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STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

SPECIALIZED HEALTH CARE SERVICES-

ACUTE INPATIENT REHABILITATION SERVICES

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.01 Incorporation by Reference. This Acute Inpatient Rehabilitation Services Chapter (Chapter) of the State Health Plan for Facilities and Services is incorporated by reference in the Code of Maryland Regulations.

.02 Introduction and Applicability.

A. Purposes of the State Health Plan for Acute Inpatient Rehabilitation Services.

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

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

(2) It is the foundation for the Commission's decisions in its Certificate of Need (CON) program. The CON program is intended to ensure that changes in the delivery of services by regulated health care facilities are needed, cost-effective, and viable. The Commission also considers the impact of changes in the supply and distribution of health care facilities. The State Health Plan contains policies, methodologies, criteria, and standards that the Commission uses in making CON decisions.

B. Legal Authority of the State Health Plan.

The State Health Plan is adopted under Maryland's health planning law, Maryland Code Annotated, Health-General §§19-114 – 19-131. This Chapter partially fulfills the Commission's responsibility to adopt a State Health Plan at least every five years and to review and amend the Plan as necessary. Health-General §19-118(a)(2) provides that the State Health Plan shall include:

(1) The methodologies, standards, and criteria for CON review; and

(2) Priority for conversion of acute capacity to alternative uses where appropriate.

C. Organizational Setting of the Commission.

The Commission is an independent agency located within the Department of Health and Mental Hygiene for budgetary purposes. The purposes of the Commission, as enumerated at Health-General §19-103(c), include responsibilities to:

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission; and

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by advocating policies and systems to promote the efficient delivery of and improved access to health care services, and enhancing the strengths of the current health care service delivery and regulatory system.

The Commission has sole authority to prepare and adopt the State Health Plan and to issue CON decisions and exemptions based on the State Health Plan. Health-General §19-118(e) provides that the Secretary of Health and Mental Hygiene shall make annual recommendations to the Commission on the State Health Plan and permits the Secretary to review and comment on the specifications used in its development. However, Health-General §19-110(a) clarifies that the Secretary does not have power to disapprove or modify any decision or determination that the Commission makes regarding or based upon the State Health Plan. The Commission pursues effective coordination of its health planning functions with the Secretary, with State health-related agencies, and with the Health Services Cost Review Commission in order to assure an integrated, effective health care policy for the State. The Commission also consults the Maryland Insurance Administration as appropriate.

D. Applicability.

Under §19-120 of Health-General Article, Annotated Code of Maryland, and COMAR 10.24.01.02A, a CON is required to establish a hospital, to relocate a hospital, to change the bed capacity of a hospital, or to make certain changes in the type or scope of health care service offered by a hospital. A CON is also required for a capital expenditure by or on behalf of a hospital that exceeds the threshold for capital expenditure established in law.

"Rehabilitation" is defined as a "medical service" under §19-120 of Health-General Article, Annotated Code of Maryland, and COMAR 10.24.01.01B that, if introduced as a new service by a hospital, requires a CON.

This Chapter of the State Health Plan is applicable to proposals for:

1. The establishment of a freestanding special hospital for acute rehabilitation;

2. The relocation of a freestanding special hospital for acute rehabilitation or a general hospital with a distinct special hospital unit for acute rehabilitation;

3. A change in the bed capacity of a freestanding special hospital for acute rehabilitation or in the bed capacity of a distinct special hospital unit for acute rehabilitation located within a general hospital;

4. The introduction of acute inpatient rehabilitation as a new service in an existing hospital; or

5. A capital expenditure by an existing hospital that exceeds the threshold for capital expenditures established in law and primarily involves construction or renovation of facilities used in the provision of acute rehabilitation services.

This Chapter is applicable to all of the following subcategories of acute rehabilitation: comprehensive; brain injury; spinal cord injury; and pediatric services.

E. Effective Date.

An application submitted after the effective date of these regulations is subject to the provisions of this chapter.

