STATE OF MARYLAND

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

MEMORANDUM

TO: Commissioners, Maryland Health Care Commission

Seasons Hospice and Palliative Care of Maryland, Inc.
Gilchrist Hospice Care, Inc.
Stella Maris, Inc.

FROM: Reverend Robert L. Conway RLC/w
Commissioner/Reviewer

RE: Recommended Decision in the Matter of the Application of Seasons Hospice and Palliative Care of Maryland, Inc. to Establish an Inpatient Hospice Unit on the campus of MedStar Franklin Square Medical Center
Docket Number 11-03-2318

DATE: June 28, 2013

Enclosed is my Recommended Decision regarding the application of Seasons Hospice and Palliative Care of Maryland, Inc. ("Seasons") to establish a 16-bed inpatient hospice unit on the campus of MedStar Franklin Square Medical Center in Baltimore County. I have considered Seasons' applications, comments by Gilchrist Hospice Care, Inc. ("Gilchrist") and Stella Maris, Inc. ("Stella Maris") on the application, additional information, arguments of counsel for the parties, and the record in this review. For reasons stated in my Proposed Decision, I recommend that the Commission **APPROVE** the project with a condition that, prior to first use approval, Seasons must provide a revised Payment for Services policy that clarifies the household income bands eligible for partial charity care

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission to be held on Thursday, July 18, 2013, beginning at 1:00 p.m., at 4160 Patterson Avenue.

COMAR 10.24.01.09B(1), provides that an applicant or interested party "may submit written exceptions to a proposed decision ... by submitting written argument and supporting documentation from the record." Written exceptions and arguments must identify specifically those findings or conclusions to which exception is taken, citing those portions of the record on which the exceptions are based. The regulations do not specify a page limit. The Commission would appreciate double spacing of exceptions and responses to exceptions.

The applicant and interested parties must file 30 copies of the written exceptions or responses to exceptions with the Commission and must also deliver copies of the exceptions to all applicants and the interested parties. Copies of exceptions and responses should also be sent to parties and Commission staff by email.

Oral arguments during the exceptions hearing before the Commission will be limited to no more than 10 minutes per applicant and interested party, unless the time is extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and responses to exceptions is as follows:

Submission of exceptions	July 8, 2013 No later than 12:00 noon
Submission of responses	July 15, 2013 No later than 12:00 noon
Exceptions hearing	Thursday, July 18, 2013 Meeting begins at 1:00 p.m.

IN THE MATTER OF	*	
	*	
SEASONS HOSPICE &	*	
	*	**BEFORE THE MARYLAND**
PALLIATIVE CARE OF	*	
	*	**HEALTH CARE COMMISSION**
MARYLAND, INC.	*	
	*	
DOCKET NO. 11-03-2318	*	

*** ***

Recommended Decision

June 28, 2013

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I. INTRODUCTION

A. The Applicant

Seasons Hospice & Palliative Care of Maryland, Inc. ("Seasons") is a proprietary Subchapter "S" corporation that provides hospice services. It was formed and began providing services in Maryland in 2003 after purchasing an existing general hospice. It is licensed to provide general hospice services in Anne Arundel, Baltimore, Carroll, Cecil, Harford, Howard, and Prince George's counties, and the City of Baltimore.

The applicant is part of a national corporation, Seasons Hospice & Palliative Care, which identifies itself as the fifth largest hospice company in the United States, with hospice operations in 14 states. Todd Stern is the Chief Executive Officer, and its national headquarters is located in Rosemont, Illinois. Seven individuals and five entities identified as trusts have ownership shares in the applicant entity, with the largest shares of ownership and a majority of ownership shares (60.8%) held by two persons and two trusts: Susan Stern of Skokie, Illinois (25%); the Todd Andrew Stern Trust of the same address (15.0%); Robert Hartman of Chicago, Illinois (10.4%); and the Rajchenbach Family Trust of Lincolnwood, Illinois (10.4%). Six other individuals and two other trusts are identified as having ownership interests in the applicant entity ranging between 2.1% and 8.6%.

B. The Project

Seasons seeks Certificate of Need ("CON") authorization to operate a 16-bed general inpatient ("GIP") hospice unit in 9,600 square feet ("SF") of existing building space, described as vacant space, leased from and located on the campus of MedStar Franklin Square Medical Center ("MFSMC" or "Franklin Square"), located at 8000 Franklin Square Drive in northeast Baltimore County. The proposed unit is described as a third-floor wing of a three-story building that will be renovated and equipped to suit its intended purpose. The building is part of the main hospital and is located immediately west of the main entrance of the hospital. MFSMC is a 355-bed general acute care hospital and is part of MedStar Health, a not-for-profit hospital system operating three general acute care hospitals in Baltimore City and three other general hospitals in suburban Washington, DC (Montgomery, Prince George's, and St. Mary's counties, Maryland). It also operates hospitals in the District of Columbia.

The proposed unit floor plan shows all patient rooms as single-occupancy with each containing its own water closet. (A single isolation room has its own shower.) The unit will also contain a family lounge/kitchenette.,

The project is estimated to require $400,000 of renovation expenditures and $100,000 for equipment, and will be funded with cash. The renovations are described as "predominantly aesthetic." The "equipment" is described as furnishings. Architectural fees, permits, and legal/consulting fees add an additional $105,000 of estimated project cost and Seasons included an inflation allowance of $16,197, for a total estimated project cost of $621,197.

C. Background

Seasons is the second largest general hospice operating in Maryland, based on the aggregate total number of reported patients served in 2011. In 2011, it was also the second largest provider of inpatient hospice care in Maryland among the State's general hospices, based on the unduplicated count of inpatient admissions reported. Seasons is not currently recognized as operating inpatient hospice beds under its general hospice license, but did operate such a unit from 2008 through early 2012 in space leased from Northwest Hospital ("NWH") in Randallstown (Baltimore County). This is a 225-bed general hospital that, with Sinai Hospital of Baltimore (426 beds) is one of the two general acute care hospitals in LifeBridge Health. Seasons has continued to operate this unit at NWH, after termination of the lease arrangement with NWH in 2012 and a return of the beds to general acute care hospital licensure status.

Seasons has used a strategy of developing inpatient hospice facilities located on hospital campuses to grow its hospice patient base. Information gathered as part of this project review indicates that these hospital campus inpatient hospice units, at least in some cases, have been successfully marketed to terminally ill patients of the host hospital, who perceive the units as specialized service lines of the hospital, and that this perception and the availability of the unit increase the likelihood that a large proportion of patients who will eventually use the unit elect to enroll in hospice care, rather than expiring without hospice program participation. Its first venture of this type in Maryland was the previously noted unit on the campus of Northwest Hospital. It leased space from the hospital and began operating a 14-bed unit under its general hospice license in 2008. It was informed by MHCC staff in 2007 that it did not require CON approval to establish this unit.

In 2010, MHCC staff informed hospices in Maryland that its previous determinations with respect to the development of inpatient hospice bed capacity by general hospices was incorrect because Maryland law requires CON approval of changes in the bed capacity of hospices, which are defined as "health care facilities." Seasons disagreed with this determination but did not seek review. The determination did not affect the ability of Seasons to continue to operate its facility on the NWH campus, which was already established at the time of the determination. Seasons sought "grandfathering" of the proposed project at Franklin Square based on planning expenses but staff determined that Seasons had not incurred or obligated a capital expenditure prior to August 24, 2010 that qualified for grandfathering and advised Seasons to file a CON application for this project.

Seasons has a history of agreements with nursing homes and hospitals, mostly nursing homes or nursing home units operated as subacute facilities in hospitals, for the provision of GIP care that does not involve the operation by Seasons of dedicated hospice units within those facilities. Such an arrangement is permitted under applicable federal and State law and is also done in Maryland hospitals, since every licensed general hospice is obligated to make provisions for inpatient care. General hospices can establish such agreements with hospitals without CON review and approval when they conform with HSCRC policies (the General Inpatient Hospice Care Project). HSCRC grants permission for hospitals to enter into HSCRC-approved arrangements with hospices to accept less than HSCRC-approved rates and to write off as a voluntary contractual allowance the difference between approved charges and the reimbursement by the hospice. Seasons filed, with HSCRC, several agreements with general hospitals pursuant

to this HSCRC policy, including MedStar Franklin Square Medical Center, in 2011 and 2012. MHCC has been informed by counsel (DI#50) to Seasons that this MFSMC agreement was never implemented.

Hospitals are required to report hospice activity to the HSCRC on a quarterly basis. General Inpatient Care covered under the Project includes, but is not limited to: care required for procedures necessary for pain control; and acute or chronic symptom management or medication adjustment that cannot feasibly be provided in other settings. The costs and revenue associated with General Inpatient Care patients admitted to the acute hospital are reported in the Monthly Reports of Volumes and Revenues, on the inpatient discharge abstract data tape submitted to the HSCRC, and on the Annual Report of Revenue, Expenses, and Volumes. A recent review of HSCRC records indicates that 26 general hospitals and 16 hospices, including Seasons, have filed such agreements with HSCRC. The MHCC exempts the establishment of such hospital/hospice agreements from the scope of CON regulation because such arrangements historically have not involved the establishment of distinct inpatient hospice beds dedicated to the provision of inpatient hospice care and operated by a hospice, but instead have involved the use of hospital beds on an "available bed" basis.. As such, the provision of inpatient hospice care under these agreements does not change the bed capacity operated by a general hospice or of the hospital that is party to the agreement.

An agreement between Sinai Hospital of Baltimore ("Sinai"), a LifeBridge hospital located in Baltimore City, and Seasons that was filed with HSCRC on July 20, 2011 is typical in this regard. It specifies as a "responsibility" of Sinai in paragraph 4.1 that the "Hospital shall make available to Hospice Patients Hospital beds as available and as may be authorized by the Hospice Team Director from time to time." The fundamental character of the hospital beds used by hospice patients under this type of agreement does not change. Such beds continue to function as general acute care hospital beds that, in the vast majority of cases, are used for patients who are not terminally ill, who are not enrolled in a hospice program, and who are obtaining a variety of acute medical/surgical services. Such general acute care hospital beds, when available, can be used to accommodate hospice patients when the need arises

In January 2013, Seasons and Sinai, announced the opening of a Seasons-operated inpatient hospice unit at Sinai. in licensed hospital beds under an agreement similar to that established between Seasons and NWH. As previously noted, Seasons also entered into an agreement with MFSMC to establish a Seasons-operated inpatient hospice unit with 16 beds. The space for this unit described in this agreement appears to be the same space identified in the CON application but, contrary to the application's characterization of this space as "vacant," the 2012 agreement describes it as "Medicare and Medicaid certified acute hospital beds." Seasons has affirmed that this project on the MFSMC campus was not implemented and that no funds have been spent or obligated to implement the project. It also states that the space is vacant, as described in the CON applicaton.

In response to a complaint concerning the Sinai Hospital unit, the Office of Health Care Quality of the Department of Health and Mental Hygiene, investigated the establishment and operation of the program at Sinai and determined, in February 2013, that this contractual arrangement was not compatible with health care facilities licensure law in Maryland. OHCQ

determined that the operation of such a unit, as outlined in the Seasons/Sinai agreement, required that the beds be licensed under the general hospice license of the hospice operating the unit. OHCQ affirmed its determination on May 12, 2013 and left in place its earlier order that new admission of hospice patients to the Seasons unit be discontinued after May 15, 2013. This determination also clarifies that Seasons cannot avoid CON requirements by contracting with hospitals to establish dedicated hospice units under Seasons control in licensed hospital beds. MHCC's determination with respect to CON requirements was provided to Seasons in April, 2013 and affirmed on May 13, 2013.

In 2013, MHCC staff first learned that Seasons has continued to operate the 14-bed unit at NWH as a dedicated inpatient unit under its exclusive control with respect to admission of patients and the direct provision of care to patients. This appeared to MHCC staff to be inconsistent with the representations made by LifeBridge in 2012 that: (1) Termination of the lease between NWH and Seasons would involve the hospital regaining "control" of the beds'; and (2) Hospice patients, going forward, would be "served directly" by NWH. Under the agreement, NWH accommodates care of the Seasons patients in the formerly leased space, now licensed as acute general medical/surgical hospital bed capacity. The beds are contractually dedicated for the exclusive use of Seasons with limited exceptions. The 2012 Inpatient Hospice Agreement between NWH and Seasons specifies that NWH "shall maintain no fewer than fourteen (14) beds at all times for the use of Hospice Patients (the 'Dedicated Beds')." The term "Hospice" in this agreement refers to Seasons. Also under this agreement, Seasons personnel authorize admission of patients, establish the plan of care, and implement the plan of care through an Interdisciplinary Team, supervised by a Seasons employee, the Hospice Team Director.

