

STATE OF MARYLAND



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MEMORANDUM

TO: Commissioners

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

DATE: July 19, 2012

SUBJECT: Hospice of Queen Anne's, Inc.
Change in the Bed Capacity of a Hospice
Docket No. 12-17-2329

Hospice of Queen Anne's, Inc. ("HQA") is a general hospice authorized to serve Queen Anne's County. In 2008, it established a "Residential Hospice Center" in Centreville. This six-bed facility is unlicensed and provides a setting where hospice patients can reside and receive general hospice services from HQA just as they would if residing in their own homes. HQA seeks Certificate of Need authorization to operate the Residential Hospice Center as a General Inpatient ("GIP") hospice facility under its general hospice license. This will allow HQA to bill Medicare and other third party payors for inpatient hospice care. HQA states that the Center will continue to provide routine hospice care in the facility in addition to GIP care, i.e., care consistent with that provided since 2008 that falls below the level of general inpatient care. All patient rooms are single-occupancy with private bathrooms.

HQA states that the existing physical facility of the Center currently meets code requirements for GIP care, and that only minimal fire safety renovations would be required to complete the project. There is no debt service on either the land or existing building. The total projected capital costs of \$11,400 would come from cash on hand.

Staff recommends approval of the project.

IN THE MATTER OF

HOSPICE OF QUEEN ANNE'S

DOCKET NO. 12-17-2329

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BEFORE THE MARYLAND

HEALTH CARE COMMISSION

Staff Report and Recommendation

July 19, 2012

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I. INTRODUCTION

Background and Project Description

Hospice of Queen Anne's, Inc. ("HQA") is one of two licensed general hospice providers authorized to serve Queen Anne's County on the Eastern Shore and serves nearly all of the general hospice patients originating in that county's population. 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."

HQA was founded in 1985. In 2008, it established a "Residential Hospice Center" in Centreville. This six-bed facility is unlicensed and provides a setting where hospice patients can reside and receive general hospice services from HQA just as they would if residing in their own homes. HQA states that patients from Queen Anne's, Kent, Caroline, and Talbot County have been served in this facility. A similar facility is operated in Talbot County by the Talbot Hospice Foundation and, until recently, a smaller facility of this type was operated in Caroline County by the Caroline Hospice Foundation. The Maryland Department of Health and Mental Hygiene's Office of Health Care Quality is currently developing licensure regulations for facilities of this type.

HQA seeks Certificate of Need ("CON") authorization to operate the Residential Hospice Center as a General Inpatient ("GIP") hospice facility under its general hospice license.¹ This will allow HQA 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. HQA states that the Center will continue to provide routine hospice care in the facility in addition to GIP care, i.e., care consistent with that provided since 2008 that falls below the level of general inpatient care.

The Residential Hospice Center is built on a 3.5-acre tract of land owned by the applicant, and an adjacent two-acre parcel has recently been purchased, providing the potential for expansion of the Center. There is no debt service on either the land or building. All patient rooms are single-occupancy with private bathrooms. HQA states that the existing physical facility of the Center currently meets code requirements for GIP care, and that only minimal fire safety renovations would be required to complete the project. The purchase of a laptop computer and documentation cart are the only planned equipment purchases. The total projected capital costs of \$11,400 would come from cash on hand. The applicant reports that all necessary land use approvals and all required utilities are currently in place. Implementation of GIP services is anticipated within one year of CON approval.

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)]

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 Queen Anne's, Inc. a letter of intent for this project on July 20, 2011. Staff acknowledged receipt of the letter of intent on September 21, 2011 (Docket Item ["D.I."] #1).

On January 26, 2012, HQA filed a CON application (D.I. #2) and it was assigned Matter No. 12-17-2329.

On January 27, 2012, staff acknowledged receipt of the CON application. (D.I. # 3). On that same day, staff requested that the *Record Observer* and the *Maryland Register* publish notice of receipt of the application. (D.I. #s 4-5).

