Home Health Agency Advisory Group

April 14, 2015
Meeting Summary

Attendance

HHA Advisory Group Members in Attendance:

Jackie Bailey	Laura Hughes (representing Tim Kuhn)
Keith Ballenger	Patrick O'Malley
Heidi Brown	Lauren Simpson
Rosellen Fleishman	Roslyn Tyson
Patti Heagy	Dawnn Williams

Others in Attendance:

Geoff Abraskin	Bruce Kozlowski
Mohamed Badawi	Denise Matricciani
Lori Bryan	Philip Onomora
William Drew	Denise Ridgely
Linda Gray	Shauna Thompson
Donald Green	Catherine Victorine
Shade Green	Gladys Wallace
Siobhan Hawthorne	Suellen Wideman
Keith Hobbs	Hannah Young
Keith Jacobs	

MHCC Staff:

Carol Christmyer	Ben Steffen
Linda Cole	Cathy Weiss
Paul Parker	

Update: Home Health Quality

Carol Christmyer referred to the two articles sent with today's meeting's mailing; *Public Reporting as a Quality Improvement Strategy*, an evidence-based report (No. 208) issued in July, 2012 by the Agency for Healthcare Research and Quality and, "The Association of Nursing Home Compare Quality Measures with Market Competition and Occupancy Rates," published in the March/April, 2008 issue of the *Journal for Healthcare Quality.* Ms. Christmyer noted that these two articles are relevant to the discussions held at the Advisory Group's March 18, 2015

meeting regarding the value of public reporting on quality, and provide some evidence that quality and performance scores improve over time in competitive markets.

As a recap to discussions held at the past two Home Health Agency (HHA) Advisory Group meetings, Ms. Christmyer distributed a handout summarizing the suggested HHA quality measures to be used in Certificate of Need (CON) determinations (refer to attachment). The proposed nine measures include three process measures (the pneumococcal vaccination measure originally proposed was removed) and six outcome measures used for the Centers for Medicare and Medicaid Services (CMS) Star Rating Program, plus an additional outcome measure, improvement in oral medication management. These are suggested for use in qualifying an agency for docketing of a CON application to expand or establish an HHA. As discussed by the HHA Advisory Group members, the measure concerning how often urgent care is needed was dropped from the initial suggested list of possible measures. In addition, Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) measures are also recommended for use and Ms. Christmyer noted that CMS plans to incorporate the HHCAHPS measures into the HHA Star Rating in late 2015. As suggested by Advisory Group members, Ms. Christmyer endorsed weighting of certain measures. These include drug education on all medications from provider to patient/caregiver, acute care hospitalization of home health patients, improvement in oral medication management, and overall rating of care (under HHCAHPS, the percent of patients who gave a rating of 9 or 10).

In summary, to qualify an applicant that has operated a Medicare-certified HHA in Maryland or in another state for docketing of an application to expand an existing HHA or establish a new HHA, it is recommended that three qualifications be met: achievement of a minimum CMS rating of 3.5 stars; achievement of a minimum threshold level of performance on a specified number of ten process/outcome measures (see list in attachment) for most recent 12-month period, and five HHCAHPS measures; and, a demonstration of maintenance or improvement in scores over the most recent three years.

For persons who have not operated a Medicare certified HHA (but have specified experience in providing other types of health care facility services) to obtain docketing of an application to establish an HHA, it is suggested that submission of evidence of an established quality program that systematically collects outcome and process measures comparable to Home Health Compare be required. (Refer to attachment for details on types of quality measures.) Ms. Christmyer noted that staff is suggesting that quality measures be fairly equivalent for similar patient populations served by the non-Medicare certified HHA applicant.

Paul Parker briefly described the vision of a regulatory process structured around performance on quality measures by HHAs and how the overall methodological approach for selecting certain quality measures will be incorporated into the new HHA Chapter of the SHP. Because quality measures and the art of quality evaluation are evolving, the HHA Chapter would describe the manner in which considerations of quality would be used in qualifying applicants for scheduled

review cycles. The HHA Chapter would not include the specific measures, thresholds, or improvement targets. Rather, these would be published for review and comment prior to initiation of review cycles in which applications could be filed. After review of any comments received, the specific measures, performance thresholds, and other qualifying criteria would be published in the *Maryland Register,* along with the review schedule, well in advance of letter of intent and application filing deadlines.