On May 15, 2013, Seasons filed a letter of intent for a CON application to change its bed capacity by establishing an inpatient hospice unit in designated space at Sinai Hospital.

D. Summary of Recommended Decision

Based on my review of the record in the review and having listened carefully to oral argument of the parties, I am recommending that the Maryland Health Care Commission approve this project with the condition that, before issuance of a first use approval for this project, Seasons must provide a revised Payment for Services policy that clarifies the household income bands eligible for partial charity care. With completion of this project, Seasons will be authorized to operate a single inpatient hospice unit on the MFSMC campus under its general hospice license

My recommendation is based on my findings with respect to the compliance of the proposed project with the applicable standards of the State Health Plan and my findings with respect to the need for this project, the costs and effectiveness of alternatives to this project, the viability of this project, and the impact of this project. My findings on these review criteria are fully outlined in this Recommended Decision.

II. PROCEDURAL HISTORY

A. Review of the Record

On March 22, 2011, Seasons filed a letter of intent for the project and a request of a waiver of the waiting period for filing of an application. MHCC acknowledged receipt of this letter on March 25, 2011 and informed Seasons that identification of an anticipated filing date for the application would be needed to respond to the request for a waiver of the waiting period for filing of an application. (Docket Item [DI] #1)

On July 8, 2011, Seasons filed a CON application for the project (DI #2). On July 15, 2011, MHCC acknowledged receipt of the application (DI #3). On that same date, MHCC requested publication of a notice of the receipt of the application in the *Baltimore Sun* (DI #4) and the *Maryland Register* (DI #5)

On July 19, 2011, MHCC received certification of publication of the application filing notice from the *Baltimore Sun.* (DI #7)

On July 25, 2011, MHCC Staff provided the applicant with a request for additional information to complete its application. (DI #6)

On August 9, 2011, Seasons requested and received approval for an extension of time to respond to the July 25, 2011 request for additional information. (DI #8)

On August 16, 2011, Seasons provided a response to the request for additional information. (DI #9)

On September 1, 2011, MHCC staff notified Seasons that the application could not be deemed complete based on the responses provided on August 16, 2011 and outlined the additional information that would be required. (DI #10)

On September 15, 2011, Seasons provided a response to the September 1, 2011 request for additional information. (DI #11)

On September 23, 2011, MHCC requested that a notice of the docketing of Season's CON request be published in the *Maryland Register*. (DI #12) On September 26, 2011, MHCC requested that a notice of the docketing of Season's CON request be published in the *Baltimore Sun.* (DI #13)

On October 11, 2011, MHCC received certification of publication of the docketing notice from the *Baltimore Sun.* (DI #14)

On October 12, 2011, Gilchrist Hospice Care, Inc. provided "registration" as an interested party in the review of the Season's application and requested copies of all relevant material. On October 20, 2011, MHCC responded to this correspondence, providing information on the process of becoming an interested party in the review. (DI #15)

On October 21, 2011, MHCC notified Seasons that its application was docketed for review effective October 7, 2011 and that notice of the application's docketing was published in the *Maryland Register* on that date. Commission staff also requested additional information from the Hospital regarding the proposed project. (DI #16) On that same date, a copy of the application was sent to the Baltimore County Health Department for review and comment. (DI #17)

On November 3, 2011, the applicant and two other parties, Stella Maris, Inc. and Gilchrist Hospice Care, Inc. agreed to extend the date for filing of comments on the application to November 17, 2011. (DI #18) Notification of this agreement was published on the MHCC website. (DI #19)

On November 3, 2011, Charlotte Hawtin, Executive Director of Joseph Richey Hospice, filed a letter opposing approval of the Seasons application. (DI #20)

On November 7, 2011, Seasons provided a response to the October 21, 2011 request for additional information. (DI #21)

On November 16, 2011, Gilchrist Hospice Care, Inc. provided comments on the Season's application, seeking interested party status, and requested an evidentiary hearing in the matter. (DI #22)

On November 17, 2011, Stella Maris, Inc. provided comments on the Season's application, seeking interested party status, requesting an evidentiary hearing in the matter, and requesting that the application be de-docketed. (DIs #23-25)

On December 2, 2011, Seasons requested and received approval for an extension of time to respond to November 16 and 17, 2011 filings. (DI #32)

On December 6, 2011, Seasons responded to the comments, interested party filings, and requests of Stella Maris, Inc. and Gilchrist Hospice Care, Inc. This included a motion in opposition to the request of both parties to be recognized as interested parties, a reply to the motion of Stella Maris, Inc. to de-docket the application, opposition to the requests for an evidentiary hearing, and a request for oral argument. (DIs #26-31)

On December 20, 2011, Stella Maris, Inc. replied to the motion by Seasons in opposition to its request for interested party status. (D.I.# 33)

On December 22, 2011, Gilchrist Hospice Care, Inc. replied to the motion by Seasons in opposition to its request for interested party status. (D.I.# 34)

On March 8, 2012, Commissioner Robert L. Conway granted Stella Maris, Inc. and Gilchrist Hospice Care, Inc. interested party status in the review of the Seasons application and denied the motion by Stella Maris, Inc. to de-docket the Seasons application. He indicated that

he would rule on the remaining motions, concerning the convening of an evidentiary hearing or oral argument in this matter at a later date. (D.I.#35)

On April 23, 2013, Commissioner Conway denied the request for an evidentiary hearing in this matter but approved the request for oral argument. He outlined the procedure to be followed for the oral argument and asked the applicant and interested parties to provide feedback concerning their availability for oral argument on May 7th, 8th, or 10th of 2013. (D.I.#36)

On April 23, 2013, Gilchrist indicated, via e-mail from counsel, that May 10, 2013 was the only date possible for oral argument of the three dates provided by Commissioner Conway. On that same date, Stella Maris, via e-mail from counsel, indicated that May 10, 2013 was acceptable. On April 24, 2013, Suellen Wideman, Assistant Attorney General, asked Seasons, via e-mail, about its availability on May 10, 2013. Seasons responded on that same date, via e-mail from counsel, that it was still waiting for confirmation on the dates provided. Ms. Wideman and Seasons exchanged additional e-mails on this topic (D.I.#38)

On April 25, 2013, Seasons, via e-mail from counsel, agreed to the May 10, 2013 date for oral argument.(D.I.#39)

On May 2, 2013, Seasons wrote to Commissioner Conway, asking that Seasons be allowed 60 minutes of oral argument, to be divided at its discretion between oral argument and rebuttal, or, in the alternative, the two interested parties be limited to splitting 30 minutes of argument. (D.I.#40)

On May 7, 2013, Commissioner Conway wrote to the applicants confirming the May 10, 2013 date for oral argument and outlining the procedure that would be followed. (D.I.#41)

On May 9, 2013, a letter of support for the project was received from Samuel E. Moskowitz, President of MFSMC, and two MFSMC Vice Presidents. (D.I.#42)

On May 9, 2013, Gilchrist wrote to Commissioner Conway asking that the letter of support received on that same date from MFSMC be excluded from the record. (D.I.#43) On that same date, Seasons, via e-mail from counsel, asked that MHCC staff let Commissioner Conway know that they intended to respond to the request for exclusion of the letter. (D.I.#44)

On May 10, 2013, Commissioner Conway heard oral argument on this matter from Seasons and the opposing interested parties. (D.I.#45)

On May 10, 2013, Seasons responded to Gilchrist's May 9 request, asking that the letter of support be accepted into the record. (D.I.#46)

On May 10, 2013, Stella Maris communicated its support, via e-mail from counsel, for the May 9, 2013 request by Gilchrist for exclusion of the MFSMC letter of support. (D.I.#47)

On May 10, 2013, Commissioner Conway wrote to Mr. Moskowitz, informing him that the letter of support would not be accepted for filing in the record of this review. (D.I#48)

On June 26, 2013, Commissioner Conway wrote to Seasons, via its counsel, asking for clarification with respect to the implementation of a 2012 agreement between Seasons and MFSMC concerning operation of a hospice unit. (D.I.#49)

On June 27, 2013, Seasons responded to Commissioner Conway, affirming that the 2012 Seasons/MFSMC agreement had not been implemented in any aspect. (D.I.#50)

B. Local Government Review and Comment

No comments on the application were provided by local government.

C. Interest Parties in the Review

Stella Maris, Inc. ("Stella Maris") and Gilchrist Hospice Care, Inc. ("Gilchrist"), two general hospices serving patients in Baltimore County and other central Maryland jurisdictions are interested parties in this review, opposing the project. Their comments in opposition to this project will be reviewed in the body of this Recommended Decision.

Stella Maris is a not-for-profit corporation authorized to provide general hospice services to Anne Arundel, Baltimore, Carroll, Harford, and Montgomery Counties, and Baltimore City. . It is also a provider of comprehensive care facility services at a Baltimore County facility, operating under the name Stella Maris. This general hospice is recognized as operating a general inpatient hospice facility under its general hospice license, sharing a campus with its nursing home operations in Baltimore County. The GIP facility has 22 beds. It is part of Mercy Health System, a Maryland-based organization that operates Mercy Hospital, a 233-bed general acute care hospital in Baltimore City and a continuing care retirement community near the Stella Maris campus.

Gilchrist is a not-for-profit corporation authorized to provide general hospice services to Anne Arundel, Baltimore, Carroll, Frederick, Harford, Howard, and Prince George's Counties, and Baltimore City. It operates two freestanding GIP facilities, a 34-bed facility in Towson (Baltimore County) and a 10-bed facility in Columbia (Howard County). It is affiliated with Greater Baltimore Medical Center, a 270-bed general acute care hospital in Towson.

D. Other Support and Opposition to the Project

A June 15, 2011 letter of support for the project was provided by Adrienne Kirby, Ph.D., President of Franklin Square Hospital Center.

The applicant also provided copies of two letters written in May 2011, from the spouse and cousin of Seasons' patients cared for at Northwest Hospital, which are appreciations of the patient care received by their relatives, and copies of responses to those letters from Eric G. Wexler, President, and Shari Waters, Assistant to the President, at Northwest Hospital, written in June 2011.

A general hospice, Joseph Richey Hospice, wrote a letter of opposition to this project. It did not request interested party status. This general hospice operates a GIP facility with 20 adult beds and 10 pediatric beds in Baltimore City. It is authorized to serve Anne Arundel, Baltimore, Harford, Howard, Prince George's, and Washington Counties, and Baltimore City. Joseph Richey Hospice believes that the CON should not be approved because "the number of inpatient beds for end of life in Maryland has exploded." It cites Medicare efforts to limit continuous care billing as the reason for this "explosion," incentivizing hospices to "expand their inpatient billing." It states that a large number of hospice beds in the state "are vacant on any given day."

III. DEMOGRAPHIC BACKGROUND

A. Service Area Population

The applicant presents population data for Baltimore City and County in its discussion of the "need" for this project, in particular the projected growth in the elderly population of these jurisdictions. (DI#2) It identifies the Maryland Department of Planning as projecting that the 65+ population of Baltimore City will grow between 10-11 percent in the five year period of 2010 to 2015 and in the succeeding five year period from 2015 to 2020. For Baltimore County, 65+ population growth projections for the same five-year periods, is reported to fall within the 14 to 15 percent range.

In modeling projected use of the proposed GIP facility, Seasons focuses on hospitals as a referral source of patients. Based on its experience at Northwest Hospital, it projects that 4.4 percent of the MFSMC patients admitted to medical/surgical/gynecological/addictions ("MSGA") beds in a given year will become hospice inpatients at the proposed hospice unit. It further projected that the three other general hospitals operated by MedStar Health in Central Maryland (all in Baltimore City) will be important secondary referral sources. It projects their contribution to be equivalent to 1.5 percent of annual MSGA admissions, and cites the experience of the NWH unit's reliance on Sinai Hospital of Baltimore (a sister hospital of NWH operated as part of LifeBridge Health) as a referral source for the NWH unit, as the basis for this assumption. These four hospital referral source assumptions would total to 737 patients, based on 2010 utilization. Seasons projected 600 admissions to the proposed GIP unit in the first year of operation and 725 admissions in Year 2. Seasons notes that the LifeBridge hospitals, as referral sources, accounted for approximately 67 percent of total admissions to the NWH GIP unit in 2010 and that, "therefore, the unit at Franklin Square can expect to receive additional referrals from other hospitals" (i.e., other than the four MedStar Health hospitals specifically used to model demand at the proposed unit).

The Maryland Department of Planning projects that the overall rate of population growth in Baltimore County and Baltimore City, the mature urban and suburban home jurisdictions of the four hospitals used by Seasons as "referral source" generators of projected admissions to the proposed GIP unit, will substantially lag growth for the total State population during the 2010 to 2020 period. These two jurisdictions have a projected 2020 elderly population that is only slightly greater, as a proportion of total population, than the State as whole. The projected rate of growth of the 65 and older population for the combined two-jurisdiction region, at 26.0% from

2010 to 2020, is lower than that projected for all of Maryland, 41.4%. Hospice care is primarily a geriatric health care service. In FY 2011, 83% of the State's total hospice patients were aged 65 and older; 67% were aged 75 and older.