On February 1, 2012, the *Record Observer* sent confirmation regarding publication of the notice of receipt for the application. (D.I. # 6).

On February 17, 2012, staff asked completeness questions (D.I. # 7).

On March 7, 2012, HQA filed a revised CON application (D.I. # 8) and a response to completeness questions (D.I. #9).

On March 26, 2012, staff requested the *Maryland Register* publish notice of the docketing of the application. (D.I. #10) On April 10, 2012, staff requested that the *Record Observer* publish notice of docketing of the application (D.I. # 11).

On April 10, 2012, staff submitted a request for review and comment, along with a copy of the application, to the Queen Anne's County Health Department (D.I. #12). On April 17, 2012, the Queen Anne's County Health Department indicated no comment to the MHCC's request (D.I. # 13).

On April 20, 2012, staff sent a letter informing the applicant that the CON application was docketed effective April 6, 2012 and requested additional information (D.I. # 14).

On April 25, 2012, the *Record Observer* submitted confirmation regarding the publication of the notice of docketing (D.I. #15)

On May 4, 2012, HQA responded to the request for additional financial information (D.I. #16).

On May 24, 2012, the Washington Examiner submitted proof of publication regarding notice of docketing on notice of docketing of the CON application (D.I. #21).

B. Interested Parties

There are no interested parties in this review.

C. Letters of Support and Comments

No letters of support for this project were filed. No comments were provided by local government.

II. DEMOGRAPHIC BACKGROUND

Service Area Population

The applicant defines the service area for this project as the largely rural counties of Queen Anne’s, Caroline, Kent and Talbot, all on Maryland’s mid-Eastern Shore.

As shown in the following table, the Maryland Department of Planning projects that the overall rate of population growth in all but one of the service area counties will be slightly higher than the state average during the 2010 to 2015 period. All but Caroline County have an older than average population but only Queen Anne’s County’s elderly population is currently projected to be growing faster than that for the state as whole. Hospice care is primarily a geriatric health care service. In FY 2010, 81% of the state’s total hospice patients were aged 65 and older; 65% were aged 75 and older.

**Table 1: Overall Population and Age 65+ Population Growth, 2010-2015
Proposed Service Area and Maryland**

	Overall Population			Population 65+			
	2010	2015	% Change 2010-2015	2010	2015	% of 2015 Overall Pop.	% Change 2010-2015
Queen Anne’s	47,372	49,807	5.1%	7,140	8,580	17.2%	20.2%
Caroline	32,624	34,061	4.4%	4,410	4,790	14.1%	8.6%
Kent	18,671	19,136	2.5%	4,400	5,100	26.7%	15.9%
Talbot	37,399	38,794	3.7%	8,960	10,410	26.8%	16.2%
Four-County Region							
Maryland	5,635,177	5,817,347	3.2%	735,660	882,090	15.2%	2.0%

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

Hospice Programs in the Mid-Shore

Queen Anne’s County is served by two general hospice providers, HQA and Chester River Home Care and Hospice, based in Kent County. HQA serves the vast majority of county residents, having provided care to 185 residents in FY 2010 compared with 2 residents served by Chester River Home Care and Hospice. HQA operates the only residential hospice center in the county, which accepts patients from the surrounding counties when there is a need and beds are available.

Caroline County is served by one general hospice program, Shore Home Care and Hospice. This program reported serving 95 Caroline County residents in FY 2010. The Caroline Hospice Foundation operates a hospice program under a “limited license.” A “limited hospice care program” is defined in state regulation as “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 nonskilled services during illness and bereavement through a home-based hospice care program.” Until April of 2012, Caroline Hospice Foundation operated a three-bed residential hospice center, similar to that currently operated by HQA, in Denton. HQA reports that referrals from Caroline County to HQA’s Residential Hospice Center have increased since this closure.