.03 Issues and Policies.

Specialized Hospital Services

Acute inpatient rehabilitation is a specialized hospital service. For specialized services, the public is best served if a limited number of hospitals provide specialized services to a substantial regional population base. This pattern promotes both high quality care and an efficient scale of operation. The State Health Plan outlines standards intended to influence the geographic distribution, capacity, and scope of services for acute inpatient rehabilitation providers based on cost-effectiveness and efficiency considerations. The Commission also seeks to balance cost-effectiveness with access and quality considerations when considering changes in the delivery of acute rehabilitation services requiring Commission approval.

Cost-Effectiveness and Efficiency of Care

Congress has shown interest in gaining a better understanding of the resources expended on patients in various post-acute care settings covered by Medicare Part A and requested that the Centers for Medicare and Medicaid Services (CMS) implement the Post-Acute Care Payment Reform Demonstration (PAC-PRD) in the Deficit Reduction Act of 2005. The PAC-PRD included developing a patient assessment instrument that could be used in acute care hospitals, long term care hospitals (LTCHs)[1], inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs)[2], and home health agencies (HHAs).[3] This instrument was then used to measure patient outcomes and resource expenditures. As a result of research conducted with this instrument, CMS concluded that it is possible to develop a common case-mix adjustment system for three inpatient post-acute care settings: LTCHs, IRFs, and SNFs.[4] The system would be used

[1] CMS describes long-term care hospitals (LTCHs) as hospitals that are certified as acute care hospitals, but that focus on patients who, on average, stay more than 25 days. In Maryland, LTCHs are licensed as special hospitals-chronic.

[2] In this context, skilled nursing facility refers to a nursing home or unit that provides short-term rehabilitative care. In Maryland, a skilled nursing facility is licensed as a comprehensive care facility.

[3] Department of Health and Human Services, Centers for Medicare and Medicaid Services. "Report to Congress: Post Acute Care Payment Reform Demonstration." January 2012. < https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads//Flood_PACPRD_RTC_CMS_Report_Jan_2012.pdf>

[4] *Id.*

to calculate payments in the same manner across settings, for patient-specific expenditures.[5] Although CMS has not announced that it plans to reform payment for IRFs and other facilities in this manner, such changes appear to be on the horizon and would potentially affect the use of post-acute care services, including acute inpatient rehabilitation.

Because the Health Services Cost Review Commission (HSCRC) regulates rates for hospital services, including acute inpatient rehabilitation care in Maryland, changes in Medicare payment policy for IRFs would have a muted influence on the provision of acute inpatient rehabilitation services at most Maryland hospitals[6]. However, payment reform for post-acute care could influence practice of care patterns, encouraging a shift toward greater use of skilled nursing facilities, which are not rate-regulated, resulting in a need for less acute rehabilitation bed capacity.

Efficient use of inpatient rehabilitation services means that patients receive the therapies appropriate to their rehabilitative needs in a setting suitable to their capacity for receiving those therapies. From the perspective of resource allocation, it means the development of facilities and bed capacity that matches the demand for these beds, so that facilities will operate at a high level of production capacity. Although some states with Certificate of Need regulations for inpatient rehabilitation services prospectively have adopted regulatory standards for the maximum number of inpatient rehabilitation beds per 100,000 population, the basis for these standards is not well explained. These standards range from seven beds per 100,000 population in Oregon[7] to 12 beds per 100,000 population in Alabama and New Hampshire[8]. Several other states rely on utilization projections or do not include any formula to define the maximum or minimum number of inpatient rehabilitation beds. Therefore, the regulations in other states provide only minimal guidance regarding how Maryland should define the appropriate supply of inpatient rehabilitation facilities and bed capacity. Published research also fails to provide support for a precise numerical definition of the appropriate level of utilization of inpatient rehabilitation services at a regional or state level.

