients	Number	%Change 2009-2010
Anne Arundel	10.1%	1,816	10.0%	1,903	4.8%	9.5%	1,960	3.0%
Prince George's	9.2%	1,657	8.1%	1,544	-6.8%	8.6%	1,761	14.1%
MARYLAND	100.0%	18,000	100.0%	18,973	5.4%	100.0%	20,525	8.2%

Source: MHCC Hospice Survey

IV. PROJECT CONSISTENCY WITH REVIEW CRITERIA

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a) State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The applicable section of the State Health Plan ("SHP") for this review is COMAR 10.24.08, the State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services. The specific standards to be addressed are found at COMAR 10.24.08.14, Hospice Standards.

COMAR 10.24.08.14: Hospice Standards. The Commission uses the following standards to review Certificate of Need proposals to establish new general hospice program or expand the service of an existing hospice program to additional jurisdictions. The current SHP does not contain standards specifically addressing GIP services.

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

HOC is a general hospice currently licensed to serve Anne Arundel and Prince George's counties, which together constitute the proposed service area for the project. Each county is served by a total of 9 general hospice programs. As previously noted, two hospice facility programs operate in the service area, both operated by HOC; the Tate Hospice House in Linthicum (8 residential beds) and MICC, in Harwood (8 general inpatient beds). The applicant has complied with this standard.

B. Admission Criteria. An applicant shall identify:

1) Its admission criteria; and
2) Proposed limits by age, disease or caregiver.

HOC states that "the GIP unit will provide short-term medical crisis intervention for hospice patients who require pain control or symptom management that cannot be provided in a home-care setting" and cites the criteria governed by the Centers for Medicare and Medicaid Services (CMS) for GIP services as its admission guidelines. No limitations based either upon age, disease or caregiver are noted by the applicant.

The application is consistent with this standard.

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

The applicant has confirmed that it directly provides the listed services, and is compliant with this standard.

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.

The applicant states that it provides, either directly or indirectly, all of the listed services. The project is consistent with this standard.

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

The applicant notes that bereavement services are available for a period of at least 13 months following the death of a patient, exceeding the standard.

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.

The applicant has specified that GIP services will be provided in the proposed facility, consistent with this standard.

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

Volunteers trained in the care of hospice patients and bereavement are members of the HOC care team, and provide non-medical support for patients and family members. HOC is a licensed and Medicare-certified hospice. HOC projects the ability to have sufficient numbers and commits to provide appropriate training to volunteers to meet the needs of GIP patients. The proposed project is consistent with this standard.

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.

This standard is not directly applicable to this project proposal. While HOC is a provider of hospice services in patients' residences and, in that role, states that it currently provides appropriate instruction and support for primary care givers, the proposal before the Commission is the creation of a GIP facility that will deliver services outside of the patient's residence.

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.

HOC is both licensed and Medicare-certified, and will accept both Medicare and Medicaid patients in its GIP service. The *Payment for Services* policy, a copy of which was provided by HOC, states that HOC "shall accept appropriate patients and their families regardless of their ability to pay for services." The project is consistent with this standard.

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.

HOC notes that it "maintains a team of professionals who are responsible for educating the medical community on the programs and services it offers." The proposal is considered to be consistent with the standard. MHCC has calculated that Anne Arundel County experienced a "hospice use rate" (hospice deaths/population deaths) of 0.44 in 2010, among the highest in the

state, which indicates that HOC, the jurisdictions dominant hospice service provider, may be effective in providing information to its service area population. The 2010 hospice use rate for Prince George's County residents, as calculated by MHCC, was 0.23. The project is consistent with this standard.

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

HOC's current daily fees for general hospice care are identified in its *Payment for Services and Requests for Charitable Adjustments* policy, a copy of which was provided. The policy does not address fees for general inpatient care; however, the HOC *Private Insurance Financial Plan* form, indicates that the current daily rate is equal to the CMS rate which is $698.33. The *Payment for Services* policy states that payments received from Medicare or Medicaid will be considered payment in full for care provided. The project is consistent with this standard.

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.