Kent County has only one authorized general hospice provider, Chester River Home Care and Hospice. It served 96 patients in FY 2010. The applicant states that Chester River Home Care and Hospice provides general inpatient hospice care through an arrangement with a nursing home in Chestertown and that this hospice frequently make referrals to HQA’s Center.

Talbot County is served by a single general hospice program, Shore Home Care and Hospice, that reported serving 166 residents of Talbot County residents in FY 2010. The Talbot Hospice Foundation operates under a limited hospice license and operates a six-bed residential hospice facility in Easton similar to the HQA facility. Shore Home Care and Hospice provides needed “skilled services” to the residents of that facility. Shore Home Care and Hospice is a subsidiary of Shore Health System, which operates the only general hospital in Talbot County. Shore Health System is part of the University of Maryland Health System.

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 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 programs, or expand an existing hospice program to one or more additional jurisdictions. As such, they are of limited relevance to the proposed project.

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

HQA is a general hospice currently authorized to only serve Queen Anne’s County. The proposed GIP facility serve patients referred from other jurisdictions. There are no GIP facilities on the Eastern Shore operated by a general hospice. This level of care has been provided

through arrangements between general hospice programs and hospitals and nursing homes. 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.***

HQA has provided a copy of its proposed "General Inpatient Admission Criteria" for review. Admission to the GIP service will be "made available to all hospice patients who are in need of pain control or symptom management that cannot be provided in any other setting." No limitations based upon age, disease or caregiver are noted in the policy, which states "The policy of HQA is to consider all applicants for general inpatient admission regardless of age, race, creed, gender, religion, sexual orientation, diagnosis or ability to pay."

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 the 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 has documented that provides, directly or indirectly, all of the listed services, consistent with the 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.

HQA notes that its bereavement services are available for a period of 13 months following the death of a patient, in compliance with this 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.

HQA provides hospice services in private homes and in its Residential Hospice Center. It proposes to continue to provide services in these settings but seeks Certificate of Need approval to establish licensed bed capacity for inpatient care services within its Residential Hospice Center in order to provide GIP hospice care. It states that it is already providing care in the Center at this level but is unable to bill Medicare for GHP hospice care, which is a primary motivation for this request for CON authorization. The applicant has complied 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 HQA care team and provide companionship and caregiving for patients and respite care for family members. As a licensed and Medicare-certified hospice, it may be reasonably assumed that the numbers and training of HQA volunteers will also be sufficient to meet the needs of GIP patients. The proposed program is considered to be consistent with the 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 HQA is a provider of hospice services in patients' residences and, in that role, would be expected to provide appropriate instruction and support for primary care givers, the proposal before the Commission is the creation of a GIP service capability, for care delivered 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.

HQA is both licensed and Medicare-certified, and accepts Medicare and Medicaid patients, 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.*

The applicant has provided a copy of its "2012 Communications Plan" that addresses each of the required information elements and audiences and includes each of the listed entities. The proposal is consistent with the standard.

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

HQA's fees are clearly identified in the informational packet presented to clients and their families before services are rendered, a copy of which has been provided with the application. The project is consistent with the 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.*

HQA has provided copies of its *Financial Responsibility* policy, its *Determination of Adjusted Daily Rate* notice, its *Financial Worksheet for Calculating the Adjusted Daily Rate*, its *Promissory Note* form, its *Contract for Hospice Center Services* and its *Notice of Service* form, all of which are discussed, as appropriate, with the patient or representative prior to admission. The applicant complies 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 services are begun;*
5. *Provide documentation that an individual notice of charity care is provided to each person who seeks services in the hospice program; and*
6. *Make a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.*

HQA's proposed budgets for FY 2012 and 2013 project charity care provision at 1% of gross patient revenues, amounting to \$7,646 in charity care for GIP patients in the first full year of operation of the program.

As noted under Standard I, above, the applicant has provided a complete set of policies, procedures, notices, promissory note forms and contracts covering charity care and sliding fee arrangements. It cannot be determined from these documents whether these arrangements are consistently concluded within two business days of initial requests for financial assistance in paying for clients' care; however, the policies clearly state that the arrangements are to be completed upon admission, which appears to be consistent with the spirit of the standard.