Discussion: Home Health Quality

Laura Hughes asked for clarification on what was meant with regard to requiring non-Medicare certified HHA applicants to submit fairly equivalent quality measures for "similar HHA patient populations." Ms. Christmyer replied that staff would expect to see a good description of the population being served and assessed for quality, using measures similar to those used for the home health patient population. Cathy Weiss noted that staff would anticipate that such an applicant would be describing its patient population. With respect to residential service agencies (RSAs), staff understands that the patient population will be different than that served by an HHA (e.g., its patient population may receive services on a longer-term basis than the intermittent skilled nursing services typically provided by an HHA). A potential applicant without experience operating a Medicare-certified HHA should begin thinking about collecting appropriate performance measure data prospectively to demonstrate that it can provide high quality health care services specific to the needs of the patient population it serves.

Jackie Bailey noted that HHAs are required to have an independent outside body come in to assess the data collection process. Ms. Weiss noted that she did not believe that the Commission could require that a non-Medicare HHA applicant replicate the requirements related to quality assurance for HHA; however, accreditation can be required.

Heidi Brown noted that HHA data collection through OASIS is strictly regulated, and is unsure how other non-HHA applicants would collect data. Ms. Christmyer noted that such applicants would need to describe in detail how their data is collected.

Keith Ballenger commented that he concurred with the staff proposal that non-Medicare HHA applicants could include RSAs who have provided skilled nursing services and have operated with a Level 3 license. He noted that data should be collected to assure that the applicant is serving all payor types.

Mr. Parker noted that staff relies on the meeting summary for drafting regulations, and asked Advisory Group members to review the meeting summaries to assure that the Advisory Group members' discussion is accurately reflected. Any comments should be directed to the Chairperson, Cathy Weiss.

HHA Acquisitions

Ms. Weiss described how the landscape of new HHA providers in Maryland has changed as a result of acquisitions of existing agencies. Acquisition of health care facilities do not require CON approval; only a determination that CON review is not required. CON procedural rules regarding the acquisition of a health care facility require that certain information be provided regarding a proposed acquisition at least 30 days prior to the transaction, including information required by any applicable chapter of the State Health Plan (SHP). In addition, CON procedural rules currently contain a specific provision that the purchaser of an HHA may only acquire the right to serve authorized jurisdictions that were actually served in FY 2001, or for which a CON was granted after that date. The HHA Chapter of the SHP does not contain specific requirements regarding acquisition of an HHA.

Ms. Weiss suggested that acquisition rules be incorporated in the HHA Chapter update to require assurances that purchasers provide access for all types of patients (Medicare, Medicaid, commercially insured, and HMO patients, and the indigent). The information required for determinations of coverage should also provide more transparency about the purchaser and its track record in providing health care services. Such information would be useful for consumers and necessary to improve accountability for the HHA industry in Maryland, as it changes through acquisitions. HHAs are an important part of the continuum of care and changes in how they operate can have an impact on hospitals, other types of rehabilitative facilities and services, and access, effectiveness, and cost for consumers.

Staff believes that the look-back to 2001 for the service area that a purchaser obtains when an HHA is acquired should be eliminated. This means that purchasers of an HHA would acquire the right to serve all authorized jurisdictions of the HHA being acquired.

Ms. Weiss also sought discussion of possible acquisition rules that would prohibit acquisition of HHAs by persons with a history of Medicare or Medicaid fraud or abuse, or other serious criminal activity. She asked whether the Advisory Group thought that there should be time limitations regarding considerations of past fraud, abuse, or other activity, as part of such a rule. Ms. Weiss also sought input on requiring a commitment by persons acquiring HHAs to serve patients regardless of the patients' payor source, as well as the uninsured and indigent patients.

Finally, Ms. Weiss also suggested an acquisition rule requiring that only operational HHAs be eligible for acquisition. This prohibition on trading licenses, with no actual health care facility operating under that license, would reserve the MHCC's prerogative to establish new HHAs, through CON regulation. She also recommended requiring a purchaser to: maintain compliance with ongoing operational conditions placed on the CON previously obtained by the HHA being acquired; to commit to providing the services provided by the HHA being acquired; and, to maintain Medicare and Medicaid certification and participation.

Discussion: HHA Acquisitions

In response to Ms. Weiss' question regarding the impact of recent HHA acquisitions, Patrick O'Malley noted that Bayada acquired an HHA with authority to serve Montgomery County which allowed Bayada to broaden its service area/population base. Mr. O'Malley noted that he believes that the suggested acquisition rules are okay, and that Bayada would have been able to comply with the proposed rules.