Table 1: Total Population and Age 65+ Population Growth, 2010-2020
Baltimore County and City

Area	Total Population			Population 65+			
	2010	2020	% Change 2010-2020	2010	2020	% of 2020 Total Pop.	% Change 2010-2020
Baltimore County	805,029	847,000	5.2%	117,480	150,920	17.8%	28.5%
Baltimore City	620,961	632,500	1.9%	72,810	88,760	14.0%	21.9%
Two-County Region	1,425,990	1,479,500	3.8%	190,290	239,680	16.2%	26.0%
Maryland	5,773,552	6,216,150	7.7%	707,640	1,000,830	16.1%	41.4%

Source: Maryland Department of Planning (www.mdp.state.md.us/msdc/s3_projections.shtml)

B. Hospice Programs in Baltimore County and Baltimore City

Ten hospice programs are authorized to serve Baltimore County and eight hospices are authorized to serve Baltimore City.[1] All eight of the hospices authorized to serve Baltimore City are also authorized to serve Baltimore County. Five hospices (Gilchrist, Seasons, Stella Maris, Joseph Richey House and Dr. Bob's Place, and Heartland Hospice Services) dominate these jurisdictions. (See the following Table 2.) Seasons and the two interested party hospices opposing the Seasons project accounted for 86% of total hospice patients and 87% of hospice patient deaths of Baltimore County and City residents in 2011.

Three of the ten hospices authorized to serve Baltimore City and/or Baltimore County operate inpatient hospice facilities (four if one includes the unit operated by Seasons at NWH). Only eight of the State's 30 hospices operate inpatient hospice facilities (again, nine if one includes Seasons). Thus, Baltimore County and City have a concentration of inpatient hospice facilities and bed capacity in excess of their importance demographically. With only 25 percent of the State's population, these two jurisdictions contain 57% of the State's total existing and approved hospice inpatient bed capacity. If one includes the Seasons facilities at NWH, this concentration rises to 64%.

Table 2: Hospice Patients, Deaths, and Hospice Market Share of Patients and Deaths, 2011
Baltimore County and City (Source: Annual Hospice Survey, MHCC)

	Hospice Patients		Percentage of Total Patients		Hospice Patient Deaths		Percentage of Total Deaths	
	Baltimore County	Baltimore City	Baltimore County	Baltimore City	Baltimore County	Baltimore City	Baltimore County	Baltimore City
Gilchrist	2,184	918	46%	50%	1,772	737	45%	52%
Seasons	1,368	407	28%	22%	1,132	276	29%	19%
Stella Maris	598	211	12%	11%	505	182	13%	13%
Joseph Richey	94	201	2%	11%	63	156	2%	11%
Heartland	346	33	7%	2%	254	30	6%	2%
Other Hospices	309 (n=5)	71 (n=4)	6%	4%	224 (n=5)	45 (n-4)	6%	3%
Total Patients/Deaths	4,899	1,841			3,950	1,426		

[1] Evercare Hospice and Palliative Care is not authorized to serve Baltimore City residents generally but is permitted to serve United Health Care Group HMO subscribers in any Maryland jurisdiction. It reported serving one Baltimore City resident in 2011.

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**, which are used 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 consideration of this project, which involves changes in the bed capacity of an existing general hospice.

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

Seasons is a general hospice currently authorized to serve eight jurisdictions, including Baltimore County, the jurisdiction in which it proposes to establish its first general inpatient hospice care facility or its second facility, if one includes the NWH unit Seasons designates Baltimore County in responding to this standard. Seasons states, in addressing admissions criteria for the unit, that the patient must live in the geographic areas served by Seasons Hospice.

In response to an information request from staff, Seasons stated that it expected patient origin for the proposed GIP unit to "track" MFSMC's patient origin for elderly patients and noted that over 86% of such hospital patients resided in nine Baltimore County and City zip code areas. Seasons is authorized to serve patients residing in Baltimore County and all contiguous jurisdictions.(DI#2) I find that 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.

Seasons outlines its proposed admission criteria. (DI#2) To be admitted to the proposed unit, a patient must: be terminally ill (prognosis of six months or less) certified by a physician; recommended for admission by a physician; have decided to forego curative treatment; if a Medicare or Medicaid beneficiary, have decided to forfeit all treatment for the terminal illness under the Medicare Part A or Medicaid Plan and elected the Medicare or Medicaid benefit; be under the care of a physician responsible for medical care; and be a resident of a geographic area served by Seasons.

Seasons states that patients are not required to execute a Do Not Resuscitate order or Advanced Directive for admission and that does not require a primary caregiver. If such a caregiver is not available, the Seasons "hospice team" will plan for the patient's care, in

consultation with the patient, when the patient is no longer able to make decisions for his or her self. Seasons states that physical facilities must be adequate for proper care and safe, for the patient and staff. It states that it will not have age or disease limitations on admission.

Seasons has complied with this standard.

C. Minimum Services.

2. 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, thus, is compliant with the standard. (DI#2) It employs a Medical Director, a physician whose responsibilities are described. It outlines the responsibilities of the nurse supervisor, a registered nurse qualified by education and experience to direct hospice nursing care, who will supervise nursing care in the proposed unit. Seasons presents its plans for provision of social work, spiritual services, and nutritional counseling. Nursing staff will be on duty at the proposed unit 24 hours a day.

3. 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.

Seasons describes its plan for providing hospice aide services, which will entail assisting patients with personal hygiene, dressing, ambulation/transfer, exercise, food/fluid intake, and self-administration of drugs. (DI#2) It states that it will use volunteers, supervised by a designated Seasons employee, to provide support and companionship, caregiver relief, errand running, light chores, and visiting and bereavement. It notes that bereavement counseling and services will be provided to families for not less than 13 months following the death of a hospice patient. Seasons states that a licensed pharmacy will provide an inventory of needed pharmaceuticals 24 hours a day/seven days a week and "collaborate with the Interdisciplinary Group[2] in individual medication management." Laboratory, radiology, and chemotherapy services "as needed for palliative care" will be purchased from MFSMC and Seasons states that

[2] This "group," also referenced as the "interdisciplinary care team," is described as including "doctors, nurses, social workers, certified nursing assistants, therapists, chaplains, volunteers, and a music therapist."

supply and equipment inventories will be maintained. The special therapies listed in Part g) of the standard will be provided through contractual arrangements.

I find that the applicant has provided a satisfactory response to this standard.

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

Seasons states that its bereavement services are available for a period of no less than 13 months following the death of a patient, in compliance with this standard. (DI#2)

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.

Seasons provides hospice services in private homes. It proposes to continue to provide services in these settings but seeks Certificate of Need approval to establish licensed general inpatient service capacity in leased space. (DI#2) 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.

Seasons states that it has an active volunteer program. (DI#2) It states that volunteers are used in defined roles and are qualified through completion of an orientation/training program. Any volunteer "functioning in a professional capacity shall meet the standards of the appropriate profession." The proposed program is considered to be consistent with the standard. Volunteer services are provided in accordance with the written patient plan of care and are documented. The applicant has complied 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.

Seasons states that the primary caregivers of patients discharged from the proposed GIP unit to home will be provided with instruction and support through its Home Hospice program, consistent with this standard. (DI#2)

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.

Seasons is a licensed general hospice certified for Medicare and Medicaid participation. It accepts Medicare and Medicaid patients, consistent with this standard. It projects that 85% of its patient days in the proposed GIP unit will be generated by Medicare patients and five percent will be generated by Medicaid patients. (DI#2)

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 states that it informs hospitals, nursing homes, senior information and assistance offices, the general public, and many physicians about its services, service area, reimbursement policies, office location, and phone number. (DI#2) 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.***

Seasons states that fees are disclosed to clients and families before services are begun. (DI#2) 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.***

Seasons provided a copy of its Payment for Services policy. (DI#2) It states that, "when necessary, Seasons Hospice will use extended payments or a claim on an estate for the payment of services. Regardless of payment source or ability to pay, once Seasons Hospice has accepted a patient/family, all appropriate services will be provided." This policy does not include detailed provisions for time payment options and mechanisms for clients to arrange time payment. In response to Staff's request for elaboration on these issues, Seasons stated that, in its experience, "the need, factors, and details affecting each patient/family are so different that putting limitations or further details into the policy would make Season's options too restrictive." (DI#9) It cited completion of probate, home sales, and resolution of Veterans Administration benefit requests as examples of issues that come into play in development of plans for extended payment, so that "it is not simply a case of patients/families spreading the cost of hospice care over a year." It asks for the policy to be accepted as one that allows for "individual facts in each family's request" to be considered in crafting "an individualized payment plan which may be unique to that family's ability and needs."

Seasons states that it has established special time payment plans for individuals unable to make full payment at the time services are rendered and that a written copy of its policy is

submitted to each client. I consider the applicant's response on this standard to satisfy the requirements for a finding of compliance.

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.***

As previously noted, Seasons provided a copy of its Payment for Services policy. (DI#2) Staff asked for a written policy conforming to the requirements of this standard and Seasons provided a revised Payment for Services policy. (DI#9) The revisions consist of a new Part 7, elaborating on the "financial assessment" noted in the original policy to spell out criteria for determining "the level of charity care." Patients must apply for Medical Assistance and be rejected. Full charity care will be approved ("no responsibility for payment on services rendered") if the patient's household income is equal to or less than 150% of the Federal Poverty Guideline. Responsibility for payment is reduced but not eliminated at higher household income levels, scaled to the Federal poverty Guideline with availability of extended payment plans. A new Part 10 was also added, stating that "Determination of probable eligibility for financial assistance will be made within two business days after initial submission of the Financial Assistance Application."

I find that the revised policy is consistent with the standard but should be clarified with respect to the scaling of charitable discounts provided to households with income above 150% of the poverty threshold. Therefore, I recommend that, if the Commission approves this CON application, the approval should be conditioned as follows:

> Prior to first use approval of this project, Seasons Hospice & Palliative Care of Maryland, Inc. must provide a revised Payment for Services policy that clarifies the household income bands eligible for partial charity care.

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

Seasons is licensed and Medicare and Medicaid-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.***

Seasons proposes direct provision of inpatient care through this project, operating its own 16-bed facility under its general hospice license. It notes that it already has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services, senior information and assistance programs, adult day care programs, local social service agencies, and home-delivered meal programs within the anticipated service area of the proposed project. (DI#2) It is currently a licensed general hospice and the proposed project is to provide GIP services within the largest jurisdiction it is currently authorized to serve. I find that the applicant complies with this standard.

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

Seasons states that it will provide respite care in the proposed GIP unit. (DI#2)

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.

Seasons states that it provides Continuing Education courses for its employed nursing and social work professionals and "opens" these classes to other professions, including persons not employed by Seasons, "to continue public education and outreach about hospice, its services, and how palliative services are used when curative care no longer is an option." (DI#2) It notes that it has a website, "showcasing the variety of materials that serve to educate the public" and provides answers to "frequently asked questions" about hospice and Seasons' services and that it operates a toll-free number for responding to information requests 24 hours a day, seven days a week. Some Seasons sites have committees for education programming geared to particular ethnic groups and Seasons attends senior fairs and community events. It publishes a newsletter and other documents (e.g., a "Guide for Patients Families and Friends/Enhancing the Quality of Life", an overview of hospice care, and "Tender Legal Care, Making Choices in Life and Death, a comprehensive guide about hospice by Susan Fliker.

I find that the applicant has documented compliance with this standard.

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

Seasons provided a copy of its *Patient/Family Rights and Responsibilities* policy, which included an attached listing of rights, including decision-making rights. (DI#2) This attachment covers the rights enumerated in COMAR 10.07.21.21. It includes a provision for informing patients and families of their rights and responsibilities before services are provided, in a language and manner that the patient understands. On this basis, the applicant has demonstrated compliance with the standard.

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 current State Health Plan does not provide a need methodology or specific standards for needs assessment with respect to inpatient hospice bed capacity. Most Maryland hospices do not provide inpatient care directly through their own facilities. They have relationships with hospitals and nursing homes that accommodate their enrolled hospice patients when hospital admission is necessary. In such cases, the hospice coordinates with the admitting facility in caring for the patients, with hospice personnel providing some of the services needed by the patient during the inpatient stay.

Applicant's Response

In its CON application (DI#2), Seasons responded to this criterion by focusing on demand for inpatient hospice services that could be generated at the proposed unit. It first outlined projected growth in the elderly population in the project target jurisdictions of Baltimore County and City. (The current decade projections for the 65 and older population of these jurisdictions published on the Maryland Department of Planning web site have been previously provided in Section III of this recommended Decision.) Seasons postulates that demand for end of life care will increase primarily because of the increase in the elderly population.