Without a widely adopted standard regarding the appropriate capacity and utilization of inpatient rehabilitation services at a regional or state level, it is appropriate to create a projected range of need. It is also reasonable to use the statewide average utilization of services as one of the parameters that defines the projected range, as included in this State Health Plan Chapter, when there is wide variation in the discharge rates for HPRs that persists over time. Compared to other states, Maryland does not appear to be a clear outlier with very high or very low utilization levels of acute inpatient rehabilitation services.[9]

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[5] *Id.*

[6] HealthSouth Chesapeake Rehabilitation Hospital, a specialized hospital dedicated to the provision of acute rehabilitation services, has a waiver from HSCRC rate regulation. It is reimbursed under Medicare payment policy.

[7] Or. Admin. R. 333-645-0030 (current through June 15, 2013). <http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_333/333_645.html>

[8] Ala. Admin. Code r. 410-2-4.08 (last updated March 31, 2010) http://www.alabamaadministrativecode.state.al.us/docs/hp/410-2-3.pdf and .

[9] Commission staff analysis of discharge abstract data for Maryland hospitals and District of Columbia hospitals for CY2007-CY2011; 2008 data in the Centers for Medicare and Medicaid Services' Chronic Conditions Warehouse < http://ccwdata.org/index.php>.

Access to Care

The Medicare Payment Advisory Commission's (MEDPAC) March 2012 annual report to Congress concludes that access to acute inpatient rehabilitation services is not a problem for the Medicare population, which comprised approximately 60 percent of discharges from acute rehabilitation providers in 2010, because of the relatively stable number of providers and available beds.[10] However, there is wide variation in the use and availability of these services nationally[11] and in Maryland, and research suggests that the distance to providers, relative to a patient's residence may be a more powerful predictor of the use of acute inpatient rehabilitation services than the clinical characteristics of patients.[12]

Quality of Care

Individuals should be served by acute inpatient rehabilitation programs that appropriately meet their need for rehabilitative services based on evidence. Pediatric patients and individuals who have spinal cord or brain injuries should be served by programs staffed and equipped to best meet their specific needs. Such programs should serve a sufficient number of patients with specialized or complex needs that proficiency in care delivery can be developed.

To some extent, skilled nursing facilities may substitute for acute inpatient rehabilitation services. Several studies have focused on whether one setting is better than the other for various conditions, such as stroke, hip fracture, and joint replacements. There is some evidence that suggests stroke victims achieve greater functional gain with the more intense IRF setting than in SNFs.[13] The evidence regarding patients with hip fractures is mixed, with some studies concluding that such patients have better health outcomes in IRFs, and other studies concluding that there is not a difference.[14] For joint replacement patients, one recent study concluded that the advantage of either setting is not clear-cut.[15] The PAC-PRD project led to some conclusions about the relative benefit of IRFs compared to SNFs for certain types of patients. Patients with nervous system disorder, including stroke patients had 32 percent better functional improvement

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[10] Medicare Payment Advisory Commission. "Report to the Congress: Medicare payment Policy." Washington (DC): MedPAC; March 2012. <http://www.medpac.gov/chapters/Mar12_Ch09.pdf>

[11] Kane, R.L., Lin, W., Blewett, L.A. "Geographic Variation in the Use of Post-acute Care." *Health Services Research* 37(3): 667-682. Gage, B., Morley, M., Spain, P., Ingber, M. "Examining Post Acute Care Relationships in an Integrated Hospital System Final Report." February 2009. <http://aspe.hhs.gov/health/reports/09/pacihs/report.shtml >.

[12] Buntin, M.B., Garten, A.D., Paddock, S., Saliba, D., Totten, M., and Escarce, J.J. "How Much Is Postacute Care Use Affected by Its Availability?" *Health Services Research* 40(2): 413-34.

[13] Buntin, M.B., Colla, C.H., Deb, P., Sood, N., and Escarce, J.J. "Medicare Spending and Outcomes After Postacute Care for Stroke and Hip Fracture." *Medical Care.* 48(9):776-84.