Ms. Bailey noted that the ownership interest of a company is important when considering the impact of an acquisition. If a buyer's parent affiliation is with a hospital or nursing home, referral sources to freestanding HHAs will be affected.

Patti Heagy noted that freestanding agencies have been affected by large hospital and nursing home acquisitions. In these cases, skilled nursing facilities (SNFs) could no longer refer to the freestanding HHAs they had historically used as sources of care for discharged patients. Referrals were redirected within the consolidated corporation.

Ms. Weiss asked Advisory Group members whether the Commission should consider allowing a corporation with prior convictions for Medicare or Medicaid fraud or abuse to be allowed to acquire a Maryland HHA under certain circumstances. Ms. Heagy responded that corporations guilty of fraud or abuse should be prohibited from acquiring a home health agency. Ms. Hughes suggested consideration of those entities which had a past history of fraud, but took appropriate action vetted by the Office of the Inspector General (IOG). Ms. Heagy disagreed, noting that even if you change the owners or personnel, there is still a certain mindset and culture which may still continue. Lauren Simpson suggested and Ms. Brown generally agreed that should a Program Integrity Plan be in place, then such an entity could acquire an HHA. Ms. Heagy questioned whether such a Plan would truly foster a change.

Mr. Ballenger agreed with a rule requiring a purchaser of an HHA to serve all payors. However, he asked staff if there was a certain payor percentage standard, and how would staff enforce such a rule. Mr. Ballenger further noted that some recent purchasers of HHAs will take only Medicare, and some agencies send lists of what patients they will not take. Ms. Weiss responded that, generally speaking, the regulations could require that, in order to obtain a determination of coverage for the acquisition of an HHA, the purchaser must agree to serve a full range of payors. If review of the newly acquired HHA's payor source data obtained through the Commission's HHA Annual Survey or other payor data sources shows that an acquired HHA is not serving the full range of payors, then staff would follow-up directly and could seek judicial action to enforce the condition accepted by the HHA.

Ms. Weiss asked the Advisory Group members whether the Commission should consider the quality performance of an entity seeking to acquire a Maryland HHA. Ms. Hughes agreed that quality performance should be evaluated, and that for a non-HHA provider there should be some structure in place for its Quality Assurance Program.

In response to Mr. O'Malley's question regarding clarification as to what is considered a non-HHA provider, Ms. Weiss noted that a Medicare-certified HHA includes both in-Maryland and out-of-state providers. Non-HHA providers, based on the qualifications outlined by staff for discussion, would include hospitals, nursing homes, and Maryland licensed RSAs providing skilled nursing services.

Mr. O'Malley noted that Accountable Care Organizations (ACOs) could own a whole set of agencies. Ms. Weiss acknowledged that the health care delivery system is undergoing reorganization with some vertical integration by acquisitions. Ben Steffen responded that there is strong economic pressure for greater collaboration and building relationships with independent organizations or vertical acquisition; there is not currently a dominant model for reorganizing the health care system emerging. Mr. Steffen noted that Maryland has a number of HHAs affiliated with or part of hospitals or other organizations. Going forward, the Commission wants to make opportunities for all types of HHAs more flexible.

Rosellen Fleishman reiterated that patients should have a choice of HHAs, and hospitals should not limit choice for discharged patients requiring HHA services. Ms. Fleishman suggested that at the time of hospital discharge, the patient should obtain a list of authorized HHAs to ensure greater consumer choice.

Ms. Heagy expressed concern that the Commission may be making acquisition rules easier for hospitals and SNFs to acquire their own HHA, which would negatively affect freestanding agencies. Mr. Steffen noted that all applicants should meet the same criteria, and hospitals would not be barred from acquisitions or favored in any way. Mr. Parker responded that the acquisition rules proposed for discussion are not making it easier for anyone to make an acquisition. Currently, there are no real limitations on a purchaser. The suggested new acquisition rules would actually be narrowing the potential pool of purchasers. The Commission staff is primarily concerned with assuring that only quality performers are able to enter the Maryland HHA market.

Ms. Heagy noted that with the current focus on collaboration she is concerned that there will be an impact on her freestanding agency's ability to serve Medicare clients. She believes that there will be "cherry picking" of Medicare clients by the hospitals and nursing homes. Her agency currently struggles to attain a 50 percent proportion of Medicare clients while Medicare accounts for 72 percent of the total Maryland HHA market.