Seasons believes that an inpatient unit such as that proposed, located on a hospital campus, and thus, from the perspective of the patient, "in a hospital," provides an option that will appeal to persons in preference to the alternative of obtaining inpatient hospice care in a nursing home or freestanding hospice facility. This appeal is described as based on patient "confidence" in the hospital setting and the "pain relief" available in the hospital, as contrasted with alternative settings.

The applicant notes that many of the patients will be admitted immediately following discharge from the hospital intensive care unit and describes a hospice GIP unit as a more appropriate setting at the end of life compared to "the busy, medically intensive, technology laden environment of the intensive care unit." It provided the following 2010 information for the NWH unit it was operating at the time the application was submitted, identifying hospitals as the overwhelming source of hospice patient admissions to this unit.[3]

Table 3: Admissions by Referral Source, 2010
Seasons Hospice Unit at NWHC

Referral Source	Admissions	Percentage of Total Admissions
Northwest	291	46.5%
Sinai	123	19.6%
University of Maryland	48	7.7%
St. Agnes	34	5.4%
MedStar Good Samaritan	19	3.0%
Harbor	19	3.0%
Howard County General	17	2.7%
Mercy	17	2.7%
All Hospitals	609	97.3%
Nursing Homes	12	1.9%
Seasons Home Patient	4	0.6%
Other Hospice	1	0.2%
Total	626	100.0%

Source: CON Application (DI#2)

Based on this experience, in its original application, Seasons relies totally on hospitals as a referral source in projecting potential demand for the proposed unit. It views the unit as becoming the hospice GIP unit of choice for MFSMC and the three MedStar hospitals in Baltimore City, postulating that a similar ratio of hospice admissions to MSGA admissions as experienced at NWH will apply to MFSMC and that the three MedStar hospitals in Baltimore will match the demand profile of Sinai Hospital referrals to the NWH GIP unit, using the same ratio observed for this hospital, which is affiliated with NWH.

Table 4: Potential Sources of Admission to a Seasons Hospice GIP Unit Operated at MFSMC Based on the Volume of 2010 MSGA Admission

Hospital Referral Source	Ratio of GIP Admissions to MSGA Admissions	Projected GIP Admissions	Percentage of Total Admissions
MedStar Franklin Square	4.4 : 100	458	62.1%
MedStar Union Memorial	1.5 : 100	114	15.5%
MedStar Good Samaritan	1.5 : 100	107	14.5%
MedStar Harbor	1.5 : 100	58	7.9%
Total		737	

Source: CON Application (DI#2)

[3] It would appear from this data, that hospitals are the source for over 97% of the admissions to the NWH GIP unit and less than one percent of the patients are being admitted from Seasons pool of hospice patients receiving care at home and only about 2% of patients are being transferred from a nursing home. As will be outlined below, this is not the case.

Seasons projects that its unit would generate 600 admissions in 2013, the first projected year of operation, and 725 admissions in 2014, the second year of operation, It projects a six-day average length of stay, yielding the projections shown in Table 5.

Table 5: Projected Admissions and Patient Days
Seasons Hospice Unit at MFSMC

	Admissions	Patient Days
Year 1	600	3,600
Year 2	725	4,350

Source: CON Application (DI#2)

Seasons noted that the LifeBridge facilities accounted for only 67.7% of the referrals to the NWH unit. Thus, the use of LifeBridge hospitals and its nursing home (Levindale) as an analogy to MedStar hospital support for the proposed MFSMC unit does not mean that Seasons believes all of the admissions to the proposed unit will be generated from these sources. It "can expect to receive additional referrals from other hospitals as well."

During completeness review, MHCC staff asked for additional information about the experience of the NWH GIP unit to better understand the demand potential for the proposed project. (DI#9) Table 6 profiles the full spectrum of inpatient care provided by Seasons during the first three full years in which it operated a GIP unit under its own hospice license. Admissions to the NWH GIP unit constituted 60% of total admissions by enrolled Seasons patients in 2008 to inpatient care, the first full year of operation of the NWH unit.

Table 6: Setting of Inpatient Care, Seasons Hospice Patients, Version 1
2008-2010

Setting of Inpatient Care	Admissions			Patient Days			Average Length of Stay		
Year	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**
NWH GIP Unit	500	706	801	3,751	3,813	4,348	7.5	5.4	5.4
Other Hospitals*	111	57	66	465	218	195	4.2	3.8	3.4
Nursing Homes**	72	52	76	264	160	309	3.7	3.1	4.1
Total	683	815	943	4,480	4,191	4,852	6.6	5.1	5.1

Source: CON Application, Completeness Response (DI#9)

*These do not represent admissions to a dedicated hospice unit operated by Seasons. These settings admit patients to licensed hospital or nursing home beds on as available basis under the terms of agreements with Seasons.

Staff noted that this information was not consistent with the original information provided in the CON application, which appeared to indicate a total of 626 admissions to the NWH GIP unit in 2010 rather than the 801 reported in the completeness response, and requested an explanation. Seasons responded by stating that the earlier information "only reflected admissions from hospitals to the Northwest Inpatient Unit." (DI#9) It did not explain the inclusion of "home" or several nursing homes as referral sources in the original application data, as shown in Table 3.

After a request for more detail, Seasons provided additional information. (DI#11) It reported that, in 2007, before it operated its own inpatient hospice facility in leased space at NWH, a total of 291 of its patients were admitted to 25 different nursing homes for inpatient hospice care, generating 1,585 patient days. The only hospitals noted as settings for admission of Seasons hospice patients in 2007 were NWH, specifically its "subacute," or nursing home, unit and "Union Hospital." The additional information for the years 2008 to 2010 is summarized in the following table.

Table 7: Setting of Inpatient Care, Seasons Hospice Patients, Version 2
2008-2010

Setting of Inpatient Care	Admissions				Patient Days				Average Length of Stay			
Year	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**
NWH GIP Unit	0	500	706	801	0	3,751	3,813	4,348	NA	7.5	5.4	5.4
Freestanding NHs	92	72	52	76	384	264	160	309	4.2	3.7	3.1	4.1
NWH Subacute Unit	164	44	3	25	1,085	185	4	40	6.6	4.2	1.3	1.6
Union Hospital	35	67	54	41	116	280	214	155	3.3	4.2	4.0	3.8
Total	291	683	815	943	1,585	4,480	4,191	4,852	5.4	6.6	5.1	5.1

Source: CON Application, Completeness Response (DI#11)

Seasons was also asked to provide patient origin data for inpatients. (DI#9) It provided the following, without reference to the setting of care.

Table 8: Patient Origin of Seasons Hospice Patients Admitted to General Inpatient Care (All Settings)
2008-2010

Jurisdiction of Origin	Admissions			Patient Days			Average Length of Stay		
Year	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**
Baltimore County	526	682	810	3,564	3,521	4,209	6.8	5.2	5.2
Baltimore City	35	54	51	357	326	222	10.2	6.0	4.4
Cecil	91	53	41	372	208	155	4.1	3.9	3.8
Other or Not Available	31	26	41	187	136	266	6.0	5.2	6.5
Total	683	815	943	4,480	4,191	4,852	6.6	5.1	5.1

Source: CON Application, Completeness Response (DI#9)

Seasons was also asked to report on the discharge disposition of the Seasons GIP unit at NWH (DI#11) and responded as shown in Table 9.

Table 9: Discharge Disposition, Seasons NWH GIP Unit, 2010

Discharge Disposition	Discharges	Percentage of Total Discharge
Expired at the Unit	672	83.8%
Transferred to home (w continued hospice care)	101	12.6%
Transferred to another hospice	12	1.5%
Transferred to nursing home	10	1.2%
Discharged from hospice care	5	0.6%
Transferred to another health care facility	2	0.2%
Total	802	100%

Source: Completeness Response (DI#11)

When asked to provide evidence with respect to why the need for inpatient hospice care could not be met through current methods, Seasons took the position that its development of an inpatient facility operated by Seasons under its own license is the only method in which inpatient care can be delivered to hospice patients. It states "that the only way that this care can now be provided is to transfer the patients to either an SNF (skilled nursing facility) or [to provide the services] at NW hospital, where GIP care is available." (DI#11) The response did not speak to the use of hospital beds, on an as needed basis, for the provision of inpatient hospice care, although a number of agreements between hospitals and hospices of this nature have been developed in Maryland.

Seasons was asked how the development of the hospice facility at NWH changed the utilization of inpatient hospice care by the client base of Seasons. It responded that the opening of the unit at NWH "did not change utilization patterns at all for Seasons," noting that volumes for all settings of care had grown. (DI#9) It did state that the NWH unit brought Seasons "new patients who would otherwise not have chosen hospice care." MHCC staff questioned the basis for the response that utilization patterns had not changed, pointing out that the NWH unit appeared to be responsible for large increases in the volume of inpatient care provided by Seasons, and asked Seasons, for the second time, to "provide information on the use of inpatient hospice care by Seasons clients before and after implementation of the program at Northwest." In response, Seasons provided the data shown in the following Table 10. (DI#11)

In providing this data, Seasons noted that while substantial growth in its inpatient admissions had occurred in Baltimore City and County related to opening the NWH unit, it had also experienced a high growth rate in routine care. It reported that GIP days for these two jurisdictions had increased by a factor of 2.8 times between 2007 and 2010 while routine patient days had increased by a factor of 1.2 times. However, the ratio of GIP days to total days of care had only increased from 3.5% to 7.7% in the first year of the NWH unit's operation and declined to 5.9%. in the following two years. It did concede that, based on its experience at NWH, it expected that a majority of the admissions to its proposed unit on the MFSMC campus will be persons who would not otherwise choose hospice care. "The reason is that these are patients that are more acute, and couldn't/wouldn't elect hospice care if not for the ability to be properly served." (DI#11) It describes the proposed unit as a "high acuity unit" serving a "patient/family/physician preference for a 'specialized' unit."

Table 10: Reported Impact of Implementation of the Seasons NWH Hospice Unit on the Volume of General Inpatient Days Provided by Seasons 2007-2008

Year	GIP Days	
	Without NWH Inpatient Unit	With NWH Inpatient Unit
2007	1,585	1,585
2008	729	4,480
2009	378	4,191
2010	504	4,852

Source: Completeness Response (DI#11)

Seasons was asked if it could document a problem obtaining adequate availability of a bed for a hospice patient in need of inpatient hospice care in the Baltimore County region. It

said that beds were available for patients "who want hospice care in a long term care facility on a contracted bed basis." However, this is not the "target population" for the proposed unit. This target population is a "unique population of the type of patient who previously died in acute care beds without choosing hospice care" because an "appropriate" setting was not available. (DI#11).

Interested Party Comments

Gilchrist states that Seasons has not met its burden of proof with respect to the need for its proposed project. (DI#22) Gilchrist notes that there are three existing inpatient hospice units in Baltimore County with a total of 70 beds: Gilchrist's inpatient center in Towson, with 34 beds; Stella Maris, also in Towson, with 22 beds; and the Seasons' unit at Northwest Hospital in Randallstown, with 14 beds. Gilchrist believes that the existing inpatient bed capacity in Baltimore County is sufficient to the need for inpatient hospice care in the community and that Seasons has not identified any unmet need for hospice bed capacity in its application. Gilchrist also concludes that Seasons has failed to address the State Health Plan's need methodology for hospice services. Gilchrist states that "Seasons' discussion of 'need' focuses on its unsupported conclusion that many people prefer to receive inpatient hospice care in a hospital and its expectation of direct referrals of patients from the Intensive Care Unit."

Gilchrist argues that the growth in the elderly population of Baltimore County and Baltimore City, where four MedStar hospitals operate, does not support the need for the hospital, as argued by Seasons, because Seasons has not provided any "proof" that many people find a hospital-based inpatient hospice unit more appealing than other options.

Gilchrist argues that Seasons has not supported its expectation that it will serve a new group of hospice patients in the proposed inpatient unit who would not otherwise elect hospice care, claiming that Seasons' reference to its experience at the NWH unit does not support this claim. It claims that there is no evidence provided by Seasons that the decline in mortality at NWH after the opening of the Seasons' NWH unit was "solely or primarily due to the creation of the Northwest unit." Gilchrist states that Seasons failed to provide any evidence of need in the form of client or client family complaints or feedback. Gilchrist suggests that, "at best, Seasons' responses demonstrate that there may be a demand for a particular kind of inpatient hospice care in a hospital" but that it "has not demonstrated that there is a need in the community for inpatient hospice care that is not being adequately met by one of the three inpatient hospice providers in Baltimore County."