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

HQA 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 it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.***

HQA has not directly provided inpatient care in the past for which it can bill. It states that it has provided services equivalent to general inpatient care directly, without billing for this service, in its unlicensed Residential Hospice Center facility. It is currently a licensed general hospice and the proposed project is to provide GIP services within its existing Residential Hospice Center.

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

HQA utilizes Corsica Hills Center, a nursing home in Centreville, as a setting for respite care. A copy of the applicant's policy, and procedures for making respite care arrangements, has been provided.

N. 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 *Patient's Bill of Rights, Responsibilities and Compliant Procedure*, which includes each of the 12 rights enumerated in COMAR 10.07.21.21. The document is provided to, and reviewed with, each patient and caregiver at the time of admission,

with acknowledgement of receipt provided to the patient and placed in the patient's chart. On this basis, the applicant has demonstrated compliance with the 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 evaluated 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.

The applicant has provided an estimate of the demand for GIP services based upon its review of inquiries, referrals and admissions to its hospice program in 2011. This analysis, which was based upon clinical assessment of the need for GIP services in accordance with accepted admission criteria, is reported to have shown that approximately 40% of persons referred, admitted or inquiring about hospice care at the Residential Hospice Center would have qualified for GIP care.

Responding to MHCC staff questions regarding the recent provision of hospice services to GIP-level patients in local hospitals, skilled nursing facilities or other hospice GIP programs, HQA notes that it is the only general hospice operating a residential hospice house in its proposed four-county service area on the Eastern Shore, but that only three patients have been transferred from the Center to area hospitals for GIP care in the past three years.² It notes, however, that an additional number of Queen Anne's County residents have received hospice services provided largely by Hospice of the Chesapeake at Anne Arundel Medical Center in Annapolis. This working relationship has developed because there is no general hospital in Queen Anne's County.

HQA acknowledges that it also routinely provides acute, GIP-level care to existing patients at the Center:

"What we have done is provide care at the level it needs to be, which in many cases is over and above that provided and/or expected at a routine hospice care level. We have developed and trained an experienced team that is exceptional and committed to continuous improvement, growth and change.

Hospice of Queen Anne's operates today, not at the level we did when we were founded in 1985, but at the level where we need to be today and tomorrow. With increasing advances in treatments for life-limiting illnesses, we are now caring for

² As previously noted, there is a limited license hospice program, Talbot Hospice Foundation, that operates a similar hospice residence facility in Easton and Shore Home Care and Hospice, a general hospice, provides "skilled" services to residents of this facility, through a partnership with Talbot Hospice Foundation.

patients with conditions complicated by extended treatments or by underlying and multiple conditions that not too long ago required an inpatient hospital stay. HQA needs to be reimbursed at the proper rate for the level of care we are providing. In many cases, we're providing an acute, GIP level of care at the routine hospice care reimbursement rate...

Hospice of Queen Anne's maintains contracts with three out-of-county hospitals to provide the inpatient hospice care when needed. However, statistics clearly show the infrequency of inpatient care provided by HQA at the hospitals due in part to the fact that we do not have a hospital in Queen Anne's County and our ability to care for patients requiring more than routine hospice care."

The current State Health Plan does not provide a method for projecting the need for inpatient hospice service capacity or standards for assessing need for such service capacity. Most Maryland hospices do not directly provide inpatient care through their own facilities. They utilize other facilities, primarily hospitals and nursing homes, as the setting for inpatient hospice care, arranging for and coordinating the provision of hospice services for their patients during their inpatient stay at these facilities.

The following table shows the number of residents from the defined four-county service area that have been served by the Residential Hospice Center at HQA since it opened in early 2008.