[14] Buntin, M.B., Colla, C.H., Deb, P., Sood, N., and Escarce, J.J. "Medicare Spending and Outcomes After Postacute Care for Stroke and Hip Fracture." *Medical Care.* 48(9):776-84. Chan L, Sandel ME, Jette AM, Appelman J, Brandt DE, Cheng P, Teselle M, Delmonico R, Terdiman JF, Rasch EK. "Does Postacute Care Site Matter? A Longitudinal Study Assessing Functional Recovery After a Stroke." *Archives of Physical Medicine and Rehabilitation.* 93 (12):1067-2.

[15] Tian, W., DeJong, G. Horn, S.D., Putman, K., Hsieh, C., DaVanzo, J.E. "Efficient Rehabilitation Care for Joint Replacement Patients: Skilled Nursing Facility or Inpatient Rehabilitation Facility?" *Medical Decision Making*. 32(1):176-87.

in self care than SNF patients at discharge, after controlling for patient case-mix characteristics.[16] For musculoskeletal cases, there were no significant differences in self-care outcomes for patients in SNFs compared to IRFs.[17] Evidence regarding the best setting for certain types of patients may be an important consideration in determining whether access barriers exist.

Need for Capacity

In the past, the Commission has often relied on historic information on discharges, average length of stay, and projected population change to project demand for hospital facilities and services and the need for capacity implied by demand forecasts. Due to recent and anticipated changes that may significantly alter the capacity required for acute inpatient utilization,[18] a need projection based on historic patterns should not be the sole factor used to determine whether additional acute inpatient rehabilitation capacity is required. In addition, the wide variation in the use of acute rehabilitation beds among HPRs in Maryland suggests that there could be access barriers for some residents. Therefore, the possibility that access barriers are negatively affecting some Maryland residents should be considered as part of evaluating changes in the delivery system for acute inpatient rehabilitation.

Policy 1: Acute inpatient rehabilitation services will be provided in the most cost-effective manner possible consistent with appropriately meeting the health care needs of patients.

Policy 2: The efficient use of resources will be promoted; over and under-utilization of inpatient rehabilitation services will be discouraged.

Policy 3: A provider of acute inpatient rehabilitation services will provide high quality care.

Policy 4: Acute inpatient rehabilitation will be financially and geographically accessible to the extent possible consistent with efficiently meeting the health care needs of patients.

Policy 5: A provider of acute inpatient rehabilitation services should consider smart and sustainable growth policies as well as green design principles in facility or center design choices.

Policy 6: A provider of acute inpatient rehabilitation services will continuously and systematically work to improve the quality and safety of patient care. This includes planning, implementing, and optimizing the use of electronic health record systems and

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[16] Gage, B., Morley, M., Smith, L., Ingber, M.J., Deutsch, A., Kline, T., Dever, J., Abbate, J. Miller, R., Lyda-McDonald, B., Kelleher, C., Garfinkel, D., Manning, J. Murtaugh, C.M., Stineman, M., Mallinson, T. "Post-Acute Care Payment Reform Demonstration: Final Report Volume 1 of 4." March 2012. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/PAC-PRD_FinalRpt_Vol1of4.pdf>

[17] *Id.*

[18] United States. Centers for Medicare and Medicaid Services. (2013, May 8). *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal year 2014; Proposed Rule*. <http://www.gpo.gov/fdsys/pkg/FR-2013-05-08/html/2013-10755.htm>.

electronic health information exchange that contribute to infection control, care coordination, patient safety, and quality improvement.

.04 Standards.

A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

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

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

(2) Quality of Care.

A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally

B. Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not included the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that

offers the best balance between program effectiveness and costs to the health care system as a whole.

.05 Methodology for Projecting Adult Acute Rehabilitation Bed Need.