Mr. Ballenger provided comments on consumer choice and noted that his HHA is hospital-affiliated and they do not want to limit choice. Part of the problem is that consumers do not know about or fully understand Medicare coverage of HHA services. Furthermore, ACOs are pressuring hospitals to reduce readmissions. Mr. Ballenger suggested letting the Commission and OHCQ know if hospitals are directing Medicare HHA patients toward their own HHA, and report this behavior to Renee Webster at OHCQ. Ms. Simpson further reminded the Advisory

Group that hospitals are bound by Safe Harbor and Antitrust laws, as well as Medicare's Conditions of Participation. Mr. Ballenger noted that its HHA sends letters to hospitals to confirm that its HHA is on the hospital's list.

Specialty HHAs

Ms. Weiss described how Maryland's CON program has been recognizing two types of HHAs: general and specialty, and regulating them differently. General HHAs serve the general population without any specified limitations in types of patients or services. A general HHA may only apply for a CON when there is need identified by the Commission. The second type of agency is a "specialty" HHA, which does not serve the general population but rather serves a specified population group, such as pediatric patients or residents of a continuing care retirement community (CCRC). The burden of proof for demonstrating need for a specialty HHA is on the applicant, and such applicants are not bound to a specific CON review schedule. Ms. Weiss noted that the Commission's specialty agency designation is not recognized by OHCQ in its licensure program or by Medicaid or Medicare, in its certification processes.

Ms. Weiss described the six specialty HHAs in Maryland by type of population served; four are CCRC-based and exclusively serve their own CCRC residents, and two are limited to serving pediatric clients, including medically fragile children and maternal/newborn dyads.

An analysis of utilization by the pediatric age group shows that most pediatric clients are served by general HHAs. Furthermore, CCRC residents are not precluded from being served by other general HHAs authorized to serve the jurisdiction in which they live. Ms. Weiss noted that staff believes that the choices available to CCRC residents are adequate and do not require the maintenance of a specialty designation in order for CCRC residents to have access to quality HHA services. Therefore, staff is suggesting that it is not necessary to continue the specialty designation for HHAs.

Ms. Weiss noted that a proposed new general HHA or an existing general HHA planning to expand can seek to tailor its services to serve a niche market. Discontinuing the ability to apply for a specialty HHA is, staff believes, the fairest approach as all applicants would be required to meet the same qualifying factors. It is also suggested that existing specialty HHAs would be grandfathered, with authorization to continue to serve their special designated population as authorized by the Commission and indicated on the agency's HHA license.

Discussion: Specialty HHAs

In response to Ms. Brown's question, CCRC-based HHAs are Medicare certified. Ms. Weiss asked the Advisory Group if there are specific types of populations requiring specialized training of HHA staff that a general HHA does not routinely provide, or specific types of medical conditions or services their HHA is unable to address. Advisory Group members generally responded that there were no specific types of patients an agency could not serve. Ms. Hughes

noted that under its RSA license they serve pediatric and ventilator dependent clients under Medicaid; each HHA has the responsibility to fully understand the types of patients it may accept. Dawnn Williams noted ventilator type patients are an "unorthodox" type of HHA patient, given the parameters of Medicare payment for intermittent skilled services, and not for longer term services. Ms. Williams indicated that there is one agency serving ventilator patients and such an agency faces challenges given that it generally takes much longer than one hour for the visit. Some patients' families use private duty nursing. Ms. Williams further noted that Maryland Medicaid cannot recognize an agency if it is not Medicare-certified. There was general consensus by the Advisory Group members to the proposal to discontinue the ability to apply for a specialty HHA and to allow the existing specialty HHAs to be grandfathered.

Use of Regional Service Areas in CON Regulation of HHAs

Mr. Parker introduced the concept of creating multi-jurisdictional regions for purposes of CON review scheduling by combining certain jurisdictions meeting identified qualifying factors. Mr. Parker noted that the Commission has historically regulated HHA services on a jurisdictional basis. However, many Maryland jurisdictions have populations that are too small to establish viably-sized home health agencies. Mr. Parker illustrated his point by noting that only 16 existing HHAs have a potential customer base of less than 1 million while all but one Maryland jurisdiction has a population that falls within this size range. Thirteen agencies have between one to two million residents in the jurisdictions they are authorized to serve; nine HHAs have service areas containing two to three million; three agencies have between three and four million; and seven HHAs have authorized service areas that have a population greater than four million.