HOC's *Payment for Services and Requests for Charitable Adjustments* policy is provided to, and discussed with, patients and their families prior to admission. The policy states "When necessary and determined feasible, Hospice of the Chesapeake will use extended payments or a claim on an estate for the payment for hospice services." The applicant is consistent with this standard.

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 serves 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.

HOC's proposed budgets for FY 2015 and 2016 project charity care provision equivalent to 5% of gross inpatient revenues, amounting to $117,288 and $153,233, respectively, in charity care for GIP patients in the first two full years of operation for the program.

The applicant has provided a complete set of policies, procedures, notices, application forms and contracts covering charity care and sliding fee arrangements, which are provided to all patients and families at the time of admission. The policy provides that the determination of eligibility for charitable adjustment of fees will be made within two days of request for consideration, satisfying the requirements of this standard.

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

HOC is licensed and Medicare-certified in good standing, attesting to its compliance with this standard.

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 is 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.

The project will provide GIP services directly through its nursing staff in the proposed 14-bed facility. The applicant states that, where necessary, HOC will utilize its established contractual relationships with other health care providers in Anne Arundel County to provide additional services, satisfying this standard.

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

HOC states that "the GIP unit will provide respite care which will be billed at the appropriate rates." HOC indicates that the daily rate for respite care is $164.44. The project is consistent with the standard.

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.

HOC's Life Center provides an extensive array of public education and outreach programs for the community at large. The applicant notes that the proposed GIP unity will have access to, and benefit from, all of the educational programs offered by HOC. The proposal is consistent with this standard.

O. Patients' Rights. An applicant shall document its compliance with the patients' rights requirements of COMAR 10.07.21.21.

HQA has provided a copy of its *Statement of Patient and Family Rights and Responsibilities*, which includes each of the 12 rights enumerated in COMAR 10.04.21.21. This, and other related policies including Patient Self Determination, Primary Caregiver Responsibilities and the Patient/Hospice Agreement are provided to, and discussed with, the patient and family members during the admission process. The project complies with this standard.

PART TWO: REMAINING CERTIFICATE OF NEED REVIEW CRITERIA

The project's compliance with the five remaining general review criteria in the Regulations governing Certificate of Need is assessed below:

B. NEED

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

In the absence of quantitative need analysis methodologies in the State Health Plan, the applicant has provided an assessment of the unmet need for GIP services for its hospice patients in Anne Arundel and Prince George's counties who require acute medical care. This assessment is summarized and discussed below.

HOC cites data provided through the National Hospice and Palliative Care Organization revealing that demand for hospice services nationally has grown at an annual rate of 4% since 2007, a pace identical to the average annual growth in patients served by HOC since 2009. Despite the very rapid historical and anticipated growth rate of the elderly population, and the growth in acceptance of hospice care generally, the applicant has conservatively estimated that this annual rate of growth in demand its for services will remain flat at 4% for the purposes of program planning. Table 3 below shows historical and projected overall utilization of HOC's services from 2009 to 2016.

Table 3: HOC Historical and Projected Utilization 2009-2016

	2009	2010	2011	Avg. Annual % Change 2009-2011	2012	2013	2014	2015	2016
Total Patients Served	1,881	1,917	2,037	+4%	2,118	2,203	2,291	2,383	2,478

Source: Historical data from HOC records

The applicant anticipates that 38% of all patients served annually by HOC will receive GIP care in its dedicated facilities each year. This is equivalent to the experience of the seven other

hospices in Maryland that report availability of GIP services operated under their general hospice license. The table below shows the utilization experience of these hospice inpatient facilities.

Table 4: Inpatient Use Rates for Maryland Hospice GIP Programs 2009-2010

	2009			2010		
	Inpatients	Patients Served	IP/ Total Patients	Inpatients	Patients Served	IP/ Total Patients
Carroll	374	747	50%	351	728	48%
Coastal	371	820	45%	390	821	48%
Gilchrist	1116	3301	34%	1453	3702	39%
Joseph Richey	171	296	58%	155	246	63%
Montgomery	406	1462	28%	554	1856	30%
Seasons	691	2241	31%	697	2615	27%
Stella Maris	503	820	61%	467	875	53%
Total – All GIP	**3,632**	**9,687**	**37%**	**4,067**	**10,843**	**38%**

Source: MHCC Hospice Survey, 2009 and 2010

While this percentage is significantly higher than the 22.4% of HOC's patients who receive acute care in contracted general hospital beds currently, the applicant explains that the prospect of admission to an ordinary acute care hospital facility has proven to be very unattractive to patients who have chosen to die at home, or in a home-like environment. Staff notes that the target GIP utilization rate of 38% is similar to the 40% rate projected by Hospice of Queen Anne's, whose GIP proposal was reviewed and approved recently by the Commission, based upon its review of the clinical appropriateness for such care using the Centers for Medicare and Medicaid Services admission criteria.