Table 2
Patients by County of Residence
HQA Residential Hospice Center, 2008 - 2011

County	2008	2009	2010	2011	Total/County
Queen Anne's	38	42	59	52	191
Caroline	1	3	6	8	18
Kent	5	3	6	8	22
Talbot	0	5	1	5	11
TOTAL	44	53	72	73	242

Source: CON Application

In 2011, the number of admissions to the Center amounted to just under 28% of all new HQA patients, including those served in their homes and at other healthcare facilities. Since it opened, HQA estimates that the Center has admitted approximately 20% of all patients receiving hospice service. The Center had an occupancy rate of 83% in 2010 and 72% last year. With increased community awareness of the facility, and the availability of GIP services, HQA projects occupancy to reach 87% this year and 92% in 2013. It estimates that, on an average daily basis, 2 of the facility's beds will be occupied by GIP patients for the balance of this calendar year, rising to 3 in 2013.

All general hospices need to assure that inpatient care for pain control and symptom management is available and accessible for their patient population. Given that HQA has developed this residential facility and, from a demand perspective, it has been well-received in the area, MHCC staff believes it is reasonable for the Commission to find that it is an appropriate venue for HQA to meet the needs of its hospice population for inpatient services. Given that all of the Center beds would continue to be available for routine hospice care, i.e., care identical to that routinely provided by HQA in a patient's home, approval of the project would provide HQA

with the flexibility to provide higher-acuity end-of-life care to patients closer to their homes irrespective of the relative demand for GIP and routine care and to obtain reimbursement available from third-party payors, primarily Medicare, available for inpatient care.

The project would arguably improve the continuity of care and quality of life for routine hospice patients within the community whose symptom management needs occasionally and temporarily require general inpatient care. They will be able to obtain this level of care without leaving their local area.

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.

HQA believes that providing GIP services to patients in its own facility is less costly than having this service provided through a contracted hospital and assures more effective care, because it can more directly assure adherence to the patients plan of care on a full time basis through exclusive use of its own staff to care for the patient throughout the patient's course of hospice care.

The obvious existing alternative to the proposed project is the provision of GIP services in area hospitals, and as noted above, there is no general acute care hospital in Queen Anne's County. From a cost perspective, given that this is overwhelmingly a Medicare-funded service, HQA will have to structure its cost profile to match available levels of reimbursement. Overhead cost are very likely to be lower for the Residential Center setting than the hospital setting and, by providing the service directly, HQA has the ability to potentially generate income from this alternative. The availability of GIP within the Residential Hospice Center is arguably a more effective alternative than hospitalization for patients, caregivers and significant others in terms of continuity of care, more local accessibility and, in most cases, a preferred care environment.

To a large extent, Commission staff's perspective on this criterion is dictated by the fact that HQA has already developed and paid for the facility setting it wants to use for GIP. It is reasonable to conclude that offering GIP services in its Center is the most cost-effective means of meeting the short-term acute care needs of its target population.

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.

HQA has provided budget data for the past two calendar years, for 2012, and its projected budget for 2013, the first full year of operation of the GIP service, as shown in Table 3.

Table 3
Revenues and Expenses (Including Proposed Project)
Hospice of Queen Anne's, 2010 - 2013

	Two Most Recent Years		Current Year	First Full Year of Operation
	2010	2011	2012	2013
REVENUES				
Gross Pt. Revenue	1,987,523	2,100,831	2,275,848	2,654,147
Bad Debt Allowance	(4,852)	(8,511)	(8,000)	(8,000)
Contractual Allowance	(2,303)	(2,595)	(4,640)	(7,595)
Charity Care	(201,192)	(207,599)	(145,700)	(100,000)
Net Pt. Svcs Revenue	1,779,176	1,882,126	2,117,508	2,538,552
EXPENSES				
Salaries, wages, fees, Including benefits	1,529,169	1,628,364	1,882,165	2,034,146
Contractual Services	22,253	36,603	43,480	89,960
Current Depreciation	146,366	140,312	140,312	140,612
Supplies – Pt. Costs	197,967	148,851	162,936	244,404
Other Expenses	551,741	472,226	483,732	507,919
Total Operating Expenses	2,452,334	2,426,356	2,712,625	3,017,041
INCOME				
Income from Operation	1,779,176	1,882,126	2,117,508	2,538,552
Non-Operating Income	556,971	513,996	500,000	500,000
Subtotal	2,336,147	2,396,122	2,617,508	3,038,552
NET INCOME (LOSS)	(111,3419)	(30,234)	(95,117)	21,511