Mr. Parker suggested that making new market entry a realistic possibility in some parts of Maryland would require the creation of regional service areas through combining several jurisdictions which meet the qualifying criteria (e.g., inadequate consumer choice and/or highly concentrated markets). This approach of using a regional service area would create an initial population base large enough to attract serious proposals to establish a new HHA. It is staff's belief that it is unlikely for a new HHA entrant to be interested in serving most single jurisdiction markets in Maryland. The potential customer base is just too small to make such new agencies viable or, at the very least, economically competitive.

Examples of four possible multi-jurisdictional regional service areas were outlined: Western Maryland (Allegany, Garrett and Washington Counties) with a total estimated population of 256, 000; Southern Maryland (Calvert, Charles and St. Mary's Counties) with a total estimated population of 363,000; Upper Eastern Shore (Caroline, Cecil Dorchester, Kent, Queen Anne's and Talbot Counties) with a total estimated population of 281,000 and Lower Eastern Shore (Somerset, Wicomico and Worcester Counties), with a total estimated population of 185, 000.

Discussion: Regional Service Areas

Mr. Parker asked the Advisory Group if the HHA Chapter should allow for the creation of multi-jurisdictional regions for purposes of CON review scheduling, clarifying that staff is not suggesting creating standard planning regions. Mr. Parker suggested that a general rule could be implemented in the HHA Chapter of the State Health Plan to create the opportunity for combining certain jurisdictions into regional service areas for the specific purpose of establishing a specific CON review cycle. Determination of whether the jurisdictions meet the specified qualifying criteria would first need to be assessed. Then staff would determine if it makes sense to combine those identified jurisdictions for purposes of CON review. Mr. Parker noted that using jurisdictions to frame CON review is necessary under current law and regulation, but staff wants to have greater flexibility in creating more logical service areas for applicants proposing to establish new HHAs in any given review cycle.

Mr. Ballenger agreed that the proposed approach for either HHA establishment or expansion conceptually made sense; it is more attractive to combine jurisdictions into regional service area than individual jurisdictions. For example in Charles County nurses are more readily available for staffing than in St. Mary's and Calvert Counties. Ms. Fleishman suggested working with community colleges in those jurisdictions for purposes of training staff if HHAs are established.

Mr. Parker presented a hypothetical scenario of opening up a regional service area comprised of three jurisdictions, but the approved HHA only serves one of the three jurisdictions. Mr. Parker noted that he was unsure whether the Commission could sanction the HHA for not serving all three jurisdictions. There are currently HHAs with authorized jurisdictions not served; it is a business decision. Staff recognizes that certain jurisdictions are more difficult to serve but the intent is to encourage more serious applicant proposals to serve the more rural or less densely populated areas of the state.

Mr. O'Malley agreed that greater incentives need to be provided to address the challenges for serving the rural areas. Creating a bigger population base is a good idea, and wondered if there was a predetermined population size. Mr. Parker did not believe it is necessary to establish a minimum standard. Staff would simply like the ability to create the potential for compact and contiguous regions where the indicators of need are present and new HHAs could be more feasibly scaled for success.

Ms. Bailey suggested that this approach may not make much economic sense when it is difficult to get the necessary staff to serve in the rural jurisdictions. Ms. Simpson noted that nurses and other staff also need to be incentivized to travel to less populous geographic areas; the focus should not be only on creating incentives for agencies to establish businesses in rural areas. Mr. Ballenger suggested that perhaps by using an ACO model, the lack of available staff in rural areas could be addressed by expanding the work settings of nursing staff from skilled nursing

facilities and assisted living facilities, extending their service to HHA clients in the ACO patient population.

Limiting the Pace of Change and Potential Negative Impact

Mr. Parker noted that the recommended changes in CON regulation of HHAs, as described in the White Paper, are intended to create an easier process for high performing providers to expand their geographic range in Maryland or enter Maryland's HHA market. The new HHA Chapter will provide a new structure for expansion and development, recognizing that there will be trade-offs with limiting the number of applicants and jurisdictions to be opened based on qualifying factors. While opportunities will be created for high performing agencies, staff does not seek to create rapid change, but rather a steady and gradual change in the supply and distribution of HHAs.

Mr. Parker distributed three spreadsheets which show the impact on caseload and market share in the three jurisdictions opened for consideration of home health agency CON applications in 2007, the last time that the HHA Chapter of the SHP provided such opportunities. The three jurisdictions were Frederick, Baltimore and Montgomery Counties. It was noted that Frederick County has a concentrated market and adding the two new approved HHAs for expansion did not significantly change the market share of the existing HHAs. In Baltimore and Montgomery Counties, which do not have highly concentrated markets, there was still very little penetration by the new HHA entrants.