Applying the 38% benchmark of demand for GIP services to the projected overall volume of patients from Table 4, the applicant estimates that 805 patients will utilize GIP services in 2012, with the number increasing to 942 patients in 2016.

HOC has used a target average length of stay (ALOS) of 7.0 days for its proposed GIP program. This duration of treatment is somewhat longer than the 6.1 day ALOS experienced in its Mandrin Center during the first 7 months of its operation, but less than the average of dedicated GIP programs in Maryland, as shown in the table below.

The lengths of stay calculated in Table 5 are clearly skewed by the data reported by the Joseph Richey House in Baltimore, and removing this outlier from the ALOS calculations for 2009 and 2010 would result in mean lengths of stay of 6.6 and 6.4 days, respectively. The applicant addresses this issue by stating that it has targeted its ALOS based upon the experiences of Montgomery Hospice and Gilchrist Hospice, as these two non-profit programs are most similar to HOC in terms of service area demographics, overall size and patterns of care. These two GIP programs' ALOS averaged 7.0 days in 2010.

Table 5: Average Lengths of Stay in Maryland Hospice GIP Programs 2009-2010

	2009			2010		
	GIP Days	Inpatients Served	ALOS	GIP Days	Inpatients Served	ALOS
Carroll	1,551	374	4.1	1,572	351	4.5
Coastal	2,623	371	7.1	2,551	390	6.5
Gilchrist	8,529	1,116	7.6	9,416	1,453	6.5
Joseph Richey	5,672	171	33.2	7,597	155	49.0
Montgomery	3,217	406	7.9	4,158	554	7.5
Seasons	4,308	691	6.2	5,000	697	7.2
Stella Maris	2,451	503	4.9	2,364	467	5.1
Total – All GIP	**28,351**	**3,632**	**7.8**	**32,668**	**4,067**	**8.0**

Source: MHCC Hospice Survey, 2009 and 2010

Finally, the applicant used a target occupancy rate of 85% for the purposes of projecting the demand for GIP beds for its patients. Applying the projected ALOS and occupancy rates to the expected inpatient volume, the applicant calculates the following need for GIP beds in its service area by 2016.

Table 6: Calculated GIP Bed Need, HOC Service Area
2016

	Forecast GIP Volume	Patient Days At 7.0 Day ALOS	GIP Avg. Daily Census	Bed Need at 85% Bed Occupancy
Anne Arundel County	745	5,215	14.3	16.8
Prince George's County	197	1,379	3.8	4.5
Total	**942**	**6,594**	**18.1**	**21.3**

Source: Application; calculations corrected by MHCC staff

HOC has rounded up the calculated need to 22 beds, citing its desire to be certain of meeting its patients' needs. Since the service area currently has an inventory of 8 GIP beds operated at HOC's MICC, the applicant concludes that a net unmet need for 14 GIP beds exists in Anne Arundel and Prince George's counties.

Responding to MHCC staff's request, HOC has provided utilization data for its Mandrin Center from its opening in mid-September 2011 to mid-April 2012. During this roughly 7 month ramp-up period, the GIP program has treated a total of 137 patients for a total of 836 patient days, achieving an average daily occupancy of nearly 50%, using an estimated 1,702 possible days of care (7 months x 30.4 days per month x 8 beds).