Gilchrist takes exception to what it sees as a lack of consideration by Seasons of whether the inpatient units of Gilchrist and Stella Maris are adequate to population need, focusing instead on its own ability to provide such care. It states that Seasons has incorrectly defined its current options for providing inpatient care as being limited to transfer to a nursing home or the NWH unit, ignoring the option of transferring patients to the Gilchrist or Stella Maris units. Gilchrist notes that it receives patient admissions from MedStar Franklin Square Medical Center (identifying 69 admissions in the twelve months ending September 30, 2011) and from other MedStar hospitals and MedStar referring physicians (78 patients during the same period).

Stella Maris states that Seasons' proposed project is not consistent with the Need review criterion because it failed to perform the need analysis set forth in the State Health Plan for hospice services, which it concludes is an applicable State Health Plan methodology applicable to this project.(DI#23-25) It claims that this failure means the project cannot be approved, as a matter of law.

Additionally, Stella Maris argues that Seasons has not demonstrated an unmet need for its proposed project, commenting that no evidence was produced by Seasons to support its assertion that its proposed inpatient hospice unit will largely serve patients transferred from the MFSMC Intensive Care Unit that otherwise would not have been served by a hospice. Stella Maris states that Seasons has not shown that MFSMC patients have been denied care or are unable to obtain care at the existing inpatient hospice units in Baltimore County.

Stella Maris counters Seasons' claim of need for additional beds by noting that its 22 beds experienced an average annual occupancy rate of 64% in the twelve months ending June 30, 2011 and also states that the occupancy rate declined to 59% for the third quarter of CY 2011. It states that Gilchrist has also had "vacant beds" and has also experienced a "decline in hospice inpatient admissions."

Stella Maris questions what it identifies as Seasons' "assertion" that ICU patients are not currently part of the patient population cared for by existing inpatient hospice programs, based on the fact that Seasons' projected ALOS of 6 days is "not atypical" for inpatient hospice care. It notes that the Stella Maris' inpatient hospice unit cares for patients transferred from hospital ICUs and experienced an ALOS of 7.1 days in FY 2011.

Stella Maris disputes the ability of Seasons to project utilization patterns for the proposed hospice unit at MFSMC based on its experience at NWH, stating that Seasons failed to "provide any direct evidence that the great majority of patients in its Northwest Hospital inpatient unit are patients who would not otherwise have selected hospice care offered by existing providers."

Stella Maris states that the 50 ICU beds at MFSMC operated with an average daily census of 32 in the year ending September 30, 2010, and states that this indicates that "there is no capacity problem at MedStar Franklin Square Medical Center's ICU, countering Seasons' implication that the project meets a need to "free up ICU capacity at MFSMC."

Stella Maris states that Seasons employs an "ad hoc" need methodology in attempting to demonstrate a need for its project, based on its experience at NWH, referring to Seasons' projection that its proposed MFSMC campus hospice unit will receive referrals representing 4.4% of the MSGA admissions aged 65 and older at MFSMC and 1.5% of such admissions at the three MedStar hospitals in Baltimore City. This "methodology," which Stella Maris characterizes as based on experience with referrals from two hospitals in one fiscal year, would result in a need projection for 258 hospice beds statewide, according to Stella Maris. Given that this is over twice the number of hospice beds operating in Maryland, Stella Maris concludes that this methodology is flawed.

Applicant's Response to Interested Party Comments

Seasons believes that Gilchrist and Stella Maris have failed to demonstrate why the need methodology of the State Health Plan is applicable in a review of this type, involving a change in bed capacity by an existing general hospice, and points out that the SHP methodology is only applicable to projects involving the establishment of new hospices or the expansion of existing hospices into new jurisdictions. (DI#26-31)

Seasons responds to the interested parties' comments concerning the lack of demonstrated need for the project by noting the impact of the NWH campus unit operated by Seasons on increasing the demand for hospice within that hospital, suggesting that this is an unmet need that was not expressed in the market until a setting that appealed to this market segment of patients and families was established at NWH. Seasons states that recent data show service volumes at the interested party hospices is growing, as would be expected given target population growth, but that the freestanding (not located on a hospital campus) hospice units "are not having the same effect" on inpatient hospice bed demand as the NWH campus unit, an effect likely to be replicated at the proposed unit

Seasons suggests that Stella Maris' call for identification of specific patients denied inpatient hospice care is "anti-planning" in its implication that harm to patient access must be found as a prerequisite to approving an expansion of service capacity. It also claims that Stella Maris has overstated the relevance of its recent occupancy rate declines to consideration of the proposed project and provides no factual basis for referencing "vacant beds" at Gilchrist as demonstrating a lack of need.

Reviewer's Analysis and Findings

There is no "need" for general hospices to operate their own facilities for the provision of inpatient hospice care, in the conventional sense that most people would define the term "need." General hospices, as health care facilities, are not required to operate such inpatient facilities in order to fulfill all of their legal requirements for licensure and certification. Most general hospices operating in Maryland do not operate such facilities. There has been no evidence presented in this application that hospice patients who have a care-related need to be inpatients, i.e., a need to be housed for one or more days and nights in a facility setting outside of their home where they can receive all of the services defined to be most appropriately and safely delivered in such a setting, can only obtain these services in an inpatient facility owned and/or operated by a general hospice. (Of course, the "home" of some hospice patients is a nursing home, which is an inpatient care setting itself.) I do not find that any evidence has been presented indicating that general hospices cannot arrange for adequate access and availability of bed capacity in hospitals and/or nursing homes in Maryland in order to fulfill their requirement to assure that the needs of their hospice patients for inpatient care can be met. A great deal of the applicant's supportive case for this project is misleading because it implies that there is only one way to deliver inpatient hospice services, which is through a dedicated facility operated by a general hospice.

It is clear that some hospices, in particular the large general hospices that are participants in this project review, want to operate their own inpatient hospice facilities and perceive

advantages for themselves and their patient populations in this model of care. They have the operating scale to make the direct provision of inpatient care through their own facilities feasible. I also believe there are advantages for patients with respect to the continuity of care that can be achieved through this model and the ability to have a facility that is specifically designed and managed to create the optimal environment for hospice patients and their families and friends. Additionally, given that this service is overwhelmingly used by Medicare patients and is reimbursed as a Medicare benefit, the potential impact on charges that could be a concern with respect to development of excess service capacity is limited. For these reasons, I believe it is reasonable, as a general proposition, that MHCC be open to allowing general hospices to develop and operate their own inpatient facilities when such facilities can be feasibly established and operated and when there is no evidence indicating that such development and operation will alter the provision of inpatient hospice care in ways that may diminish quality or patient safety or result in inappropriate delivery of hospice services.

As can be seen in the following table, six of the nine general hospices in Maryland that operate general inpatient facilities rank as the six largest hospices in the State, in terms of patient volume.

Table 11: Population of Authorized Service Areas, 2010, and Total Patients Served, 2011 Maryland General Hospices

Hospice	Population of Authorized Service Area, 2010	Total Patients Served 2011	Inpatient Hospice Facility
Gilchrist	3,758,496	4,120	Yes
Community	3,627,219	393	No
Seasons	3,627,219	2,683	Yes*
Joseph Richey	3,506,407	305	Yes
Stella Maris	3,347,383	1,042	Yes
Evercare	2,640,226	289	No
Heartland	2,495,557	489	No
Professional Healthcare Resources	2,250,731	236	No
Holy Cross	2,122,282	558	No
Heartland Beltsville	1,835,197	535	No
Amedisys	1,771,924	673	No
Hospice of the Chesapeake	1,401,076	2,282	Yes
Carroll	1,205,548	721	Yes
Hospice of Frederick County	1,205,162	651	No
Jewish Social Service Agency	971,777	424	No
Montgomery	971,777	2,011	Yes
Capital	863,420	581	No
Coastal	209,275	1,003	Yes
Hospice of Washington County	147,430	816	No
Hospice of Charles County	146,551	303	No
Hospice of St. Mary's	105,151	346	No
Calvert	88,737	272	No
Western Maryland	75,087	254	No
Shore	70,848	252	No
Chester River	67,995	99	No
Hospice of Queen Anne's	47,798	194	Yes
Hospice of Garrett County	30,097	117	No

Source: MHCC Records and MHCC Annual Hospice Survey, 2011;; *Licensure status uncertain..

In this review, Gilchrist and Stella Maris, both of which operate inpatient facilities and the largest and third largest hospice programs serving Baltimore County and, as a major secondary market, Baltimore City, urge MHCC to deny the application of Seasons, the second largest hospice program in the area and a major competitor, to establish an inpatient unit. (A third inpatient hospice provider, Joseph Richey Hospice, in Baltimore City, while not an interested party, has also written to MHCC recommending denial of the project.) Thus, approval of the proposed project would establish the first CON-approved inpatient hospice program operated by Seasons since the termination of its lease at NWH in 2012. Denial of the project would result in elimination of the ability of Seasons to incorporate an inpatient program that it controls and operates under its own license, until and unless it obtains CON approval for the unit it wants to operate at Sinai. As noted in the background information reviewed at the beginning of this Recommended Decision, the unit operated at Northwest Hospital by Seasons has the same problems with respect to licensure found to exist with the unit previously operated by Seasons at Sinai.

The arguments put forward by the two interested parties fall under two headings. First, they claim that need for the project has not been demonstrated by Seasons. Secondly, they argue, in effect, that need could not be demonstrated unless the inpatient facilities that they operate in Baltimore County were experiencing excess demand, as they define that condition, which is not defined in the State Health Plan. The Annual Survey of Hospices conducted by MHCC indicates the following with respect to bed occupancy at the Gilchrist and Stella Maris hospice facilities.

Table 12: Average Daily Census, Beds, and Average Annual Occupancy
Gilchrist and Stella Maris Inpatient Hospice Facilities*
2007-2011

	2007	2008	2009	2010	2011
Gilchrist					
Average Daily Census	22.8	22.5	23.4	25.8	29.1
Beds	34	34	34	34	44
Average Annual Occupancy Rate	67.1%	66.1%	68.7%	75.9%	66.2%
Stella Maris					
Average Daily Census	6.2	8.2	6.7	6.5	9.7
Beds	22	22	22	22	22
Average Annual Occupancy Rate	28.3%	37.1%	30.5%	29.4%	44.1%

Source: MHCC Annual Hospice Survey
*includes only GIP utilization

There is no basis for finding that the State Health Plan methodology for hospice services is applicable to this project, as suggested by the Interested Parties. An examination of this methodology leaves no doubt that it is applied to overall hospice utilization as an approach to determining what jurisdictions may qualify for the expansion of overall hospice service capacity, through new market entry or expansion of an existing general hospice into the jurisdiction. Inpatient service volume is such a minor proportion of the overall patient service volume used in this methodology is not applicable to this project.

The demonstration of need for a project of this type is, of necessity, of a different order than that applicable to many of the projects regulated under CON. In this case, when a general

hospice program proposes to establish or expand its bed capacity, it can be viewed as primarily proposing to change the manner in which it delivers one of the services that it is already required to make available to its hospice patients. In the case of a general hospice program such as Seasons, inpatient care is not the primary mode of delivering hospice services and is not likely to be in the future. Medicare has payment policies that hinder the ability of general hospices to become, first and foremost, providers of inpatient care. In contrast, hospitals, nursing homes, or residential treatment centers that propose CON applications that change their bed capacity are proposing to alter capacity at the core of their service model, i.e., inpatient care. Unlike hospice programs, they cannot meet their mission to serve patients without bed capacity. Bed capacity under the control of these facilities is needed, in an absolute sense. Hospices do not need to operate bed capacity but it is an option that may make sense for meeting their patients' needs.

In the case of Seasons, its experience in operating its own hospice unit at NWH indicates that it was successful in creating a new market niche by operating a GIP unit on a hospital campus, effectively marketed as an extension of the hospital's services. I am convinced that it has generated a substantial proportion of its demand at the NWH unit from a patient population that it correctly assesses might not have become hospice patients without the existence of the unit. It is logical to assume that this experience may be replicated at the proposed MFSMC campus unit. For this reason, while I think it is true that implementation of the proposed project will have some affect in reducing or limiting future demand for inpatient services at Gilchrist and Stella Maris, the potential shift in demand is overstated by these interested parties, which mutes the strength of the arguments they have made under the "need" criterion with respect to the available capacity they have already developed. Much of the Seasons bed capacity proposed at the MFSMC campus is likely to be filled with new demand created by the unit, not demand that would be using the bed capacity already developed by Gilchrist and Stella Maris.