Adult acute rehabilitation bed need is projected using the following methodology. There is no need projection for pediatric acute inpatient rehabilitation beds. The need for pediatric acute rehabilitation beds will be evaluated on a case-by-case basis, considering the needs assessment provided by the applicant.

A. Period of Time Covered.

(1) The base year from which projections are calculated is the most recent calendar year for which discharge abstract data is available from Maryland and District of Columbia acute general hospitals and special hospitals that provide acute inpatient rehabilitation services.

(2) The target year for which projections are calculated is five years after the base year.

B. Services and Age Groups.

Use rates (discharges per thousand population) for the following age groups will be calculated: under 18; 18 to 44; 45 to 64; 65 to 74; and 75 and over. The rate for the under 18 age group will be calculated based only on discharges from Maryland hospitals that are not providers of specialized pediatric acute inpatient rehabilitation services.

C. Geographic Areas.

The need for acute rehabilitation hospital bed capacity will be calculated for each of the five health planning regions defined in this Chapter.

(1) The Eastern Shore is comprised of Caroline, Dorchester, Kent, Queen Anne's, Talbot, Somerset, Wicomico, and Worcester Counties.

(2) Southern Maryland is comprised of Charles, Calvert, Prince George's, and St. Mary's Counties.

(3) Montgomery County is comprised of Montgomery County.

(4) Central Maryland is comprised of Baltimore City and Anne Arundel, Baltimore, Carroll, Cecil, Harford, and Howard Counties.

(5) Western Maryland is comprised of Allegany, Frederick, Garrett, and Washington Counties.

D. Assumptions.

(1) Interstate patterns of migration from states bordering Maryland (Delaware, District of Columbia, Pennsylvania, Virginia, and West Virginia), by age group, will be accounted for in the baseline projection at the health planning region level, using the most recent population projections developed for official state government use in the applicable states. Discharges and days for patients from non-bordering states, foreign countries, or unidentified locations will be held constant as a proportion of total days from the base year to the target year for each health planning region.

(2) Health planning region target year discharge rates are calculated as follows:

(a) Calculate the average annual rates of discharges per thousand population by age group for Maryland residents by HPR for the most recent five-year period available. For residents of border states (Delaware, District of Columbia, Pennsylvania, Virginia, West Virginia), calculate a discharge rate per thousand population based on discharges from Maryland hospitals, for the most recent five-year period available.

(b) Calculate the statewide average annual rates of discharges per thousand population by age group for all Maryland residents, excluding Maryland residents from unidentified counties, for the most recent five-year period available.

(c) Determine the minimum target year projected discharge rate for each age group in each HPR by choosing the lower of either the five-year average annual discharge rate per 1,000 population calculated for the HPR or the five-year statewide average discharge rate per 1,000 population.

(d) Determine the maximum target year projected discharge rate for each age group in each HPR by choosing the higher of either the five-year average annual discharge rate per 1,000 population by the projected population for the HPR or the five-year statewide average discharge rate per 1,000 population.

(e) Both the minimum and maximum target year projected discharge rate for residents in each age group from bordering states will be the five-year average annual discharge rate per 1,000 population.

(3) Health planning region target year average lengths of stay (ALOS) are calculated as follows:

(a) Calculate the average length of stay for each of the most recent five years of data by dividing the total number of days by the total number of discharges by geographic location and age group. Then add the calculated ALOS for each group for all five years and divide by five.

(4) Health planning region bed capacity is calculated as follows:

(a) Sum the total number of beds licensed for acute rehabilitation services, by HPR; and

(b) For beds dually licensed for chronic care and acute rehabilitation, the number of acute rehabilitation beds will be based on the average daily census for chronic and acute rehabilitation patients and the proportion of beds available for acute rehabilitation patients.

(5) Minimum Occupancy Standard.

(a) The minimum occupancy standards used in calculating gross bed need are based on the average daily census projected for the HPR, applied at the hospital level, and are as follows:

Average Daily Census	***Minimum Percent Occupancy***
0-49	75%
50-99	80%
100+	85%

E. Data Sources.

(1) Acute Rehabilitation Discharges.