The applicant has provided a reasonable needs assessment for the proposed project. The proposed facility, like the existing Mandrin Center, is intended to accommodate patients needing GIP services but both will have the flexibility to also be used for respite care, as needed, and for routine hospice care, below the GIP acuity level, if a bed is needed for these purposes. Overflow in demand for routine hospice care can be accommodated and may be needed, based on waiting list that have been experienced at the Tate Hospice House. So, even if demand projections for GIP are not realized, the proposed facility will serve a wider range of patient demands, providing a greater level of assurance that the service capacity proposed will be utilized.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

The only existing alternative to the proposed project, other than the HOC-owned MICC GIP program, is the provision of acute care services in area hospitals or other inpatient settings.

From a cost perspective, given that hospice care, in general, and GIP care, in particular, is primarily used by Medicare patients, a potential provider must show that it will be able to subsist financially with its primary income generated through Medicare's GIP per diem rate. As shown in the discussion of the *Viability* criterion later in this report, HOC has projected that it will generate positive cash flow from the GIP operation by its second full year of operation in 2016.

Additionally, the applicant notes that under its current contractual relationships with area hospitals for the provision of acute care services, it must assign 90% of the Medicare GIP per diem to the hospital caring for the patient, and the hospital must accept that reimbursement as full payment for the care it provides, including room and board, nursing care and all ancillary and medication expenses. As an example, HOC states that the current GIP per diem for Anne Arundel patients is $689.33, meaning that the two major hospital providers[2] for these HOC patients must accept about $620 as payment in full for care which reportedly costs the hospitals in excess of $1,000 per day to provide, *exclusive* of ancillary and medications expense. Likewise, HOC argues that the remaining $69 must cover the cost of its patient care planning and coordination, bereavement, social work and other services. HOC reports that its costs exceed this reimbursement level.

Beyond financial considerations, the availability of GIP in a dedicated free-standing facility is arguably a more effective and desired alternative than hospitalization for patients, their caregivers and significant others in terms of the continuity of patient care, accessibility and preferred treatment environment. This view is corroborated in letters of support for the project from Baltimore Washington Medical System and from the chief executive officer of Anne Arundel Medical Center, who notes in her letter that "…a hospice inpatient unit will offer our patients and their families a more appropriate and less costly alternative for end of life care."

Commission staff finds that the applicant has reasonably demonstrated that offering GIP services in its proposed facility is the most cost-effective means of meeting the short-term acute care needs of its target population.

[2] Anne Arundel Medical Center and Baltimore Washington Medical Center.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Project Cost

HOC has engaged the services of the firm Marks, Thomas Architects (MTA)[3] to assist with the development of the GIP. An existing building is located on the proposed site. The applicant states the need to complete renovations to this building before relocating the HOC offices, then starting with the construction for the proposed GIP facility. The proposed project will consist of two phases during construction. Phase 1 will include the renovations to the existing 26,000 square foot office building located on the HOC campus. The project will complete renovations to the Hospice Service Center, the Life Center, a Conference Center, and to administrative offices. The total estimated cost for the renovations is $1,642,072, which will include minor work to the building, plumbing, HVAC, and electrical systems.

Upon completion of these renovations, Phase 2 will involve the construction of a 14,000 square foot GIP that will include 14 inpatient beds. HOC's plans for the GIP are in the "concept stage" with the size of the proposed facility similar to the existing 14-bed Casey House inpatient hospice operated by Montgomery Hospice in Rockville, Maryland. The applicant states it will complete the final plans for the proposed GIP with the completion and approval of the CON application. The project budget estimate and the sources of funds are outlined in the following Table 7.

HOC estimates that the proposed costs for the 14,000 square foot GIP will be $180.00 per square foot and that the costs for furniture and fixtures will be $71.42 per square foot.

Regarding the sources of funds for this project, HOC has received a $600,000 bond bill from the State of Maryland for the renovation of the office building. Interested donors have also given $500,000 in restricted funds for the renovation project. The balance of the project, $4,132,072, will be raised through a Capital Campaign.

Revenues and Expenses

All hospices receive a standard payment per day for a given level of care. The Centers for Medicare & Medicare Services sets a flat per diem rate annually for hospice care, which other payers utilize to set their level of payment. The flat per diem rate covers all services provided by the hospice for care of the terminally ill, including drugs and bereavement care given to the family after death. Hospice care is all-inclusive, with no service-based fee schedule that might be altered.