With respect to available bed capacity at Gilchrist and Stella Maris, the data indicate that these facilities could accommodate additional patient demands, especially Stella Maris. However, for the reasons I have already discussed, this fact does not provide a strong basis for denying this project. Seasons generated substantial new demand in recent years with its NWH campus facility, but it does not appear that this merely shifted demand from Gilchrist and Stella Maris. Average daily census at these facilities did not decline between 2007 and 2011, when the NWH unit, in its first operational year of 2008, exceeded the demand occurring at Stella Maris and grew 16% over the next two years. One could argue that the Stella Maris facility has been chronically underutilized in recent years, but this would not appear to be the result of competing facilities holding bed use down. And it is important to recognize that these inpatient facilities and operations are not the largest business line of these organizations. The efficiency of their bed capacity use has not been demonstrated to be a key to their economic well-being.

The interested parties did not claim and I have not found that this new source of inpatient hospice service demand should be rejected by MHCC as illegitimate or not indicative of a need perceived by patients, their physicians, and their families. I consider the application to have demonstrated that an unmet demand for inpatient hospice care does exist that can be met by a project of this type. Of equal importance, I also find that it is reasonable to allow for a general hospice of Seasons size to effectively compete in the Baltimore area with the other two large hospice programs by being allowed to develop similar service offerings when its size makes this

feasible. The interested parties paint an unrealistic picture of the seamless way in which a region with competing hospice organizations can function in providing optimal care for patients if only some of the organizations, all of which are large, have certain types of facilities, necessitating patient transfers, not only between different settings of care but also between distinctly separate providers of care. Hospice care is a service, especially when it becomes an option chosen in the final days or weeks of life, in which patients and families can reap substantial benefits from the continuity and care coordination that can be achieved within a single program, as their needs change.

However, I also believe that Seasons has made inappropriate choices in the approach it has taken to meeting regulatory requirements associated with CON and licensure for inpatient hospice care in the past year. The unit it now operates at NWH is not in compliance with a recent determination made by OHCQ and MHCC with respect to operation of dedicated hospital units comprised of licensed general hospital beds. Continued operation of the NWH program by Seasons may be in jeopardy as a result. Authorization of this project will assure that Seasons has the ability to operate an inpatient hospice program under its general hospice license, the same capability enjoyed by the two other major providers of hospice services to Baltimore County.

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.

Applicant's Response

In response to this criterion, Seasons notes that renovating vacant space at MFSMC is more cost effective than building new space. It compares the estimated cost of the project with the Marshall Valuation Service cost index for a similar space newly constructed and finds the project cost to be low by comparison. (DI#2)

It states that the number of deaths in licensed hospital beds at MFSMC will decline a projected 50 percent as a result of this project, reducing hospital length of stay. The implication is that these deaths will "transfer" to the proposed hospice unit. This projection is based on Seasons' operation of the NWH unit. It attributes this phenomenon primarily to increased willingness of patients and families to choose hospice when they perceive the on-site unit to be part of the hospital and "culture change" among hospital staff, leading to more recommendations to patients supporting the choice of hospice care. It notes that shifting general medical/surgical or intensive care unit days to hospice days results in substantial cost reductions, citing, as an example, the $1,898 average revenue per diem at MFSMC in FY 2010 for an ICU day and the $1,284 average revenue per diem for a general medical/surgical day and the $633 per day in total revenue that Seasons projects for the proposed inpatient hospice unit. (DI#2)

Interested Party Comments

Gilchrist states that Seasons failed to adequately address this criterion because it did not address the alternative of providing inpatient hospice care at the existing inpatient hospice units operating in Baltimore County, focusing instead on the "purported advantages of putting a hospice unit in a hospital." Gilchrist argues that Seasons' comparison of the cost of putting a unit in existing vacated space, as proposed, rather than constructing a unit is irrelevant. Gilchrist states that Seasons' claim of cost-effectiveness for its project because it will result in fewer patients dying in the ICU is "simply an allegation," that ignores that the same result would be achieved by referral of patients to one of the existing inpatient hospice units. Gilchrist argues that Seasons has failed to provide evidence supporting its claims that mortality in acute care hospital beds will drop and acute care length of patient stay will decline as a result of the proposed project.(DI#22)

Similarly, Stella Maris states that Seasons has not demonstrated the cost-effectiveness of the proposed project because it has failed to analyze whether the proposed project would be more cost-effective than the alternative existing facilities, such as Stella Maris. Limiting consideration of cost and effectiveness to the alternative of patients declining hospice care and patients making the choice for hospice care ignores the comparative cost and effectiveness implied by the project with respect to patients who would have made the choice for hospice care by using an existing hospice if the project were not implemented. (DI#23-25)

Applicant's Response to Interested Party Comments

Seasons responds that its proposed facility is not truly comparable to those of the interested parties because it will provide services to patients on ventilators, patients receiving onsite palliative chemotherapy and radiation therapy, and patients requiring intensive symptom management. (DI#26-31) It postulates that there are no costs to the health care delivery system implied by its project because rates charged to payors are fixed and are the same for every hospice in the same region. Costs at MFSMC and patient out-of-pocket costs will go down as a result of the project's relocation of patients from expensive acute care units to the proposed hospice unit.

Seasons states that Gilchrist falsely identified Seasons as claiming that its proposed project will "demonstrate superior patient care effectiveness." Rather, it notes that it has only identified an unmet need that only a unit of the proposed type can meet. Its project will shift the setting in which many patients die, with demonstrable benefits, and this shift will not occur, in many cases, if only the interested party inpatient hospice alternatives are available.

Reviewer's Analysis and Findings

I find that Seasons reported experience in establishing and operating the NWH unit supports its contention that establishing an inpatient hospice unit on a hospital campus will generate a new stratum of demand for inpatient hospice care. I am also convinced that this new market segment will experience lower cost and that no evidence has been presented that indicates the end-of- life care possible in a hospital campus hospice unit operated by a general hospice is less effective at achieving the palliative care objectives desirable for a dying patient, when

compared to the alternative of end-of-life care provided in conventional medical/surgical units of general hospitals. The information suggests that development of the NWH unit did produce a change in patient and/or family preferences. The NWH unit was originally established as a Seasons unit in space leased from NWH on its campus, similar to the model proposed by Seasons in this project.

As I have noted, there is no doubt that the establishment of a Seasons hospice unit at MFSMC will have the effect of reducing demand for inpatient hospice care that would otherwise utilize the facilities of Gilchrist and Stella Maris. However, I believe this will largely be limited to the patient population that uses inpatient hospice care at some point in their course of hospice care, which is well below the projected numbers produced by Seasons in this review. I believe that Seasons is correct in its expectation that a large number of its projected patients at MFSMC would be lost to any hospice program as a potential patient, without the type of inpatient unit that Seasons is proposing, i.e., one that operates on the hospital campus. Therefore, most such patients are not being prevented from availing themselves of a more cost-effective mode of service delivery if this unit is developed. I believe that hospice patients enrolled for delivery of care at home by Gilchrist or Stella Maris, who come to need inpatient care during the course of their end-of-life care, will continue to choose Gilchrist or Stella Maris facilities for inpatient care if they, their families, and physicians are satisfied with the service they are receiving.

I conclude that it is reasonable for Seasons, given its market presence and patient volume, to be able to compete across the full spectrum of hospice facilities and programming with its main competitors in the Baltimore market, in the interest of patient care continuity and choice. I believe that continuity in care provision is an important dimension of care effectiveness. I find that the establishment of a Seasons inpatient hospice unit as proposed should be able to operate at a level of cost relative to effectiveness that is comparable to that of the comparable hospice-operated inpatient options available in the Baltimore area. It is less cost effective, from the standpoint of capital cost, than utilizing existing hospital or nursing home beds, on an as-needed basis, when the inpatient needs of the hospice patient and their family can be fully met by such an option and such settings do not discourage the patient and family from making the choice to obtain hospice care. However, this is a very modest cost consideration over the life of a program and Seasons has successfully used this option to deliver some inpatient hospice care after the development of its unit on the NWH campus. I find that comparison of the costs and effectiveness of this project with its alternatives does not justify its denial.

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.

Applicant's Response

In response to this criterion, Seasons provided a letter from an accountant attesting that it has adequate funds to implement the project, at its estimated cost of just over $621,000. (DI#2)

It later provided an unaudited 2009 balance sheet and income statement for the applicant entity. The balance sheet reported current assets, including accounts receivable (net of doubtful accounts), prepaid insurance, prepaid expenses, and monies due from related parties of $7.77 million as of December 31, 2009.(DI#9) Current liabilities totaled $5.11 million and retained earnings of $3.39 million were reported as of December 31, 2009. It reported net income of $870,077 for the applicant entity in CY 2009 on net revenue of $17.1 million dollars,

Seasons stated that the project will only have an impact on the unit operated by Seasons on the NWH campus, a projected loss of 42 admissions, and projects that this will have only short-term impact on that unit, because of prospects for continued growth in demand. It projects cost reductions at MFSMC related to substitution of hospice care for intensive and general medical care for dying patients.

It presented financial projections for the proposed facility. At an average daily census of 9.9 patients in the first year of operation, it projected net operating revenue of $2,278,582 ($633 per day) and total operating expenses of $2,194,300 ($610 per day), generating about $23 per day in income, or $84,282. It projects that ADC will increase to 11.9 patients in the second year of operation and has held revenue per day constant, consistent with the application instructions. However, it projects that expenses per day will decline to $574 in Year 2, with no impact on administrative overhead related to the 21% jump in patient day volume. Net income in Year 2 is projected at $58 per day, or $254,102.

Interested Party Comments

Gilchrist states that Seasons has not provided sufficient financial information for evaluation of viability, citing the lack of audited financial statements and the inadequacy of the accountant letter attesting that Seasons has adequate financial resources for the project and the unaudited financial statements provided with review by the accountant. It also questions the six day average length of stay ("ALOS") projected for the proposed FSH hospice unit, finding this stay to be long for the primary source of patients projected by Seasons, "severely ill patients who are discharged from the ICU." If the ALOS proves to be shorter, Seasons will need more admissions to utilize the bed capacity proposed, calling viability into question. (DI#22)

Applicant's Response to Interested Party Comments

Seasons rebuts the Gilchrist comments by arguing that it met the requirements for documentation and that Gilchrist has failed to specifically identify any parts of the documentation that it finds wanting to satisfy this criterion. (DI#26-31) It states that its length of stay assumptions are based on the actual experience of hospice units of the proposed kind that it operates.

Reviewer's Analysis and Findings

I find that the applicant's documentation with respect to financial resources for implementation of this project is adequate for a privately held corporation and an expenditure of this size. While cash reserves of $621,000 were not explicitly identified, the balance sheet and income statement data, coupled with the independent accountant's confirmation that the

applicant entity has access to an "equity contribution" of $650,000 is sufficient to demonstrate that this applicant can, in all likelihood, fund the renovations required at the cost estimated.

The following table shows reported average length of stay (reported patient days/admissions) for the Seasons inpatient hospice unit at Northwest and for all inpatient facilities reporting in Maryland from 2008 to 2011.

Table 13: Reported Inpatient Hospice Facility Average Length of Stay, Seasons and All Maryland Inpatient Hospice Facilities 2008-2011

	2008	2009	2010	2011
Seasons NWH Unit	8.6	6.3	7.1	6.3
All Maryland Inpatient Hospice Facilities	8.7	8.0	8.2	8.1

Source: MHCC Annual Hospice Survey

This data would suggest that the assumption of a six-day ALOS for the proposed project is not unreasonable.

I find that the project is likely to be economically viable in both the short- and long-term, and that Seasons has the financial and non-financial resources necessary to implement and sustain the project. An important perspective informing my finding with respect to viability and its importance in making a recommendation on this project is that inpatient hospice care is not the primary business activity of the applicant entity and the downside risk involved for Seasons if the proposed project does not perform as anticipated is not great.

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.

Seasons has never received a Certificate of Need in Maryland

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.

Applicant's Response

As noted, Seasons stated, in addressing the Viability criterion, that the proposed project will only have an impact on the unit operated by Seasons on the NWH campus, a projected loss

of 42 admissions, and projects that this will have only a short-term impact on that unit, because of prospects for continued growth in demand.(DI#2) It projects cost reductions at MFSMC related to substitution of hospice care for intensive and general medical care for dying patients.

Seasons projects a need for 22.25 full-time equivalent ("FTE") staff for the proposed unit by the second year of operation, when it projects the provision of 4,350 patient days of care, an ADC of 11.9 patients. The staff breakdown (all in FTEs) is: 3.0 administrative staff (Unit Director and 2.0 Team Assistants); 17.25 direct care staff (1.0 Medical Director, 8.0 Registered Nurses, 3.25 Licensed Practical Nurses, and 5.0 Certified Nursing Assistants); and 2.0 Social Workers.