(a) For patient discharges from Maryland hospitals with licensed acute rehabilitation beds, records with nature of admission coded as rehabilitation or DRG 462 are counted as acute rehabilitation discharges for years 2007-09. For years 2010 to the present, hospital discharges with DRG codes 945 or 946 and nature of admission coded as rehabilitation and counted as acute rehabilitation discharges. Hospital discharges, regardless of the DRG code, with type of daily service coded as rehabilitation are also counted. The DRG codes used to count acute rehabilitation discharges may change to achieve consistency in counting these discharges, as DRG codes are updated. Notice of changes in the DRG codes used to count acute rehabilitation discharges will be published on the Maryland Health Care Commission's website and in the *Maryland Register*.

(b) For discharges from District of Columbia hospitals, for all years, only patients age 18 and older are counted. For years 2007-09, records with DRG 462 are counted as acute rehabilitation discharges. For years 2010 to the present, acute rehabilitation discharges with updated DRG codes that correspond to DRG 462 will be counted. In version 28 of DRG codes, the DRG 462 is replaced by DRGs 945 and 946. The DRG codes used to count rehabilitation discharges may change to achieve consistency in counting these discharges, as DRG codes are updated. Notice of changes in the DRG codes used to count acute rehabilitation discharges will be published on the Maryland Health Care Commission's website and in the *Maryland Register*.

(2) Population.

(a) Base year population data, by area of residence and age, is obtained from the following sources.

(i) Maryland population is obtained from the most recent Maryland Department of Planning projections; and

(ii) Population in other states is obtained from the most recent projections prepared by respective state agencies charged with preparing the projections, or from the U.S. Census Bureau.

(b) Projections of future target year population, by area of residence and age, are obtained from the following sources:

(i) Maryland population is obtained from the most recent Maryland Department of Planning projections; and

(ii) Population in other states is obtained from the most recent projections prepared by respective state agencies charged with preparing the projections, or from the U.S. Census Bureau.

F. Method of Calculation to Project Need.

(1) Adjusted Utilization for In and Out-migration of Patients Across Regions.
The minimum and maximum projected number of days for each HPR shall be adjusted for utilization patterns by multiplying the number of days projected for each age group and geographic location by the proportion of days that are attributable to each region in the base year, for each age group and geographic location.

(2) Calculation of Minimum Bed Days.
Multiply the minimum ALOS by the minimum discharge rate and projected population in the target year, for each age group and geographic location (HPR and bordering states).

(3) Calculation of Maximum Bed Days.
Multiply the maximum ALOS by the maximum discharge rate and projected population in the target year, for each age group and geographic location (HPR and bordering states).

(4) Calculation of "Other Bed Days."
Multiply the proportion of bed days in the base year that account for residents from unknown or foreign locations or non-bordering states by the projected number of days for each age group in each health planning region in the target year.

(5) Gross and Net Bed Need Projection.

(a) Before including the calculated "Other Bed Days," multiply the minimum projected number of days for each age group and patient location by the proportion of

discharges from each location that were served in each health planning region in the base year. Then, for each HPR, sum the total number of projected days across all age groups. Lastly, for each HPR, add the respective calculated "Other Bed Days" to the total projected days across all ages for each HPR. This is the minimum adjusted projected number of bed days.

(b) Before including the calculated "Other Bed Days," multiply the maximum projected number of days for each age group and location by the proportion of discharges from each location that were served in each HPR in the base year. For each age group, except those under 18, if the out-migration for residents of the HPR is greater than 50 percent, and the discharge rate is below the statewide average, then the maximum projected days for those residents should be multiplied by the overall statewide average percentage of residents that receive care in the HPR in which they reside. Then, for each health planning region, sum the total number of projected days across all age groups. Lastly, for each HPR add the respective calculated "Other Bed Days" to the total projected days across all ages. This is the maximum adjusted projected number of bed days.