[3] The firm Marks, Thomas Architects was selected because of their experience in designing the Gilchrist Inpatient Hospice Center located in Towson, Maryland.

Table 7: Project Budget Estimate – Uses and Source of Funds
Hospice of Chesapeake

A. Use of Funds	Cost Estimate
New Construction	
Building	$2,590,000
Other Capital Costs	
Other (Furniture & Fixtures	$1,000,000
Subtotal – New Construction	$3,590,000
Renovations	
Building	$1,427,888
Subtotal - Renovations	$1,427,888
General Requirements	$114,231
Overhead (at 2%)	$28,558
Contractor Profit (at 5%)	$71,394
Subtotal – Non Capital Costs	$214,184
Subtotal - Renovations	$1,642,072
Total Proposed Capital Costs	$5,232,072
B. Source of Funds	
New Construction	
Cash (Raised from Capital Campaign)	$3,590,000
Renovations	
State Bond Bill	$600,000
Restricted Funds	$500,000
Cash (Raised from Capital Campaign)	$542,072
Total Source of Funds	$5,232,072

Source: Exhibit II, CON Application (D.I. #3) and Exhibit 2, Request for Additional Information (D.I. #10)

Medicare defines four levels of care, each with its own per diem rate. These rates are subject to a wage component adjustment that varies by census region. HOC indicates all hospices in its census region will receive the following per diem rates for fiscal year 2012:

- Routine Home Care - $151.23
- Continuous Home Care - $881.80
- Inpatient Respite Care - $164.44
- General Inpatient Care - $671.84

HOC's budget data for the proposed project for the first two full years of operation of the GIP follows.

Table 8: Revenue and Expense for Proposed Project
Hospice of the Chesapeake

	2014	2015	2016
Revenues			
Inpatient Services	$369,417	$2,345,757	3,064,668
Allowance for Bad Debt	(1,513)	(10,000)	(13,000)
Contractual Allowance	(3,694)	(23,458)	(30,647)
Charity Care	(18,471)	(117,288)	(153,233)
Net Patient Care Services	$345,739	$2,195,012	$2,867,788
Expenses			
Salaries, Wages, and Professional Fees	$727,001	$1,977,442	$2,016,990
Contractual Services – Patient Related	61,662	268,299	290,148
Project Depreciation	51,339	205,357	205,357
Supplies	24,000	98,880	101,846
Other Expenses	15,000	61,800	63,654
Total Operating Expenses	$879,002	$2,611,778	$2,677,996
Income			
Income from Operation	($533,264)	($416,766)	$189,791
Non Operating Income – Donors	75,000	75,000	75,000
Net Income (Loss)	($458,264)	($341,766)	$264,791

Source: Request for Additional Information (D.I. #10)

The data in Table 8 assumes GIP services will start in October 2014, with an average daily census ramping up from four patients in 2014 to seven patients by 2015. Charity care is projected at 5% of gross revenue, contractual allowance at nearly 1%, and allowance for bad debt at about 0.4% of gross inpatient services revenue. The payer mix is projected to be:

Medicare	85%
Medicaid	1%
Blue Cross	2%
Commercial Insurance	7%
Charity Care	5%
Total	100%

Table 8 indicates that HOC projects the ability to generate income from operations by 2016.

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. To avoid penalty, the aggregate number of inpatient days may not exceed 20 percent of the total number of days of hospice care provided to all Medicare beneficiaries during any given year.

As shown in the table below, HOC reports that, historically, GIP patient days have accounted for less than two percent of total patient days. HOC projects that it will remain below two percent in the future, well beneath the CMS limitation.

Table 9
Historical and Projected Patient Days of Service
HOC GIP and Non-GIP Programs, 2010 – 2016

	2010	2011	2012	2013	2014	2015	2016
Non-GIP	93,488	102,386	109,553	117,222	125,427	134,207	143,602
GIP	997	1,624	2,030	2,100	2,135	2,153	2,170
Total	94,485	104,010	111,583	119,322	127,562	136,360	145,772
% GIP Days	1.1%	1.6%	1.8%	1.8%	1.7%	1.6%	1.5%

Source: Application, Table I (Revised)

Staffing

Hospice of the Chesapeake projects the following staffing pattern (overall operation) and costs for its payroll employees (no contract staff numbers or costs are shown) with the establishment of the 14-bed GIP.