Seasons was asked to discuss the impact of the proposed project on non-Seasons hospice programs. It repeated that no negative impact was expected "because the new unit makes the public more comfortable with and knowledgeable about hospice care." (DI#9) The implication is that the project will have a positive impact on volume for all hospice care providers. When asked why the project is not duplicative of capacity in hospitals and comprehensive care facilities that can be used by hospice patients in need of inpatient care, Seasons responded that the project is "repurposing" former hospital space; that it is not feasible "to develop a dedicated inpatient hospice unit in existing hospital and nursing home beds which are currently in operation, since the beds are being utilized for the services for which they are licensed;" that the State Health Plan references the potential problem of "non-traditional settings" for delivery of hospice care "for convenience sake;" and the project is not duplicating any service currently available at MFSMC.

Seasons stated that the project's ability to increase the willingness of patients and their families to choose hospice care is a positive impact of the project and that it will increase use of hospice in all settings. It also cited the ability of the project to increase efficient use of intensive care and emergency department resources by moving patients destined to die in the ICU out of the ICU more quickly, freeing up the throughput capability of emergency departments stabilizing and moving patients to intensive care. It also projects a reduction in hospital cost, through an increase in the number of persons dying in a lower-cost hospice unit rather than a high-cost acute care unit at MFSMC.

Interested Party Comments

Gilchrist states that Seasons failed to adequately address the impact of the proposed project on existing providers of inpatient hospice services and specifically claims that the proposed project will have a "tremendous negative impact" on Gilchrist, citing an estimate of $2.8 million in lost revenue, considering what Gilchrist believes will be the overall impact of the proposed project on all categories of patient admission to Gilchrist. (DI#22) It notes that Seasons claimed that only its own NWH inpatient hospice unit would be affected by the proposed project and counters that claim by noting the number of admissions for hospice care it receives from MFSMC, two other MedStar hospitals, and MedStar attending physicians (147 in FY September 30, 2011, or 16 percent of total admissions). It also claims that the Seasons' application indicates that it expects to expand its non-inpatient hospice service volume as a result of the project, by increasing referrals of "homecare" hospice patients from the MedStar network of hospitals and physicians. Gilchrist agrees with this projection, stating that this could result in

a potential loss of 208 home care service hospice patients by Gilchrist, based on its FY September 30, 2011 admissions experience.

Stella Maris states that Seasons' assessment that its proposed project "should not have a negative impact on other hospice programs" is not true. (DI#23-25) It supports this position by referencing growth in Seasons' admissions from Baltimore City and County from 2007 to 2009, 121 percent, compared to growth of 8.2% during the same period from those same jurisdictions for other hospice providers. It also cites Seasons' increase in the market share of hospice patients from the same two jurisdictions during the same period. Stella Maris notes that this increased from a 10.6 percent share to a 20.9 percent share in Baltimore City and from a 16.1 percent share to a 27.2 percent share in Baltimore County. Stella Maris suggests that this growth corresponds with the initiation of the NWH hospice unit by Seasons in 2008 and, given that correspondence, claims that "it is difficult to believe that opening an even larger inpatient unit at MFSMC in the eastern part of Baltimore County will not increase Seasons' market share to the detriment of other providers." In this regard, Stella Maris states that it "depends on MedStar hospitals, citing the 60 inpatient admissions from MFSMC in FY 2010, 10.5 percent of that facility's total inpatient admissions, and the 76 inpatient admissions from MFSMC in FY 2011, 11 percent of total inpatient admissions.

Stella Maris also notes the total of 97 total inpatient admissions in FY 2010 it received from all MedStar hospitals in Baltimore City and Baltimore County (17 percent of total inpatient admissions) and the 128 total inpatient admissions from these four hospitals in FY 2011 (18 percent of total Stella Maris inpatient hospice admissions). Stella Maris concludes that many of the patients who will receive care at the proposed Seasons' inpatient hospice unit, if it is implemented, are patients who would otherwise go to Stella Maris and other existing providers.

As a further indication of the negative impact that Stella Maris suggests will arise from the proposed project, it notes that Seasons' CON application indicates that the opening of the Seasons' inpatient hospice unit at NWH in 2008 resulted in a 120-patient reduction in the number of hospice inpatients served in the sub-acute unit at NWH. Stella Maris concludes that this indicates that it is likely that Stella Maris could lose all or most of its hospice inpatient admissions originating from MFSMC. Similarly, Stella Maris draws inferences similar to those drawn by Seasons from the Seasons' experience serving Sinai Hospital patients at its NWH inpatient hospice unit. Stella Maris states that Seasons' CON application indicates that it received no hospice inpatients from Sinai Hospital before opening the NWH unit but served 123 patients from Sinai Hospital at the NWH unit in 2010. Stella Maris indicates that this experience suggests that the proposed unit on the MFSMC campus will draw a substantial number of patients from MedStar Good Samaritan Hospital, causing the loss of all or most of such patients who would otherwise obtain services from Stella Maris. As previously noted, in FY 2011, Stella Maris reports that 18 percent of its total inpatient hospice admissions came from the four MedStar hospitals in Baltimore City and Baltimore County.

Stella Maris projects an impact of the proposed project beyond inpatient hospice care. It states that 17 percent of its home hospice patients in FY 2010 were transfers from the local MedStar hospitals and the proportion in FY 2011 was 20 percent. Stella Maris suggests that "having a highly visible and continuous presence at MFSMC would enable Seasons to gain a

marketing advantage for its home hospice business over Stella Maris and other existing providers of home hospice care in eastern Baltimore County."

Stella Maris states that Seasons' experience with the NWH unit, as described in the CON application, indicates that it is likely to experience a large increase in general inpatient days if the proposed project is implemented, noting that Seasons' reported ratio of general inpatient days to total hospice patient days nearly doubled from 2007 to 2010, from 3.52 percent to 5.94 percent and its volume of inpatient days increased from 1,150 to 4,512 over the same period, an increase attributable to the opening of the NWH unit, given that 4,430 of those 2010 days occurred at that facility. Stella Maris suggests that the proposed unit on the MFSMC will be large enough to accommodate all of the patients it saw in FY 2011 referred from MedStar Hospitals. Under this scenario, Stella Maris projects it would have lost $1.3 million in revenue in FY 2011.

Applicant's Response to Interested Party Comments

Seasons argues that the interested party comments fail to account for population growth and the corresponding growth in demand for hospice care. (DI#26-31) It points out that all hospices saw growth in volume in the period following establishment of its inpatient hospice unit at NWH and there is no reason to believe that growth will stop at Gilchrist and Stella Maris if the proposed project is established. It repeats its assertion that the project will increase public awareness of hospice generally in ways that will benefit all hospice providers and emphasizes the evidence that much of the demand it will generate will be from new demand creation, eliminating the interested parties' implication that increased demand for Seasons hospice beds can only come from the flow of patients to other hospice facilities. For these reasons, it labels Gilchrist's projection of a total loss of 355 patients and $2.8 million in revenue as unjustified, without any support or backup reference. These estimates wrongly assume a static environment. In Seasons' view, Gilchrist has "simply expressed its fears to argue against enhanced services elsewhere, and has provided no information the CON regulations require to question Seasons' application."

Seasons finds the Stella Maris' comments regarding market share to be "irrelevant" because Stella Maris and Gilchrist are not limited to providing inpatient hospice services. Because hospice is mainly a home-based service, Seasons notes that capacity is not a constraint on market share and the interested party hospices "have a limitless opportunity for growth." Both serve other large jurisdictions where they have opportunities to benefit from growing elderly populations. Both benefit from being part of larger health systems, with hospital affiliates and, in the case of Stella Maris, additional types of health care facilities and programs, including a continuing care retirement community, all of which have an affinity relationship with the Catholic Church. Seasons does not have these "assured source of referrals internally" and must rely on negotiations.

Seasons criticizes the analogy drawn by Stella Maris between the shift of patients from the NWH subacute unit to the leased NWH unit when that latter unit was developed and the loss of MFSMC patients that Stella Maris will experience if the proposed project is approved. It claims that the proposed project will not prevent the referral of home hospice patients from MedStar hospitals and notes that it has not assumed, in its analysis, that it will capture all of the

referrals of inpatient hospice patients from MedStar hospitals. It notes that Stella Maris projects revenue losses but ignores cost and charges, as referenced in the criterion.

Reviewer's Analysis and Findings

I believe that the applicant has made unrealistic claims with respect to the likely impact of the proposed project on the two hospices that operate inpatient hospice facilities in Baltimore County, the interested party hospices. It essentially claims that there would be no impact on these competing hospices other than an undefined positive impact from greater general receptivity to hospice as a service option, identified as a by-product of a new hospice unit on the MFSMC campus. However, I also believe that the two interested parties have overstated the likely impact of the proposed project on the demand for their services.

My starting point for assessing the impact of this project is summarized in the following table. It shows that demand for the services of Seasons and the two interested party hospices during the period in which Seasons established and operated a new 14-bed inpatient hospice facility in Baltimore County on the campus of Northwest Hospital in space leased from the hospital, a project that is very similar to that under review. With respect to total inpatients served at hospice-operated facilities, all three hospices saw growth: 52% for Gilchrist and 12% for Stella Maris. Seasons first reported inpatients for its NWH facility in 2008 and its census grew from 421 patients in 2008, the first year of service in the new unit at NWH to 679 patients in 2011, the last full year that Seasons operated the NWH facility in leased space, an increase of 61% in just three years.

All three hospices also saw growth in total patients during the 2007 to 2011 period; 56% for Gilchrist; 60% for Stella Maris; and 127% for Seasons.

Table 14: Reported Inpatients Served and Total Patients Served
Gilchrist, Stella Maris, and Seasons
2007-2011

	2007	2008	2009	2010	2011
Gilchrist					
Inpatients Served	1,055	1,115	1,116	1,453	1,599
Total Patients Served	2,649	2,814	3,329	3,708	4,120
Stella Maris					
Inpatients Served	414	482	503	467	464
Total Patients Served	652	765	822	882	1,042
Seasons					
Inpatients Served	0	421	691	697	679
Total Patients Served	1,181	1,893	2,241	2,615	2,682

Source: MHCC Annual Hospice Survey

This data certainly suggests that the market for inpatient hospice care is less static in nature than one would conclude from the interested parties' comments. Seasons generated 421 inpatients in its first year of operating the hospice facility on the NWH campus in 2008. That was equivalent to 29% of the total hospice unit patients of Gilchrist and Stella Maris combined in the previous year, 2007. Yet both Gilchrist and Stella Maris report experiencing growth in

inpatients in 2008, a combined increase in inpatients of almost 9 percent in that year. While Seasons experienced strong growth in inpatient demand in the three years after opening the unit in Randallstown, this does not appear to have significantly damaged the other two Baltimore County inpatient units. Gilchrist reported overall growth from 2008 to 2011 in its inpatient count of 43%.[4] Stella Maris inpatient count declined between 2008 and 2011, but only by a modest 3.7 percent and remained above the level reported for 2007, the year before the Seasons' unit on the NWH campus opened.

As I have found previously in this report, the Seasons' experience at NWH indicates that it is likely to see new demand generation as a result of the development of an inpatient hospice unit on a hospital campus. This convinces me that impact of the proposed Seasons project on the MFSMC campus cannot be viewed as a "zero sum game," i.e., Seasons' likely gain in inpatient census will not exactly correspond to losses in inpatient census or overall patient census at Gilchrist or Stella Maris. The experience of the Baltimore hospice programs during the period in which the Seasons NWH program was established suggests that such a relationship is far from likely.

With respect to the appropriate perspective to bring to an assessment of impact, I believe that Seasons makes a valid point in its counterarguments that touch on the size and scope of services that can be offered by the interested party hospices. The following tables profile the reach of Seasons, the two interested party hospices, and Joseph Richey Hospice in their respective service area jurisdictions.

Table 15: Patient Origin, Total Patients, Selected Hospices
2011

	Anne Arundel	Baltimore City	Baltimore County	Carroll	Cecil	Frederick
Gilchrist	10	918	2,184	90	NA	2
Joseph Richey	3	201	94	NA	NA	NA
Stella Maris	15	211	598	60	NA	NA
Seasons	181	407	1,368	46	301	NA
Total	2,145	1,841	4,899	820	637	697

	Harford	Howard	Montgomery	Prince George's	Total
Gilchrist	279	614	NA	82	4,100
Joseph Richey	4	2	NA	0	304
Stella Maris	131	NA	1	NA	1,016
Seasons	163	85	NA	132	2,683
Total	1,053	776	3,369	1,820	21,739

Source: MHCC Annual Hospice Survey
Note: "NA" designates that the hospice is not authorized to serve the jurisdiction

[4] Gilchrist developed a second freestanding hospice facility in Howard County during the 2010-2011 period.