Mr. Parker referred to the spreadsheets which illustrate hypothetical scenarios for each of the three jurisdictions based on a normalized approach for assessing potential impact on market share assuming three different levels of market share capture by new entrants to the jurisdiction: 10 percent, 20 percent and 30 percent. He suggested that this type of approach could be used to determine some threshold level for estimating the impact of new market entry, which would then guide limitations on the number of applications that could be approved. Consideration of such impact on very small agencies would also need to be addressed. Mr. Parker noted that this type of approach for assessing caseload impact was used informally in the CON reviews conducted in 2008 and 2009. Mr. Parker suggested that a general rule for structuring a review cycle could be written whereby potential applicants would know upfront the limits on approvals that would be likely in any give review for a jurisdiction or region.

Discussion: Limiting the Pace of Change and Potential Negative Impact

Mr. Parker noted that including an approach to limiting the number of existing agencies that could expand into a given jurisdiction or region or the number of new HHAS that could be established will require development of preference standards or rules in the HHA Chapter so that applicants can be reasonably and fairly ranked. Possible suggested preferences rules could include: track record in serving all types of patients, including the indigent; existing HHA expansion preferred over new HHA establishment; relative performance on comparable quality

measures; and growth of smaller HHAs preferred over expansion of large agencies to promote better economies of scale overall for the HHA industry.

Mr. Parker asked the Advisory Group to think about what sort of preferences should be considered to rank order competing applicants, and whether there should be limitations for expansions by existing HHAs to a single contiguous jurisdiction every three years, to slow the pace of change.

Ms. Hughes responded that she likes using preferences for expansion of existing agencies over new agencies, and asked whether an RSA operating for a number of years in Maryland would be considered as existing. Mr. Parker indicated that an existing RSA could be considered, but he was referring to existing HHAs for this preference rule.

Mr. Ballenger noted the minimal caseload impact of the smaller agencies in Frederick and Montgomery Counties. Both Mr. Ballenger and Mr. O'Malley supported the notion of existing HHAs expanding, recognizing that it will be a struggle for new agencies to enter the HHA market given that it is a costly and labor intensive process. Existing HHAs already have a platform and can grow faster than a brand new HHA.

Ms. Bailey noted that there are many factors which may impact an HHA's market share such as referral sources and relationships with other providers. Ms. Heagy agreed noting that it is a struggle for smaller agencies that are not hospital-based or hospital-affiliated.

Public Comments

Denise Matricciani representing Erickson Living, manager of Charlestown, Oak Crest and Riderwood CCRCs, presented written comments from Adam Kane, Senior Vice President. Ms. Matricciani stated that Erickson Living does not support elimination of the CCRC exemption, as Erickson has a strong commitment to provide integrated care for the lifetime of its residents through contractual arrangements. The Commission and the General Assembly have recognized the importance of assuring continuity of care by also granting exemptions for comprehensive care beds. CCRCs are regulated by the Department of Aging, and Erickson still meets all licensure requirements. Ms. Matricciani concluded her comments by noting that it remains unclear as to the problem trying to be solved, and seniors like to receive care where they live.

Gladys Wallace, representing Minerva Home Health Care, a licensed RSA, expressed the desire to be Medicare-certified so that it can also receive reimbursement from private insurers.

Keith Jacobs, representing Maxim Healthcare, suggested that RSAs with market presence and experience should be allowed to enter the Maryland HHA market.

Linda Gray, representing Preferred Home Care, a licensed and Joint Commission accredited RSA, noted that without Medicare certification private insurers would not pay for home care services. Its RSA serves more challenging referrals; for example, young person's recovering

from gunshot wounds requiring daily services and some for longer time periods. Ms. Gray further noted that being accredited by an accreditation organization (like the Joint Commission) requires the agency to meet strict standards of quality.

Next Steps

Ms. Weiss thanked the members of the Advisory Group for their participation, noting that today was its third and final scheduled meeting. However, more time may be needed to process all the information and the Advisory Group may be reconvened for an additional meeting sometime in the future.

Mr. Parker noted that many of the proposed changes outlined in the White Paper have been discussed over the past three months and suggested taking a pause prior to possibly reconvening the Advisory Group. In the meantime, staff will begin drafting the HHA Chapter regulations for the State Health Plan. Mr. Parker further noted that there will be opportunities for comment during the informal and formal public comment periods as promulgation of a new HHA Chapter proceeds. Staff will alert the Advisory Group of new developments in this process.