Table 10: Projected Staffing – Payroll Staff Employees Only
Hospice of Chesapeake

Position	Current FTE	Change in FTEs	Total FTEs	Average Salary Rate	Total Cost
Administration					
Executive & Directors	13.9	0	13.90	$95,000	$1,320,500
Managers	17.6	1.10	18.70	85,000	1,589,500
Direct Care					
RNs	42.4	12.60	55.00	73,000	4,015,000
LPNs	10.3	0	10.30	53,200	547,960
Aides	43.4	9.24	52.64	39,000	2,052,960
Physicians	5.7	0.55	6.25	135,000	843,750
Dietary Consultant	0.2	0.66	0.86	66,000	56,760
Social Worker	13.1	1.10	14.20	50,000	710,000
Chaplain	5.8	0.55	6.35	45,000	285,750
Support					
Support	57.7	2.31	60.01	45,000	2,700,450
Subtotal	210.1	28.11			$14,122,630
				Benefits	$2,118,395
				TOTAL	$16,241,025

Summary

The applicant has reasonably demonstrated that it can obtain the resources necessary for project development and its assumptions with respect to use, revenue, expenses, staffing, and payer mix are reasonable. Staff finds that the project is viable.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e)Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

HOC received approval to extend its existing hospice services in Anne Arundel County to Prince George's County on May 19, 2000 (Docket No. 99-16-2069). There were no conditions placed on this approval. MHCC records do not indicate that HOC failed to comply with any of the terms of this CON approval.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Commission staff notes that MHCC has received no letters of objection to the proposed project from other potentially-affected hospices authorized to serve Anne Arundel and Prince George's Counties. As noted previously, the Commission has received letters of support for the project from the two acute care hospitals that provide the vast majority of GIP services for HOC patients, those being Baltimore Washington Medical Center and Anne Arundel Medical Center.

The only existing inpatient hospice facility within the two-county service area is the eight-bed Mandrin Inpatient Care Center (MICC), which is owned and operated by HOC. The two local hospitals have each submitted letters that speak to their long history and strong partnership with HOC, with both institutions indicating their support for the project. The two hospitals view the proposed project as having a positive impact on the health care system in the service area by providing a service that will improve geographic and financial accessibility, continuity of care and a preferred treatment environment for hospice patients that provides a home-like setting for those with advanced illness approaching the end of their lives.

Staff finds that the proposed project will not have a negative impact on existing providers or the health care delivery system.

III. SUMMARY AND STAFF RECOMMENDATION

Staff has analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards in COMAR 10.24.08.14, and with Certificate of Need review criteria at COMAR 10.24.01.08G(3)(b)-(f).

In summary, the applicant has presented a reasoned argument for Hospice of the Chesapeake to expand its existing inpatient service capacity in the manner proposed. HOC is certified to participate in the Medicare program, licensed by the State of Maryland, and accredited by the Joint Commission. The proposal will allow the applicant to expand and enhance services by offering hospice care to patients and their families in a private and home-like setting. The establishment of this general inpatient unit appears to be cost-effective and viable in both the short- and long-term and would not have a negative impact on access to care in the service area and is unlikely to have a measurable impact on other service providers. The project complies with the applicable State Health Plan standards.

Based on these findings, Staff recommends that the project be **APPROVED.**

IN THE MATTER OF	*	**BEFORE THE**
	*	
HOSPICE OF THE	*	**MARYLAND HEALTH**
	*	
CHESAPEAKE, INC.	*	**CARE COMMISSION**
	*	
DOCKET NO. 12-02-2333	*	

*** ***

FINAL ORDER

Based on Commission Staff's analysis, it is this 20th day of September, 2012, **ORDERED** that:

The application for Certificate of Need submitted by Hospice of the Chesapeake, Inc. to establish a 14-bed residential facility in which it can directly provide general inpatient hospice care in Pasadena and undertake other construction and renovation expenses for program and administrative space, Docket No. 12-17-2329, at an estimated cost of $5,232,072, be **APPROVED.**

MARYLAND HEALTH CARE COMMISSION

September 20, 2012