(c) Calculate the range of gross bed need for acute rehabilitation services by dividing the minimum and maximum adjusted projected number of bed days from both (5)(a) and (5)(b) above by the total number of days in the target year and then dividing by the minimum occupancy standard, for each health planning region.

(d) Calculate the range of net bed need for acute rehabilitation services by subtracting the licensed bed capacity and any beds approved through certificate of need that have not yet been developed, for each health planning region from the range of gross bed need, unless it is known that the licensed bed capacity of a facility is different from its physical bed capacity. Then, the physical capacity will be used instead of licensed bed capacity for the calculation of gross bed need. For dually licensed chronic/rehabilitation beds, the number of available rehabilitation beds will be the total number of beds, less the average daily census for chronic care patients that exceeds the number of dedicated chronic care beds, adjusted by the minimum occupancy standard in this Chapter.

(e) The gross and net bed need by health planning region will be published as a notice in the *Maryland Register*. This need projection will be applicable to the evaluation of bed need in certificate of need projects reviewed by the Commission, except as noted in this Chapter.

G. Interpretation of Bed Need Projection.

If there is a negative bed need projection, it means there may be an excess number of beds. If there is a positive bed need projection, it means there may be a need for additional beds. If the bed need projection spans both negative and positive values, it means there may or may not be an excess number of beds. In general, an applicant that proposes a project that would increase bed capacity above the minimum projected bed need faces the greater burden of demonstrating that additional beds are required.

.06 Definitions.

A. In this Chapter, the following terms have the meanings indicated.

B. Terms defined.

(1) "Access barrier" is an obstacle that prevents or strongly discourages patients from obtaining medically necessary acute inpatient rehabilitation services.

(2) "Acute inpatient rehabilitation" (or "acute rehabilitation") means an intensive rehabilitation therapy program as described in 42 CFR Part 412. It generally consists of at least three hours of therapy per day in multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) at least five days per week. One of the therapy disciplines provided must be physical or occupational therapy. In addition, it is a program that requires physician supervision by a licensed rehabilitation physician. This supervision must consist of face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

(3) "Average daily census (ADC)" means, over a 12-month period, the average number of inpatients receiving service on any given day; a figure calculated by dividing the total inpatient days per year by the number of days in a year.

(4) "Average length of stay (ALOS)" means, over a 12-month period, the average duration of inpatient stay expressed in days as determined by dividing total inpatient days by total discharges.

(5) "Certificate of need-approved (CON-approved)" means those beds for which a certificate of need has been obtained from the Maryland Health Care Commission, consistent with COMAR 10.24.01, but that are not yet licensed.

(6) "Commission" means the Maryland Health Care Commission.

(7) "Green design principles" means the design principles outlined in the LEED® for Healthcare Rating System of the U.S. Green Building Council.

(8) "Health Planning Region (HPR)" means an area designated in this Chapter for the purpose of planning for acute inpatient rehabilitation services.

(9) "Indigent" means a person without insurance who does not qualify for public insurance and who lives in a household with an income level at or below 300 percent of the current federal poverty level.

(10) "Jurisdiction" means a Maryland county or Baltimore City.

(11) "Licensed" means a facility that has received approval to operate from the Office of Health Care Quality of the Department of Health and Mental Hygiene.

(12) "Occupancy rate" means a number calculated by dividing a facility's average daily census in a given time period by its total number of licensed beds in the same time period, numerically expressed as a percentage. It measures the average percentage of a facility's licensed beds that were occupied during a specific time period. It may be calculated for a facility, department, or service.

(13) "Pediatric" means patients who are less than 18 years of age.

(14) "Specialized Acute Rehabilitation Services" refers to the acute inpatient rehabilitation services needed by pediatric patients, patients with brain injuries, patients with spinal cord injuries, or other patients with complex medical needs that are best met through a select group of providers of acute rehabilitation services, such as those with accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) in relevant specialty areas.