Table 16: Market Share, Total Patients, Selected Hospices
2011

	Anne Arundel	Baltimore City	Baltimore County	Carroll	Cecil	Frederick
Gilchrist	0.5%	49.9%	44.6%	11.0%	NA	0.3%
Joseph Richey	0.1%	10.9%	1.9%	NA	NA	NA
Stella Maris	0.7%	11.5%	12.2%	7.3%	NA	NA
Seasons	**8.4%**	**22.1%**	**27.9%**	**5.6%**	**47.3%**	**NA**

	Harford	Howard	Montgomery	Prince George's
Gilchrist	48.4%	79.1%	NA	0.2%
Joseph Richey	0.7%	0.7%	NA	0.0%
Stella Maris	22.7%	NA	0.0%	NA
Seasons	**28.2%**	**11.0%**	**NA**	**7.3%**

Source: MHCC Annual Hospice Survey
Note: "NA" designates that the hospice is not authorized to serve the jurisdiction

Gilchrist has only chosen to compete for hospice patients, in a significant way, in five of the eight jurisdictions it is authorized to serve. It has minuscule penetration in two large markets, Anne Arundel and Prince George's and one medium-sized market, Frederick. Stella Maris has only chosen to be a competitive factor in four of the six jurisdictions it is authorized to serve. Like Gilchrist, it does not effectively compete in Anne Arundel and appears to have ignored Montgomery County, both rich markets. In contrast, Seasons is making a substantive effort in all eight of its jurisdictions. It has substantial upside potential for further penetration in these areas but the important point here is that it appears to be trying to use all of its potential service area rather than concentrating its efforts to the degree that Gilchrist and Stella Maris appear to be doing. This is not a criticism of Gilchrist and Stella Maris. They are free to pursue their mission and business objectives in the areas they are eligible to serve as they see fit and I am in not in a position to second guess the wisdom of their decisions. The choices they have made could be very logical within the framework of their systems affiliations. However, it is relevant for MHCC to weight its consideration of their objections to the proposed action of Seasons in light of the potential growth opportunities they have been given but have decided not to pursue. Obviously, they have some ability to offset the negative impact they may experience in the Baltimore City and County region from the expansion of a competitor hospice's service capacity by more effectively competing in other regions where they may face other competitive challenges but may also have new opportunities.

Because of its geographic location, it is probable that a Seasons hospice unit on the MFSMC campus is more likely to have an impact on demand for hospice services by Gilchrist and Stella Maris, both of which have hospice facility campuses closer to MFSMC than NWH. Furthermore, MFSMC is linked to a larger network of affiliated hospitals than NWH. This is the basis for my finding that the Seasons assertion that this project is not likely to have any negative impact on Gilchrist or Stella Maris is unrealistic. I do not believe the likely impact, even if it falls within the 15-20 percent impact range cited by the interested parties, will be existential because of the likelihood of the continued growth in demand for hospice services and the potential for growth that has not been fully exploited by Gilchrist and Stella Maris outside of Baltimore County and City. However, the proposed project will provide MFSMC with a strong

competitive advantage for capturing hospice patients affiliated with the MedStar hospital network, an advantage that it previously established with the LifeBridge hospitals. For these reasons, I find that the likely level of impact of the proposed project on the hospice programs operated by the interested parties should not bar approval and implementation of the project. This finding is based on my expectation that Seasons will not operate the previously established unit at Sinai unless it obtains CON approval from MHCC and recognition of hospice licensure by OHCQ and the jeopardy under which the NWH unit exists because of its close similarity to the Sinai unit.

V. SUMMARY AND RECOMMENDATION

Based on my review of the materials in the record of this review and the oral arguments made by the parties, I recommend that the Maryland Health Care Commission approve this project with a condition that, before first use approval to operate the proposed facility, Seasons must provide a revised Payment for Services policy that clarifies the household income bands eligible for partial charity care.

The bases for my recommendation of approval are summarized as follows:

The State Health Plan

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. These standards were developed for use in considering proposals to establish new general hospice programs or expand an existing hospice program to one or more additional jurisdiction. As such, they outline what the elements of an acceptable hospice program should be. This proposed Seasons project is not in either of these project categories. So, the current SHP, in this review, serves as a checklist review for a large, established hospice like Seasons. which can be expected to demonstrate current compliance, in its operations, with these standards to be a successful CON applicant. I find that, as expected, Seasons has substantially complied with some exceptions. The most important concerns the standard for Charity Care and Sliding Fee Scale, reproduced below.

> **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:**
>
> **Provide documentation of financial estimates of the amount of charity care that it intends to provide annually;**
>
> **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;**
>
> **Provide documentation of a written policy for the provision of sliding fee scales for clients unable to bear the full cost of services;**

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

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

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

The review process indicated that Seasons has not operated with a written eligibility standard for charity care until the occasion of this project review arose. The policy developed in response to the SHP requirement is unclear with respect to the household income bands that will be used to scale back charitable discounting of fees as income rises. For this reason, I recommend that, if the Commission approves this CON request, approval be conditioned as follows:

> Prior to first use approval of this project, Seasons Hospice & Palliative Care of Maryland, Inc., must provide a revised Payment for Services policy that clarifies the household income bands eligible for partial charity care.

Need

I find that the application demonstrates that an unmet demand for inpatient hospice care exists that can be met by a project of this type. Of equal importance, I also find that it is reasonable to allow a general hospice of Seasons' size to effectively compete in the Baltimore area with the other two large hospice programs by being allowed to develop similar service offerings when its size makes this feasible. Hospice care is a service, especially when it becomes an option chosen in the final days or weeks of life, in which patients and families can reap substantial benefits from the continuity and care coordination that can be achieved within a single program, as their needs change.

Cost and Effectiveness of Alternatives

I find that the establishment of a Seasons inpatient hospice unit as proposed should be able to operate at a level of cost relative to effectiveness that is comparable to that of the comparable hospice-operated inpatient options available in the Baltimore area. It is less cost effective, from the standpoint of capital cost, than utilizing existing hospital or nursing home beds, on an as-needed basis, when the inpatient needs of the hospice patient and their family can be fully met by such an option and such settings do not discourage the patient and family from making the choice to obtain hospice care. However, this is a very modest cost consideration over the life of a program and Seasons has continued to use this option to deliver some inpatient hospice care after the development of the unit on the NWH campus. For these reasons, my comparison of the costs and effectiveness of this project with its alternatives does not justify its denial.

Viability

I find that the project is likely to be economically viable in both the short- and long-term, and that Seasons has the financial and non-financial resources necessary to implement and sustain the project. An important perspective informing my finding with respect to viability and its importance in making a recommendation on this project is that inpatient hospice care is not the primary business activity of the applicant entity and the downside risk involved for Seasons if the proposed project does not perform as anticipated is not great.

Impact

I do not believe the likely impact of the proposed project, even if it falls within the 15-20 percent impact range cited by the interested parties, will threaten the existence of these hospices because of the likelihood of the continued growth in demand for hospice services and the potential for growth that has not been fully exploited by Gilchrist and Stella Maris outside of Baltimore County and City. I do not believe this impact range is likely. I find that the likely level of impact of the proposed project on the hospice programs operated by the interested parties should not bar approval and implementation of the project.

IN THE MATTER OF	*	
	*	
SEASONS HOSPICE &	*	**BEFORE THE**
	*	
PALLIATIVE CARE OF	*	**MARYLAND HEALTH**
	*	
MARYLAND, INC.	*	**CARE COMMISSION**
	*	
DOCKET NO. 11-03-2318	*	

*** ***

FINAL ORDER

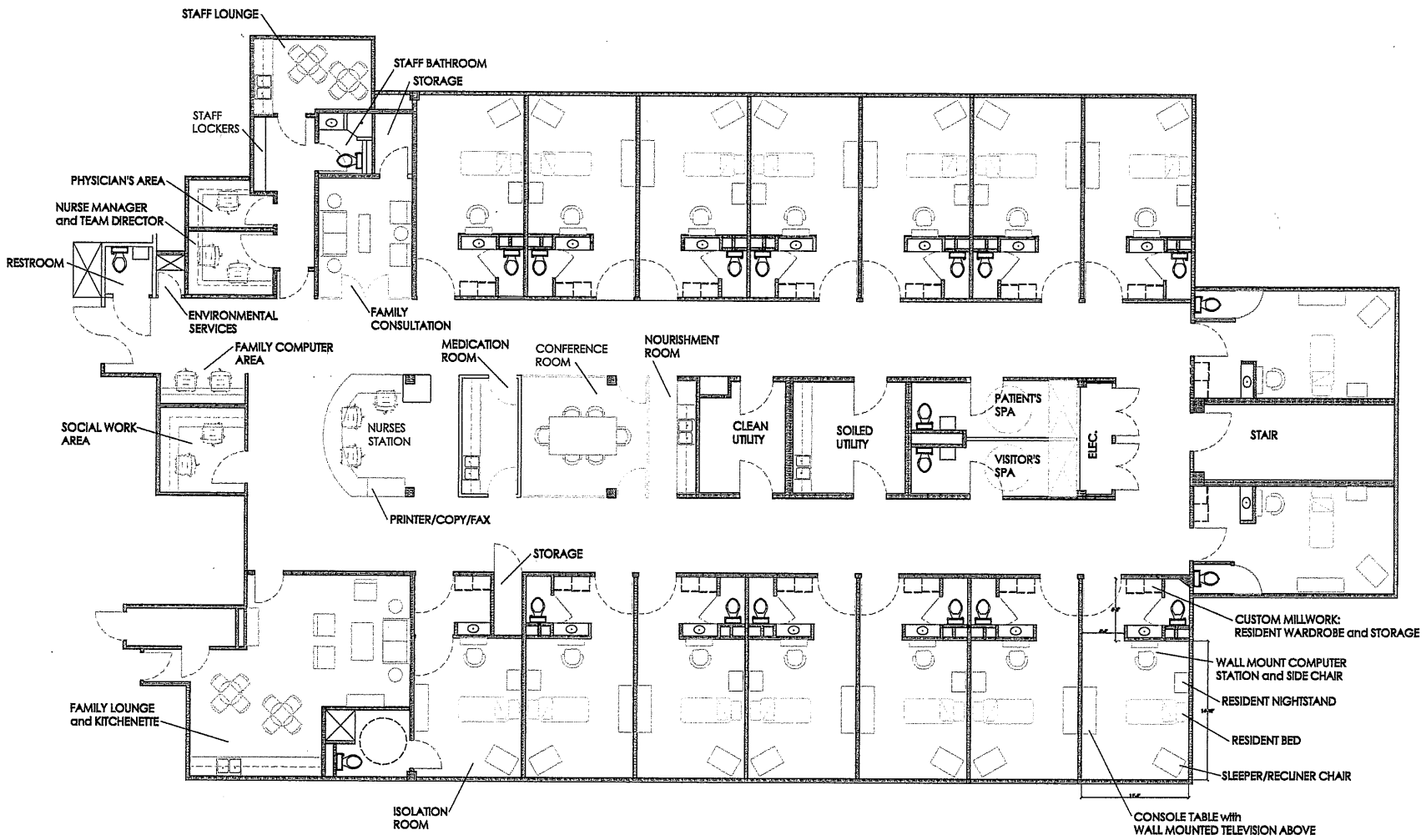
Based on the analysis and findings in the Recommended Decision and the record in this review, it is, this 18th day of July, 2013, by a majority of the Maryland Health Care Commission, **ORDERED**:

That the application filed by Seasons Hospice & Palliative Care of Maryland, Inc. Docket No. 11-03-2318, to add bed capacity by establishing a 16-bed inpatient hospice unit in vacant space leased from MedStar Franklin Square Medical Center on the campus of MedStar Franklin Square Medical Center at an estimated cost of $, is hereby **APPROVED** with the following condition:

> Prior to first use approval, Seasons Hospice & Palliative Care of Maryland, Inc. must provide a revised Payment for Services policy that clarifies the household income bands eligible for partial charity care.

MARYLAND HEALTH CARE COMMISSION
July 18, 2013

APPENDIX A
FLOOR PLAN OF PROPOSED HOSPICE UNIT


STAFF LOUNGE
STAFF BATHROOM
STORAGE
STAFF LOCKERS
PHYSICIAN'S AREA
NURSE MANAGER and TEAM DIRECTOR
RESTROOM
ENVIRONMENTAL SERVICES
FAMILY CONSULTATION
FAMILY COMPUTER AREA
SOCIAL WORK AREA
NURSES STATION
MEDICATION ROOM
CONFERENCE ROOM
NOURISHMENT ROOM
CLEAN UTILITY
SOILED UTILITY
PATIENT'S SPA
VISITOR'S SPA
ELEC.
STAIR
PRINTER/COPY/FAX
STORAGE
CUSTOM MILLWORK: RESIDENT WARDROBE and STORAGE
WALL MOUNT COMPUTER STATION and SIDE CHAIR
RESIDENT NIGHTSTAND
RESIDENT BED
SLEEPER/RECLINER CHAIR
FAMILY LOUNGE and KITCHENETTE
ISOLATION ROOM
CONSOLE TABLE with WALL MOUNTED TELEVISION ABOVE