Source: Application

The data in Table 3 assume introduction of GIP services in 2012, with an average daily census of 2 GIP patients for the balance of this year, and a GIP ADC of 3 patients next year. Bad debt and charity care reductions are attributable to coverage of daily room and board charges (currently \$200.00) by the Medicare GIP per diem, which is unavailable for routine hospice care.

As Table 3 indicates, despite anticipated reductions in non-operating income and significantly increased personnel costs, the proposed project is expected to allow HQA to generate net income in 2013. This is due largely to the expected increase in revenues attributable to Medicare reimbursement for GIP services. While increased staffing requirements will add 5.7 FTEs to the current number of employees and contracted workers, the resultant \$338,638 increase in salaries and benefits will be offset by an increase of \$503,754 in patient care revenues in 2013.

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 noted previously, HQA projects that by next year, a total of 1,095 GIP days of care will be provided at the Center, compared with a total of 12,301 days of hospice care overall. Thus, GIP will account for 8.9% of total days of care provided, well under the regulatory limitation and requiring no refund of monies received.

As noted previously, total capital costs for the project are insignificant at \$11,400 and will be expensed. HQA 2011 fiscal year-end financial statements reveal cash and cash equivalents in excess of \$300,000. Human resources needed for the project also appear to be readily available to the applicant, which notes that it consistently maintains a 0% staff vacancy rate and has “an abundance of resumes of qualified potentials from which to draw.”

Staff concludes that the project is economically viable in both the short- and long-term, and that HQA has the financial and non-financial resources necessary to implement and sustain the project.

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.

MHCC records do not indicate any recent CONs issued to HQA. There is no record of any issues with respect to compliance with terms and conditions of CON approvals for this applicant.

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 the counties of the defined service area, or from area hospitals which currently provide GIP care to the population to be served by the project.

There are no existing inpatient hospice facilities within the four-county service area, and local hospitals are unlikely to be negatively affected by the project as demonstrated by the fact that HQA has made no referrals to area acute care facilities for GIP level care in the last year. Rather, the project may be viewed as having a positive impact on the health care system on the Eastern Shore by providing a service that will improve geographic and financial accessibility and continuity of care to hospice patients.

Staff concludes that the proposed project will not have any substantive negative impact on existing providers or the health care delivery system that should bar its approval.

II. 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, given the absence of quantitative methodologies to assess the need for General Inpatient care in a residential hospice house, the applicant has presented a reasoned argument that the lack of a general hospital in Queen Anne's County, and the lack of availability of this level of care in residential hospice centers within the four-county defined service area hinders both geographic and financial access to care, and interrupts continuity of care for patients who wish to receive end-of-life care in a less institutional and more home-like environment with a minimum of disruption. The proposal appears to be cost-effective and viable in both the short- and long-term and would not have a negative impact geographic or financial 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 finding, Staff recommends that the project be **APPROVED**.

IN THE MATTER OF * BEFORE THE MARYLAND
*
HOSPICE OF QUEEN ANNE'S * HEALTH CARE COMMISSION
*
DOCKET NO. 12-17-2329 *
*

FINAL ORDER

Based on Commission Staff's analysis, it is this 19st day of July, 2012, **ORDERED** that:

The application for Certificate of Need submitted by Hospice of Queen Anne's, Inc. to directly provide general inpatient hospice care in its existing residential hospice center in Centreville, Docket No. 12-17-2329, be **APPROVED**.

MARYLAND HEALTH CARE COMMISSION

July 19, 2012